

Bill No. CS for SB 12-C, 1st Eng.

Barcode 254710

	CHAMBER ACTION	
<u>Senate</u>		<u>House</u>

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11 The Conference Committee on CS for SB 12-C, 1st Eng.
 12 recommended the following amendment:

14 **Conference Committee Amendment (with title amendment)**

15 Delete everything after the enacting clause

17 and insert:

18 Section 1. Paragraph (f) of subsection (3) of section
 19 393.0661, Florida Statutes, is amended to read:

20 393.0661 Home and community-based services delivery
 21 system; comprehensive redesign.--The Legislature finds that
 22 the home and community-based services delivery system for
 23 persons with developmental disabilities and the availability
 24 of appropriated funds are two of the critical elements in
 25 making services available. Therefore, it is the intent of the
 26 Legislature that the Agency for Persons with Disabilities
 27 shall develop and implement a comprehensive redesign of the
 28 system.

29 (3) The Agency for Health Care Administration, in
 30 consultation with the agency, shall seek federal approval and
 31 implement a four-tiered waiver system to serve clients with

Bill No. CS for SB 12-C, 1st Eng.

Barcode 254710

1 developmental disabilities in the developmental disabilities
 2 and family and supported living waivers. The agency shall
 3 assign all clients receiving services through the
 4 developmental disabilities waiver to a tier based on a valid
 5 assessment instrument, client characteristics, and other
 6 appropriate assessment methods. All services covered under the
 7 current developmental disabilities waiver shall be available
 8 to all clients in all tiers where appropriate, except as
 9 otherwise provided in this subsection or in the General
 10 Appropriations Act.

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

14 1. Supported living coaching services shall not exceed
 15 20 hours per month for persons who also receive in-home
 16 support services.

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

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

27 4. Residential habilitation services shall be limited
 28 to 8 hours per day. Additional hours may be authorized for
 29 persons who have intensive medical or adaptive needs and if
 30 such hours are essential for avoiding institutionalization, or
 31 for persons who possess behavioral problems that are

Bill No. CS for SB 12-C, 1st Eng.

Barcode 254710

1 exceptional in intensity, duration, or frequency and present a
2 substantial risk of harming themselves or others. This
3 restriction shall be in effect until the four-tiered waiver
4 system is fully implemented.

5 5. Chore Services, nonresidential support services,
6 and homemaker services shall be eliminated. The agency shall
7 expand the definition of in-home support services to enable
8 the provider of the service to include activities previously
9 provided in these eliminated services.

10 6. Massage therapy and psychological assessment
11 services shall be eliminated.

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

16 8. The agency shall implement a consolidated
17 residential habilitation rate structure to increase savings to
18 the state through a more cost-effective payment method and
19 establish uniform rates for intensive behavioral residential
20 habilitation services.

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

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

31 Personal Care Assistance services shall be limited to

Bill No. CS for SB 12-C, 1st Eng.

Barcode 254710

1 no more than 180 hours per calendar month and shall not
 2 include rate modifiers. Additional hours may be authorized for
 3 persons who have intensive physical, medical, or adaptive
 4 needs if such hours are essential for avoiding
 5 institutionalization ~~only if a substantial change in~~
 6 ~~circumstances occurs for the individual.~~

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

10 409.908 Reimbursement of Medicaid providers.--Subject
 11 to specific appropriations, the agency shall reimburse
 12 Medicaid providers, in accordance with state and federal law,
 13 according to methodologies set forth in the rules of the
 14 agency and in policy manuals and handbooks incorporated by
 15 reference therein. These methodologies may include fee
 16 schedules, reimbursement methods based on cost reporting,
 17 negotiated fees, competitive bidding pursuant to s. 287.057,
 18 and other mechanisms the agency considers efficient and
 19 effective for purchasing services or goods on behalf of
 20 recipients. If a provider is reimbursed based on cost
 21 reporting and submits a cost report late and that cost report
 22 would have been used to set a lower reimbursement rate for a
 23 rate semester, then the provider's rate for that semester
 24 shall be retroactively calculated using the new cost report,
 25 and full payment at the recalculated rate shall be effected
 26 retroactively. Medicare-granted extensions for filing cost
 27 reports, if applicable, shall also apply to Medicaid cost
 28 reports. Payment for Medicaid compensable services made on
 29 behalf of Medicaid eligible persons is subject to the
 30 availability of moneys and any limitations or directions
 31 provided for in the General Appropriations Act or chapter 216.

Bill No. CS for SB 12-C, 1st Eng.

Barcode 254710

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

8 (2)

9 (b) Subject to any limitations or directions provided
 10 for in the General Appropriations Act, the agency shall
 11 establish and implement a Florida Title XIX Long-Term Care
 12 Reimbursement Plan (Medicaid) for nursing home care in order
 13 to provide care and services in conformance with the
 14 applicable state and federal laws, rules, regulations, and
 15 quality and safety standards and to ensure that individuals
 16 eligible for medical assistance have reasonable geographic
 17 access to such care.

18 ~~1. Changes of ownership or of licensed operator may or~~
 19 ~~may not qualify for increases in reimbursement rates~~
 20 ~~associated with the change of ownership or of licensed~~
 21 ~~operator. The agency may amend the Title XIX Long Term Care~~
 22 ~~Reimbursement Plan to provide that the initial nursing home~~
 23 ~~reimbursement rates, for the operating, patient care, and MAR~~
 24 ~~components, associated with related and unrelated party~~
 25 ~~changes of ownership or licensed operator filed on or after~~
 26 ~~September 1, 2001, are equivalent to the previous owner's~~
 27 ~~reimbursement rate.~~

28 1.2. The agency shall amend the long-term care
 29 reimbursement plan and cost reporting system to create direct
 30 care and indirect care subcomponents of the patient care
 31 component of the per diem rate. These two subcomponents

Bill No. CS for SB 12-C, 1st Eng.

Barcode 254710

1 together shall equal the patient care component of the per
2 diem rate. Separate cost-based ceilings shall be calculated
3 for each patient care subcomponent. The direct care
4 subcomponent of the per diem rate shall be limited by the
5 cost-based class ceiling, and the indirect care subcomponent
6 may be limited by the lower of the cost-based class ceiling,
7 the target rate class ceiling, or the individual provider
8 target.

9 ~~2.3.~~ The direct care subcomponent shall include
10 salaries and benefits of direct care staff providing nursing
11 services including registered nurses, licensed practical
12 nurses, and certified nursing assistants who deliver care
13 directly to residents in the nursing home facility. This
14 excludes nursing administration, minimum data set, and care
15 plan coordinators, staff development, and staffing
16 coordinator.

17 ~~3.4.~~ All other patient care costs shall be included in
18 the indirect care cost subcomponent of the patient care per
19 diem rate. There shall be no costs directly or indirectly
20 allocated to the direct care subcomponent from a home office
21 or management company.

22 ~~4.5.~~ On July 1 of each year, the agency shall report
23 to the Legislature direct and indirect care costs, including
24 average direct and indirect care costs per resident per
25 facility and direct care and indirect care salaries and
26 benefits per category of staff member per facility.

27 ~~5.6.~~ In order to offset the cost of general and
28 professional liability insurance, the agency shall amend the
29 plan to allow for interim rate adjustments to reflect
30 increases in the cost of general or professional liability
31 insurance for nursing homes. This provision shall be

Bill No. CS for SB 12-C, 1st Enq.

Barcode 254710

1 implemented to the extent existing appropriations are
2 available.

3
4 It is the intent of the Legislature that the reimbursement
5 plan achieve the goal of providing access to health care for
6 nursing home residents who require large amounts of care while
7 encouraging diversion services as an alternative to nursing
8 home care for residents who can be served within the
9 community. The agency shall base the establishment of any
10 maximum rate of payment, whether overall or component, on the
11 available moneys as provided for in the General Appropriations
12 Act. The agency may base the maximum rate of payment on the
13 results of scientifically valid analysis and conclusions
14 derived from objective statistical data pertinent to the
15 particular maximum rate of payment.

16 (13) Medicare premiums for persons eligible for both
17 Medicare and Medicaid coverage shall be paid at the rates
18 established by Title XVIII of the Social Security Act. For
19 Medicare services rendered to Medicaid-eligible persons,
20 Medicaid shall pay Medicare deductibles and coinsurance as
21 follows:

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

23 1. Medicaid payments for Nursing Home Medicare part A
24 coinsurance shall be limited to the lesser of the Medicare
25 coinsurance amount or the Medicaid nursing home per diem rate
26 less any amounts paid by Medicare, but only up to the amount
27 of Medicare coinsurance. The Medicaid per diem rate shall be
28 the rate in effect for the dates of service of the crossover
29 claims and may not be subsequently adjusted due to subsequent
30 per diem rate adjustments.

31 2. Medicaid shall pay all deductibles and coinsurance

Bill No. CS for SB 12-C, 1st Eng.

Barcode 254710

1 for Medicare-eligible recipients receiving freestanding end
2 stage renal dialysis center services.

3 3. Medicaid payments for general hospital inpatient
4 services shall be limited to the Medicare deductible per spell
5 of illness. Medicaid shall make no payment toward coinsurance
6 for Medicare general hospital inpatient services.

7 4. Medicaid shall pay all deductibles and coinsurance
8 for Medicare emergency transportation services provided by
9 ambulances licensed pursuant to chapter 401.

10 Section 4. Paragraph (b) of subsection (4) of section
11 409.912, Florida Statutes, is amended to read:

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

Bill No. CS for SB 12-C, 1st Eng.

Barcode 254710

1 inappropriate or unnecessary use of high-cost services. The
2 agency shall contract with a vendor to monitor and evaluate
3 the clinical practice patterns of providers in order to
4 identify trends that are outside the normal practice patterns
5 of a provider's professional peers or the national guidelines
6 of a provider's professional association. The vendor must be
7 able to provide information and counseling to a provider whose
8 practice patterns are outside the norms, in consultation with
9 the agency, to improve patient care and reduce inappropriate
10 utilization. The agency may mandate prior authorization, drug
11 therapy management, or disease management participation for
12 certain populations of Medicaid beneficiaries, certain drug
13 classes, or particular drugs to prevent fraud, abuse, overuse,
14 and possible dangerous drug interactions. The Pharmaceutical
15 and Therapeutics Committee shall make recommendations to the
16 agency on drugs for which prior authorization is required. The
17 agency shall inform the Pharmaceutical and Therapeutics
18 Committee of its decisions regarding drugs subject to prior
19 authorization. The agency is authorized to limit the entities
20 it contracts with or enrolls as Medicaid providers by
21 developing a provider network through provider credentialing.
22 The agency may competitively bid single-source-provider
23 contracts if procurement of goods or services results in
24 demonstrated cost savings to the state without limiting access
25 to care. The agency may limit its network based on the
26 assessment of beneficiary access to care, provider
27 availability, provider quality standards, time and distance
28 standards for access to care, the cultural competence of the
29 provider network, demographic characteristics of Medicaid
30 beneficiaries, practice and provider-to-beneficiary standards,
31 appointment wait times, beneficiary use of services, provider

Bill No. CS for SB 12-C, 1st Eng.

Barcode 254710

1 turnover, provider profiling, provider licensure history,
 2 previous program integrity investigations and findings, peer
 3 review, provider Medicaid policy and billing compliance
 4 records, clinical and medical record audits, and other
 5 factors. Providers shall not be entitled to enrollment in the
 6 Medicaid provider network. The agency shall determine
 7 instances in which allowing Medicaid beneficiaries to purchase
 8 durable medical equipment and other goods is less expensive to
 9 the Medicaid program than long-term rental of the equipment or
 10 goods. The agency may establish rules to facilitate purchases
 11 in lieu of long-term rentals in order to protect against fraud
 12 and abuse in the Medicaid program as defined in s. 409.913.
 13 The agency may seek federal waivers necessary to administer
 14 these policies.

15 (4) The agency may contract with:

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

Bill No. CS for SB 12-C, 1st Eng.

Barcode 254710

1 developing the behavioral health care prepaid plan procurement
2 document, the agency shall ensure that the procurement
3 document requires the contractor to develop and implement a
4 plan to ensure compliance with s. 394.4574 related to services
5 provided to residents of licensed assisted living facilities
6 that hold a limited mental health license. Except as provided
7 in subparagraph 8., and except in counties where the Medicaid
8 managed care pilot program is authorized pursuant to s.
9 409.91211, the agency shall seek federal approval to contract
10 with a single entity meeting these requirements to provide
11 comprehensive behavioral health care services to all Medicaid
12 recipients not enrolled in a Medicaid managed care plan
13 authorized under s. 409.91211 or a Medicaid health maintenance
14 organization in an AHCA area. In an AHCA area where the
15 Medicaid managed care pilot program is authorized pursuant to
16 s. 409.91211 in one or more counties, the agency may procure a
17 contract with a single entity to serve the remaining counties
18 as an AHCA area or the remaining counties may be included with
19 an adjacent AHCA area and shall be subject to this paragraph.
20 Each entity must offer sufficient choice of providers in its
21 network to ensure recipient access to care and the opportunity
22 to select a provider with whom they are satisfied. The network
23 shall include all public mental health hospitals. To ensure
24 unimpaired access to behavioral health care services by
25 Medicaid recipients, all contracts issued pursuant to this
26 paragraph shall require 80 percent of the capitation paid to
27 the managed care plan, including health maintenance
28 organizations, to be expended for the provision of behavioral
29 health care services. In the event the managed care plan
30 expends less than 80 percent of the capitation paid pursuant
31 to this paragraph for the provision of behavioral health care

Bill No. CS for SB 12-C, 1st Eng.

Barcode 254710

1 services, the difference shall be returned to the agency. The
 2 agency shall provide the managed care plan with a
 3 certification letter indicating the amount of capitation paid
 4 during each calendar year for the provision of behavioral
 5 health care services pursuant to this section. The agency may
 6 reimburse for substance abuse treatment services on a
 7 fee-for-service basis until the agency finds that adequate
 8 funds are available for capitated, prepaid arrangements.

9 1. By January 1, 2001, the agency shall modify the
 10 contracts with the entities providing comprehensive inpatient
 11 and outpatient mental health care services to Medicaid
 12 recipients in Hillsborough, Highlands, Hardee, Manatee, and
 13 Polk Counties, to include substance abuse treatment services.

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

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

Bill No. CS for SB 12-C, 1st Eng.

Barcode 254710

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

Bill No. CS for SB 12-C, 1st Eng.

Barcode 254710

1 409.9122(2)(k), a minimum of 50,000 of those MediPass-enrolled
2 recipients shall be assigned to the existing provider service
3 network in area 11 for their behavioral care.

4 4. By October 1, 2003, the agency and the department
5 shall submit a plan to the Governor, the President of the
6 Senate, and the Speaker of the House of Representatives which
7 provides for the full implementation of capitated prepaid
8 behavioral health care in all areas of the state.

9 a. Implementation shall begin in 2003 in those AHCA
10 areas of the state where the agency is able to establish
11 sufficient capitation rates.

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

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

24 5. Children residing in a statewide inpatient
25 psychiatric program, or in a Department of Juvenile Justice or
26 a Department of Children and Family Services residential
27 program approved as a Medicaid behavioral health overlay
28 services provider shall not be included in a behavioral health
29 care prepaid health plan or any other Medicaid managed care
30 plan pursuant to this paragraph.

31 6. In converting to a prepaid system of delivery, the

Bill No. CS for SB 12-C, 1st Eng.

Barcode 254710

1 agency shall in its procurement document require an entity
 2 providing only comprehensive behavioral health care services
 3 to prevent the displacement of indigent care patients by
 4 enrollees in the Medicaid prepaid health plan providing
 5 behavioral health care services from facilities receiving
 6 state funding to provide indigent behavioral health care, to
 7 facilities licensed under chapter 395 which do not receive
 8 state funding for indigent behavioral health care, or
 9 reimburse the unsubsidized facility for the cost of behavioral
 10 health care provided to the displaced indigent care patient.

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

19 8. For fiscal year 2004-2005, all Medicaid eligible
 20 children, except children in areas 1 and 6, whose cases are
 21 open for child welfare services in the HomeSafeNet system,
 22 shall be enrolled in MediPass or in Medicaid fee-for-service
 23 and all their behavioral health care services including
 24 inpatient, outpatient psychiatric, community mental health,
 25 and case management shall be reimbursed on a fee-for-service
 26 basis. Beginning July 1, 2005, such children, who are open for
 27 child welfare services in the HomeSafeNet system, shall
 28 receive their behavioral health care services through a
 29 specialty prepaid plan operated by community-based lead
 30 agencies either through a single agency or formal agreements
 31 among several agencies. The specialty prepaid plan must result

Bill No. CS for SB 12-C, 1st Eng.

Barcode 254710

1 in savings to the state comparable to savings achieved in
 2 other Medicaid managed care and prepaid programs. Such plan
 3 must provide mechanisms to maximize state and local revenues.
 4 The specialty prepaid plan shall be developed by the agency
 5 and the Department of Children and Family Services. The agency
 6 is authorized to seek any federal waivers to implement this
 7 initiative. Medicaid-eligible children whose cases are open
 8 for child welfare services in the HomeSafeNet system and who
 9 reside in AHCA area 10 are exempt from the specialty prepaid
 10 plan upon the development of a service delivery mechanism for
 11 children who reside in area 10 as specified in s.
 12 409.91211(3)(dd).

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

15 409.9122 Mandatory Medicaid managed care enrollment;
 16 programs and procedures.--

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

31 Section 6. Effective March 1, 2008, paragraph (k) of

Bill No. CS for SB 12-C, 1st Eng.

Barcode 254710

1 subsection (2) of section 409.9122, Florida Statutes, is
2 amended to read:

3 409.9122 Mandatory Medicaid managed care enrollment;
4 programs and procedures.--

5 (2)

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

Bill No. CS for SB 12-C, 1st Eng.

Barcode 254710

1 the General Appropriations Act. When making assignments, the
2 agency shall take into account the following criteria:

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

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

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

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

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

19 Section 7. Paragraph (dd) of subsection (3) of section
20 409.91211, Florida Statutes, is amended to read:

21 409.91211 Medicaid managed care pilot program.--

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

25 (dd) To implement ~~develop and recommend~~ service
26 delivery mechanisms within capitated managed care plans to
27 provide Medicaid services as specified in ss. 409.905 and
28 409.906 to Medicaid-eligible children whose cases are open for
29 child welfare services in the HomeSafeNet system ~~in foster~~
30 ~~care~~. These services must be coordinated with community-based
31 care providers as specified in s. 409.1671 ~~s. 409.1675~~, where

Bill No. CS for SB 12-C, 1st Eng.

Barcode 254710

1 available, and be sufficient to meet the medical,
 2 developmental, behavioral, and emotional needs of these
 3 children. These service delivery mechanisms must be
 4 implemented no later than July 1, 2008, in AHCA area 10 in
 5 order for the children in AHCA area 10 to remain exempt from
 6 the statewide plan under s. 409.912(4)(b)8.

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

9
 10

11 ===== T I T L E A M E N D M E N T =====

12 And the title is amended as follows:

13 Delete everything before the enacting clause

14

15 and insert:

16 A bill to be entitled
 17 An act relating to health care; amending s.
 18 393.0661, F.S.; providing for additional hours
 19 to be authorized under the personal care
 20 assistance services provided pursuant to a
 21 federal waiver program and administered by the
 22 Agency for Persons with Disabilities; amending
 23 a specified portion of proviso in Specific
 24 Appropriation 270 in chapter 2007-72, Laws of
 25 Florida; amending s. 409.908, F.S.; deleting a
 26 provision providing that an operator of a
 27 Medicaid nursing home may qualify for an
 28 increased reimbursement rate due to a change of
 29 ownership or licensed operator; providing a
 30 limitation on the reimbursement rates for
 31 Medicaid payments to nursing homes; amending s.

Bill No. CS for SB 12-C, 1st Eng.

Barcode 254710

1 409.912, F.S.; providing for certain children
2 who are eligible for Medicaid and who reside
3 within a specified service area of the Agency
4 for Health Care Administration to be served
5 under a service delivery mechanism other than
6 the HomeSafeNet system; amending s. 409.9122,
7 F.S.; requiring that the agency give certain
8 providers priority with respect to the
9 assignment of enrollees under the Medicaid
10 managed prepaid health plan; deleting a
11 requirement that certain recipients of
12 comprehensive behavioral health services be
13 assigned to MediPass or a managed care plan;
14 amending s. 409.91211, F.S.; clarifying the
15 duties of the agency for implementing service
16 delivery mechanisms for certain children who
17 are eligible for Medicaid; providing effective
18 dates.

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