Amendment No. (for drafter's use only)

CHAMBER ACTION

Senate	House
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Representative(s) Gannon and Joyner offered the following:

Amendment to Amendment (317791)

Remove line(s) 69-247 and insert:

pursuant to s. 409.9128, Florida Statutes. Notwithstanding any other provision of law, all plans shall be required to provide mammogram testing coverage at least once annually to all women over 40 years of age.

1. Mandatory and optional services as delineated in s. 409.905, and s. 409.906, Florida Statutes may vary in amount, duration and scope based on actuarial analysis and determination of service utilization among a categorical or predetermined risk group served by the plan.

2. A plan shall provide all mandatory and optional services as delineated in ss. 409.905, and 409.906, Florida

Statutes, to a level of amount, duration and scope based on the actuarial analysis and corresponding capitation rate. Contractual stipulations for each risk or categorical group shall not vary among plans.

3. A plan shall be at risk for all services as defined in this section needed by a recipient up to a monetary catastrophic threshold pursuant to this section.

4. Catastrophic coverage pursuant to this section shall not release the plan from continued care management of the recipient and providing other services as stipulated in the contract with the agency.

(h) "Provider service network" means an incorporated network:

1. Established or organized, and operated, by a health care provider or group of affiliated health care providers;

2. That provides a substantial proportion of the health care items and services under a contract directly through the provider or affiliated group;

3. That may make arrangements with physicians, other health care professionals, and health care institutions, to assume all or part of the financial risk on a prospective basis for the provision of basic health services; and

4. Within which health care providers have a controlling interest in the governing body of the provider service network organization, as authorized by s. 409.912, Florida Statutes.

(i) "Shall" means the agency must include the provision of a subsection as delineated in this section in the waiver

application and implement the provision to the extent allowed in the demonstration project sites by the Centers for Medicare and Medicaid Services and as approved by the Legislature pursuant to this section.

(j) "State-certified contractor" means an entity not authorized under part I, part II, or part III of chapter 641, Florida Statutes, or under chapter 624, chapter 627, or chapter 636, Florida Statutes, qualified by the agency to be certified as a managed care plan. The agency shall develop the standards necessary to authorize an entity to become a state-certified contractor.

(5) ELIGIBILITY.--

(a) The agency shall pursue waivers to reform Medicaid for the following categorical groups:

1. Temporary Assistance for Needy Families, consistent with ss. 402 and 1931 of the Social Security Act and chapter 409, chapter 414, or chapter 445, Florida Statutes.

2. Supplemental Security Income recipients as defined in Title XVI of the Social Security Act, except for persons who are dually eligible for Medicaid and Medicare, individuals 60 years of age or older, individuals who have developmental disabilities, and residents of institutions or nursing homes.

3. All children covered pursuant to Title XIX of the Social Security Act.

(b) The agency may pursue any appropriate federal waiver to reform Medicaid for the populations not identified by this

subsection, including Title XXI children, if authorized by the Legislature.

(6) CHOICE COUNSELING.--

(a) At the time of eligibility determination, the agency shall provide the recipient with all the Medicaid health care options available in that community to assist the recipient in choosing health care coverage. The recipient shall choose a plan within 30 days after the recipient is eligible unless the recipient loses eligibility. Failure to choose a plan within 30 days will result in the recipient being assigned to a managed care plan.

(b) After a recipient has chosen a plan or has been assigned to a plan, the recipient shall have 90 days in which to voluntarily disenroll and select another managed care plan. After 90 days, no further changes may be made except for cause. Cause shall include, but not be limited to, poor quality of care, lack of access to necessary specialty services, an unreasonable delay or denial of service, inordinate or inappropriate changes of primary care providers, service access impairments due to significant changes in the geographic location of services, or fraudulent enrollment. The agency may require a recipient to use the managed care plan's grievance process prior to the agency's determination of cause, except in cases in which immediate risk of permanent damage to the recipient's health is alleged. The grievance process, when used, must be completed in time to permit the recipient to disenroll no later than the first day of the second month after the month

the disenrollment request was made. If the capitated managed care network, 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 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 cause does not exist for disenrollment shall be advised of their right to pursue a Medicaid fair hearing to dispute the agency's finding.

(c) In the managed care demonstration projects, the Medicaid recipients who are already enrolled in a managed care plan shall remain with that plan until their next eligibility determination. The agency shall develop a method whereby newly eligible Medicaid recipients, Medicaid recipients with renewed eligibility, and Medipass enrollees shall enroll in managed care plans certified pursuant to this section.

(d) A Medicaid recipient receiving services under this section is eligible for only emergency services until the recipient enrolls in a managed care plan.

(e) The agency shall ensure that the recipient is provided with:

1. A list and description of the benefits provided.

2. Information about cost sharing.

3. Plan performance data, if available.

4. An explanation of benefit limitations.

5. Contact information, including identification of providers participating in the network, geographic locations, and transportation limitations.

6. Any other information the agency determines would facilitate a recipient's understanding of the plan or insurance that would best meet his or her needs.

(f) The agency shall ensure that there is a record of recipient acknowledgment that choice counseling has been provided.

(g) To accommodate the needs of recipients, the agency shall ensure that the choice counseling process and related material are designed to provide counseling through face-to-face interaction, by telephone, and in writing and through other forms of relevant media. Materials shall be written at the fourth-grade reading level and available in a language other than English when 5 percent of the county speaks a language other than English. Choice counseling shall also utilize language lines and other services for impaired recipients, such as TTD/TTY.

(h) The agency shall require the entity performing choice counseling to determine if the recipient has made a choice of a plan or has opted out because of duress, threats, payment to the recipient, or incentives promised to the recipient by a third party. If the choice counseling entity determines that the decision to choose a plan was unlawfully influenced or a plan

violated any of the provisions of s. 409.912(21), Florida Statutes, the choice counseling entity shall immediately report the violation to the agency's program integrity section for investigation. Verification of choice counseling by the recipient shall include a stipulation that the recipient acknowledges the provisions of this subsection.

(i) It is the intent of the Legislature, within the authority of the waiver and within available resources, that the agency promote health literacy and partner with the Department of Health to provide information aimed to reduce minority health disparities through outreach activities for Medicaid recipients.

(j) The agency is authorized to contract with entities to perform choice counseling and may establish standards and performance contracts, including standards requiring the contractor to hire choice counselors representative of the state's diverse population and to train choice counselors in working with culturally diverse populations.

(k) The agency shall develop processes to ensure that demonstration sites have sufficient levels of enrollment to conduct a valid test of the managed care demonstration project model within a 2-year timeframe.

(7) PLANS.--

(a) Plan benefits.--The agency shall develop a capitated system of care that promotes choice and competition. Plan benefits shall include the mandatory services delineated in federal law and specified in s. 409.905, Florida Statutes; behavioral health services specified in s. 409.906(8), Florida

Statutes; pharmacy services specified in s. 409.906(20), Florida Statutes; and other services including, but not limited to, Medicaid optional services specified in s. 409.906, Florida Statutes, for which a plan is receiving a risk-adjusted capitation rate. Plans shall provide all mandatory services and may cover optional services to attract recipients and provide needed care. Mandatory and optional services may vary in amount, duration, and scope of benefits. Services to recipients under plan benefits shall include emergency services pursuant to s. 409.9128, Florida Statutes. Notwithstanding any other provision of law, all plans shall be required to provide mammogram testing coverage at least once annually to all women over 40 years of age.