(LATE FILED) HOUSE AMENDMENT

Bill No. HB 3B CS

Amendment No. (for drafter's use only)

CHAMBER ACTION

Senate House

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Representative(s) Benson offered the following:

Substitute Amendment for Amendment (563285) (with title amendment)

Remove line(s) 1228-1378 and insert:

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

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

(2)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

150 Remove lines 67-69 and insert:

151 Medicaid recipients to managed care plans; creating s. 11.72,

152 F.S.; creating the

153