

Amendment No. (for drafter's use only)

CHAMBER ACTION

Senate

House

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1 Representative(s) Benson offered the following:

2  
3 **Substitute Amendment for Amendment ( 563285 ) (with title**  
4 **amendment)**

5 Remove line(s) 1228-1378 and insert:

6 Section 6. Paragraphs (f), (k), and (l) of subsection (2)  
7 of section 409.9122, Florida Statutes, are amended to read:

8 409.9122 Mandatory Medicaid managed care enrollment;  
9 programs and procedures.--

10 (2)

11 (f) When an eligible a Medicaid recipient does not choose  
12 a managed care plan or MediPass provider, the agency shall  
13 assign the Medicaid recipient to a managed care plan or MediPass  
14 provider according to the following provisions:

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15        1. Effective January 1, 2006, Medicaid recipients who are  
16 subject to mandatory Medicaid managed care enrollment but who  
17 fail to make a choice shall be assigned to Medicaid managed care  
18 plans until not less than 75 percent of all Medicaid recipients  
19 eligible to choose managed care are enrolled in managed care  
20 plans. When that percentage is achieved, assignment of Medicaid  
21 recipients who fail to make a choice shall be based  
22 proportionally each period on the preferences of recipients who  
23 made a choice in the previous period. Such proportions shall be  
24 revised at least quarterly to reflect an update of the  
25 preferences of Medicaid recipients. Members of managed care  
26 plans operating under the provisions of s. 409.91211 shall not  
27 be included in the percentage calculation.

28        2. Effective July 1, 2007, Medicaid recipients who are  
29 subject to mandatory Medicaid managed care enrollment but who  
30 fail to make a choice shall be assigned to managed care plans.

31        3. For purposes of this paragraph, when referring to  
32 assignment, the term "managed care plans" includes health  
33 maintenance organizations, exclusive provider organizations,  
34 provider service networks, minority physician networks, the  
35 Children's Medical Services Network, and pediatric emergency  
36 department diversion programs authorized by this chapter or the  
37 General Appropriations Act.

38        4. In counties in which there are no managed care plans  
39 that accept Medicaid enrollees, assignment shall be to a  
40 MediPass provider.

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41 5. When assigning Medicaid recipients who fail to make a  
42 choice, the agency shall take into account the following  
43 criteria:

44 a. Network capacity is sufficient to meet the needs of  
45 members.

46 b. The recipient has an enrollment history with a managed  
47 care plan or a treatment history with one of the primary care  
48 providers within a managed care plan.

49 c. The agency has knowledge that the member has previously  
50 expressed a preference for a particular managed care plan but  
51 has failed to make a choice.

52 d. Primary care providers and specialists are  
53 geographically accessible to the recipient's residence. Medicaid  
54 recipients who are subject to mandatory assignment but who fail  
55 to make a choice shall be assigned to managed care plans until  
56 an enrollment of 40 percent in MediPass and 60 percent in  
57 managed care plans is achieved. Once this enrollment is  
58 achieved, the assignments shall be divided in order to maintain  
59 an enrollment in MediPass and managed care plans which is in a  
60 40 percent and 60 percent proportion, respectively. Thereafter,  
61 assignment of Medicaid recipients who fail to make a choice  
62 shall be based proportionally on the preferences of recipients  
63 who have made a choice in the previous period. Such proportions  
64 shall be revised at least quarterly to reflect an update of the  
65 preferences of Medicaid recipients. The agency shall  
66 disproportionately assign Medicaid-eligible recipients who are  
67 required to but have failed to make a choice of managed care

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68 ~~plan or MediPass, including children, and who are to be assigned~~  
69 ~~to the MediPass program to children's networks as described in~~  
70 ~~s. 409.912(4)(g), Children's Medical Services Network as defined~~  
71 ~~in s. 391.021, exclusive provider organizations, provider~~  
72 ~~service networks, minority physician networks, and pediatric~~  
73 ~~emergency department diversion programs authorized by this~~  
74 ~~chapter or the General Appropriations Act, in such manner as the~~  
75 ~~agency deems appropriate, until the agency has determined that~~  
76 ~~the networks and programs have sufficient numbers to be~~  
77 ~~economically operated. For purposes of this paragraph, when~~  
78 ~~referring to assignment, the term "managed care plans" includes~~  
79 ~~health maintenance organizations, exclusive provider~~  
80 ~~organizations, provider service networks, minority physician~~  
81 ~~networks, Children's Medical Services Network, and pediatric~~  
82 ~~emergency department diversion programs authorized by this~~  
83 ~~chapter or the General Appropriations Act. When making~~  
84 ~~assignments, the agency shall take into account the following~~  
85 ~~criteria:~~

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

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

92 ~~3. The agency has knowledge that the member has previously~~  
93 ~~expressed a preference for a particular managed care plan or~~

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94 ~~MediPass provider as indicated by Medicaid fee-for-service~~  
95 ~~claims data, but has failed to make a choice.~~

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

99 ~~(k) When a Medicaid recipient does not choose a managed~~  
100 ~~care plan or MediPass provider, the agency shall assign the~~  
101 ~~Medicaid recipient to a managed care plan, except in those~~  
102 ~~counties in which there are fewer than two managed care plans~~  
103 ~~accepting Medicaid enrollees, in which case assignment shall be~~  
104 ~~to a managed care plan or a MediPass provider. Medicaid~~  
105 ~~recipients in counties with fewer than two managed care plans~~  
106 ~~accepting Medicaid enrollees who are subject to mandatory~~  
107 ~~assignment but who fail to make a choice shall be assigned to~~  
108 ~~managed care plans until an enrollment of 40 percent in MediPass~~  
109 ~~and 60 percent in managed care plans is achieved. Once that~~  
110 ~~enrollment is achieved, the assignments shall be divided in~~  
111 ~~order to maintain an enrollment in MediPass and managed care~~  
112 ~~plans which is in a 40 percent and 60 percent proportion,~~  
113 ~~respectively. In service areas 1 and 6 of the Agency for Health~~  
114 ~~Care Administration where the agency is contracting for the~~  
115 ~~provision of comprehensive behavioral health services through a~~  
116 ~~capitated prepaid arrangement, recipients who fail to make a~~  
117 ~~choice shall be assigned equally to MediPass or a managed care~~  
118 ~~plan. For purposes of this paragraph, when referring to~~  
119 ~~assignment, the term "managed care plans" includes exclusive~~  
120 ~~provider organizations, provider service networks, Children's~~

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121 ~~Medical Services Network, minority physician networks, and~~  
122 ~~pediatric emergency department diversion programs authorized by~~  
123 ~~this chapter or the General Appropriations Act. When making~~  
124 ~~assignments, the agency shall take into account the following~~  
125 ~~criteria:~~

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

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

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

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

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

142 ~~(k)(1)~~ Notwithstanding the provisions of chapter 287, the  
143 agency may, at its discretion, renew cost-effective contracts  
144 for choice counseling services once or more for such periods as  
145 the agency may decide. However, all such renewals may not  
146 combine to exceed a total period longer than the term of the  
147 original contract.

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**(LATE FILED)**

HOUSE AMENDMENT

Bill No. HB 3B CS

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T I T L E   A M E N D M E N T   =====

Remove lines 67-69 and insert:

Medicaid recipients to managed care plans; creating s. 11.72,  
F.S.; creating the

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