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LEGISLATIVE ACTION

Senate	.	House
Comm: UNFAV	.	
02/18/2012	.	
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The Committee on Budget (Rich) recommended the following:

Senate Amendment

Delete lines 1066 - 1431
and insert:

(2)~~(a)~~ The agency shall enroll all Medicaid recipients in a managed care plan or MediPass ~~all Medicaid recipients~~, except those ~~Medicaid~~ recipients who are~~:~~ in an institution; are enrolled in the Medicaid medically needy program; are ~~or~~ eligible for both Medicaid and Medicare; are children under 19 years of age and eligible for SSI; are children determined to be dependent pursuant to s. 39.01(15); are children enrolled in the Children's Medical Services Network; are pregnant women eligible for Medicaid pursuant to s. 409.903(5); have other creditable

health care coverage; are eligible for refugee assistance; are residents of a developmental disability center, including Sunland Center in Marianna and Tacachale in Gainesville; are enrolled in the home and community-based services waiver pursuant to chapter 393 and waiting for waiver services; or have been determined by the agency to be exempt from mandatory enrollment pursuant to subsection (18). Upon enrollment, recipients may ~~individuals will be able to~~ change their managed care option during the 90-day opt out period required by federal Medicaid regulations. The agency may ~~is authorized to~~ seek the necessary Medicaid state plan amendment to implement this policy. Persons eligible for Medicaid but exempt from mandatory participation who do not choose to enroll in managed care shall be served through the Medicaid fee-for-service program. ~~However,~~

(a) To the extent permitted by federal law, the agency may enroll a recipient in a managed care plan or MediPass ~~a Medicaid recipient~~ who is exempt from mandatory managed care enrollment if~~, provided that~~:

1. The recipient's decision to enroll in a managed care plan or MediPass is voluntary;

2. ~~If~~ The recipient chooses to enroll in a managed care plan and~~,~~ the agency has determined that the managed care plan provides specific programs and services that ~~which~~ address the special health needs of the recipient; and

3. The agency receives any necessary waivers from the federal Centers for Medicare and Medicaid Services.

~~School districts participating in the certified school match program pursuant to ss. 409.908(21) and 1011.70 shall be~~

~~reimbursed by Medicaid, subject to the limitations of s. 1011.70(1), for a Medicaid-eligible child participating in the services as authorized in s. 1011.70, as provided for in s. 409.9071, regardless of whether the child is enrolled in MediPass or a managed care plan. Managed care plans shall make a good faith effort to execute agreements with school districts regarding the coordinated provision of services authorized under s. 1011.70. County health departments delivering school-based services pursuant to ss. 381.0056 and 381.0057 shall be reimbursed by Medicaid for the federal share for a Medicaid-eligible child who receives Medicaid-covered services in a school setting, regardless of whether the child is enrolled in MediPass or a managed care plan. Managed care plans shall make a good faith effort to execute agreements with county health departments regarding the coordinated provision of services to a Medicaid-eligible child. To ensure continuity of care for Medicaid patients, the agency, the Department of Health, and the Department of Education shall develop procedures for ensuring that a student's managed care plan or MediPass provider receives information relating to services provided in accordance with ss. 381.0056, 381.0057, 409.9071, and 1011.70.~~

(b) A Medicaid recipient may ~~shall~~ not be enrolled in or assigned to a managed care plan or MediPass unless the managed care plan or MediPass has complied with the quality-of-care standards specified in paragraphs (3)(a) and (b), respectively.

(c) A Medicaid recipient eligible for managed care enrollment ~~recipients~~ shall have a choice of managed care options ~~plans or MediPass~~. The Agency for Health Care Administration, the Department of Health, the Department of

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Children and Family Services, and the Department of Elderly Affairs shall cooperate to ensure that each ~~Medicaid~~ recipient receives clear and easily understandable information that meets the following requirements:

1. Explains the concept of managed care~~, including MediPass~~.

2. Provides information on the comparative performance of managed care options available to the recipient ~~plans and MediPass~~ in the areas of quality, credentialing, preventive health programs, network size and availability, and patient satisfaction.

3. Explains where additional information on each managed care option ~~plan and MediPass~~ in the recipient's area can be obtained.

4. Explains that recipients have the right to choose their managed care coverage at the time they first enroll in Medicaid and again at regular intervals set by the agency. However, if a recipient does not choose a managed care option ~~plan or MediPass~~, the agency shall ~~will~~ assign the recipient ~~to a managed care plan or MediPass~~ according to the criteria specified in this section.

5. Explains the recipient's right to complain, file a grievance, or change his or her managed care option as specified in this section ~~plans or MediPass providers if the recipient is not satisfied with the managed care plan or MediPass~~.

6. Explains the recipient's right to request an exemption from mandatory managed care enrollment if the recipient meets the criteria in subsection (18).

(d) The agency shall develop a mechanism for providing


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information to Medicaid recipients for the purpose of choosing ~~making~~ a managed care option ~~plan or MediPass selection~~. Examples of such mechanisms ~~may~~ include, but are not ~~be~~ limited to, interactive information systems, mailings, and mass marketing materials. The agency must also have mechanisms that ensure that persons required to disenroll from the MediPass program and enroll into a managed care plan can timely access information through the state or its contracted vendor to determine whether their current medications are included on a plan's preferred drug list and whether their current physicians are included in the plan's network. Managed care plans and MediPass providers may not provide ~~are prohibited from providing~~ inducements to ~~Medicaid~~ recipients to select their plans or prejudice ~~from prejudicing Medicaid~~ recipients against other managed care plans or MediPass providers.

(e) Medicaid recipients who are already enrolled in a managed care plan or MediPass shall be offered the opportunity to change managed care plans or MediPass providers, as applicable, on a staggered basis, as defined by the agency. All ~~Medicaid~~ recipients shall have 30 days in which to choose a managed care option ~~make a choice of managed care plans or MediPass providers~~. Those ~~Medicaid~~ recipients who do not make a choice shall be assigned in accordance with paragraph (f). ~~To facilitate continuity of care, for a Medicaid recipient who is also a recipient of Supplemental Security Income (SSI), prior to assigning the SSI recipient to a managed care plan or MediPass, the agency shall determine whether the SSI recipient has an ongoing relationship with a MediPass provider or managed care plan, and if so, the agency shall assign the SSI recipient to~~

~~that MediPass provider or managed care plan. Those SSI recipients who do not have such a provider relationship shall be assigned to a managed care plan or MediPass provider in accordance with paragraph (f).~~

1. During the 30-day choice period:

a. A recipient residing in a county in which two or more managed care plans are eligible to accept Medicaid enrollees, including a recipient who was enrolled in MediPass at the commencement of his or her 30-day choice period, shall choose from those managed care plans. A recipient may opt out of his or her choice and choose a different managed care plan during the 90-day opt out period.

b. A recipient residing in a county in which only one managed care plan is eligible to accept Medicaid enrollees shall choose the managed care plan or a MediPass provider. A recipient who chooses the managed care plan may opt out of the plan and choose a MediPass provider during the 90-day opt out period.

c. A recipient residing in a county in which no managed care plan is accepting Medicaid enrollees shall choose a MediPass provider.

2. For the purposes of recipient choice, if a managed care plan reaches its enrollment capacity, as determined by the agency, the plan may not accept additional Medicaid enrollees until the agency determines that the plan's enrollment is sufficiently less than its enrollment capacity, due to a decline in enrollment or by an increase in enrollment capacity. If a managed care plan notifies the agency of its intent to exit a county, the plan may not accept additional Medicaid enrollees in that county before the exit date.

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3. As used in this paragraph, when referring to recipient choice, the term "managed care plans" includes health maintenance organizations, exclusive provider organizations, provider service networks, minority physician networks, Children's Medical Services Networks, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act.

4. The agency shall seek federal waiver authority or a state plan amendment consistent with 42 U.S.C. 1396u-2(a)(1), as needed, to implement this paragraph.

(f) If a Medicaid recipient does not choose a managed care option:

1. If the recipient resides in a county in which two or more managed care plans are accepting Medicaid enrollees, the agency shall assign the recipient, including a recipient who was enrolled in MediPass at the commencement of his or her 30-day choice period, to one of those managed care plans. A recipient assigned to a managed care plan under this subparagraph may opt out of the managed care plan and enroll in a different managed care plan during the 90-day opt out period. The agency shall seek to make assignments among the managed care plans on an even basis under the criteria in subparagraph 6.

2. If the recipient resides in a county in which only one managed care plan is accepting Medicaid enrollees, the agency shall assign the recipient, including a recipient who was enrolled in MediPass at the commencement of his or her 30-day choice period, to the managed care plan. A recipient assigned to a managed care plan under this subparagraph may opt out of the managed care plan and choose a MediPass provider during the 90-

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day opt out period.

3. If the recipient resides in a county in which no managed care plan is accepting Medicaid enrollees, the agency shall assign the recipient to a MediPass provider.

4. For the purpose of assignment, if a managed care plan reaches its enrollment capacity, as determined by the agency, the plan may not accept additional Medicaid enrollees until the agency determines that the plan's enrollment is sufficiently less than its enrollment capacity, due to a decline in enrollment or by an increase in enrollment capacity. If a managed care plan notifies the agency of its intent to exit a county, the agency may not assign additional Medicaid enrollees to the plan in that county before the exit date. ~~plan or MediPass provider, the agency shall assign the Medicaid recipient to a managed care plan or MediPass provider. Medicaid recipients eligible for managed care plan enrollment who are subject to mandatory assignment but who fail to make a choice shall be assigned to managed care plans until an enrollment of 35 percent in MediPass and 65 percent in managed care plans, of all those eligible to choose managed care, 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 35 percent and 65 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~~


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~~recipients who are required to but have failed to make a choice of managed care plan or MediPass to the 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 operated economically.~~

5. As used in ~~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.

6. When making assignments, the agency shall consider ~~take into account~~ the following criteria, as applicable:

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

b.~~2.~~ Whether 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 a MediPass primary care provider ~~providers~~ has previously provided health care to the recipient.

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

a choice.

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

e. If the recipient was already enrolled in a managed care plan at the commencement of his or her 30-day choice period and fails to choose a different option, the recipient must remain enrolled in that same managed care plan.

f. To facilitate continuity of care for a Medicaid recipient who is also a recipient of Supplemental Security Income (SSI), before assigning the SSI recipient, the agency shall determine whether the SSI recipient has an ongoing relationship with a managed care plan or a MediPass primary care provider, and if so, the agency shall assign the SSI recipient to that managed care plan or MediPass provider, as applicable. However, if the recipient has an ongoing relationship with a MediPass primary care provider who is included in the provider network of one or more managed care plans, the agency shall assign the recipient to one of those managed care plans.

g. If the recipient is diagnosed with HIV/AIDS and resides in Broward County, Miami-Dade County, or Palm Beach County, the agency shall assign the Medicaid recipient to a managed care plan that is a health maintenance organization authorized under chapter 641, that was under contract with the agency on July 1, 2011, and that offers a delivery system in partnership with a university-based teaching and research-oriented organization specializing in providing health care services and treatment for individuals diagnosed with HIV/AIDS. Recipients not diagnosed with HIV/AIDS may not be assigned under this paragraph to a


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managed care plan that specializes in HIV/AIDS.

7. The agency shall seek federal waiver authority or a state plan amendment consistent with 42 U.S.C. 1396u-2(a)(4)(D), as needed, to implement this paragraph.

(g) When more than one managed care plan or MediPass provider meets the criteria specified in paragraph (f), the agency shall make recipient assignments consecutively by family unit.

(h) The agency may not engage in practices that ~~are designed to~~ favor one managed care plan over another or that ~~are designed to~~ influence Medicaid recipients to enroll in MediPass rather than in a managed care plan or to enroll in a managed care plan rather than in MediPass, as applicable. This subsection does not prohibit the agency from reporting on the performance of MediPass or any managed care plan, as measured by performance criteria developed by the agency.

(i) After a recipient has made his or her selection or ~~has~~ been enrolled in a managed care plan or MediPass, the recipient shall have 90 days to exercise the opportunity to voluntarily disenroll and select another managed care option ~~plan or MediPass~~. After 90 days, no further changes may be made except for good cause. Good cause includes, but is not limited to, poor quality of care, lack of access to necessary specialty services, an unreasonable delay or denial of service, or fraudulent enrollment. The agency shall develop criteria for good cause disenrollment for chronically ill and disabled populations who are assigned to managed care plans if more appropriate care is available through the MediPass program. The agency must make a determination as to whether good cause exists. However, the

agency may require a recipient to use the managed care plan's or MediPass grievance process prior to the agency's determination of good cause, except in cases in which immediate risk of permanent damage to the recipient's health is alleged. The grievance process, if used ~~when utilized~~, must be completed in time to permit the recipient to disenroll by the first day of the second month after the month the disenrollment request was made. If the managed care plan or MediPass, as a result of the grievance process, approves an enrollee's request to disenroll, the agency is not required to make a determination in the case. The agency must make a determination and take final action on a recipient's request so that disenrollment occurs by ~~no later than~~ the first day of the second month after the month the request was made. If the agency fails to act within the specified timeframe, the recipient's request to disenroll is deemed to be approved as of the date agency action was required. Recipients who disagree with the agency's finding that good cause does not exist for disenrollment shall be advised of their right to pursue a Medicaid fair hearing to dispute the agency's finding.

(j) Consistent with 42 U.S.C. 1396u-2(a)(4)(A) or under federal waiver authority, as needed, the agency shall ~~apply for a federal waiver from the Centers for Medicare and Medicaid Services to~~ lock eligible Medicaid recipients into a managed care plan or MediPass for 12 months after an ~~open~~ enrollment period, except for the 90-day opt out period and good cause disenrollment. After 12 months' enrollment, a recipient may select another managed care ~~plan or MediPass provider~~. However, ~~nothing shall prevent~~ a Medicaid recipient may not be prevented

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from changing primary care providers within the managed care plan or MediPass program, as applicable, during the 12-month period.

(k) The agency shall maintain MediPass provider networks in all counties, including those counties in which two or more managed care plans are accepting Medicaid enrollees. ~~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 35 percent in MediPass and 65 percent in managed care plans, of all those eligible to choose managed care, 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 35 percent and 65 percent proportion, respectively. 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~~

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~~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.~~

~~(l) If the Medicaid recipient is diagnosed with HIV/AIDS and resides in Broward County, Miami-Dade County, or Palm Beach County, the agency shall assign the Medicaid recipient to a managed care plan that is a health maintenance organization authorized under chapter 641, is under contract with the agency on July 1, 2011, and which offers a delivery system through a university-based teaching and research-oriented organization that specializes in providing health care services and treatment for individuals diagnosed with HIV/AIDS.~~

(l) ~~(m)~~ 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.

(m) To ensure continuity of care, Medicaid recipients enrolled in MediPass who have not completed a course of treatment with their current provider at the time they are required to enroll in a managed care plan shall be permitted to maintain their provider and Medicaid coverage for up to 6 months in order to complete their treatment, if otherwise eligible. Recipients who are receiving treatment covered by Medicaid from a specialty provider at the time they are required to enroll in a managed care plan shall also be permitted to continue receiving treatment from the specialty provider until their initial appointment with a similar specialty provider under their managed plan. The agency shall develop notice procedures and other mechanisms to ensure that recipients are aware of these transition benefits and how to access them.

This subsection expires October 1, 2014.