Amendment No.

CHAMBER ACTION

Senate House

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Representative Homan offered the following:

Amendment (with title amendment)

Remove lines 775-895 and insert:

pursuant to s. 409.975(2)(a)-(d). The agency shall also consider whether the organization is a specialty plan. When all other factors are equal, the agency shall consider whether the organization has a contract to provide managed long-term care services in the same region and shall exercise a preference for such plans.

(3) CHILDREN'S MEDICAL SERVICES NETWORK.-The Children's Medical Services Network authorized under chapter 391 is a qualified plan for purposes of the managed medical assistance program. Participation by the Children's Medical Services Network shall be pursuant to a single, statewide contract with the agency that is not subject to the procurement requirements

or regional plan number limits of this section. The Children's Medical Services Network must meet all other plan requirements for the managed medical assistance program.

Section 16. Section 409.975, Florida Statutes, is created to read:

409.975 Managed care plan accountability.—In addition to the requirements of s. 409.967, plans and providers participating in the managed medical assistance program shall comply with the requirements of this section.

(1) MEDICAL LOSS RATIO.—The agency shall establish and implement managed care plans that shall use a uniform method of accounting for and reporting medical, direct care management, and nonmedical costs. The agency shall evaluate plan spending patterns beginning after the plan completes 2 full years of operation and at least annually thereafter. The agency shall implement the following thresholds and consequences of various spending patterns:

(a) Plans that spend less than 75 percent of Medicaid premium revenue on medical services and direct care management as determined by the agency shall be excluded from automatic enrollments and shall be required to pay back the amount between actual spending and 85 percent of the Medicaid premium revenue.

(b) Plans that spend less than 85 percent of Medicaid premium revenue on medical services and direct care management as determined by the agency shall be required to pay back the amount between actual spending and 85 percent of the Medicaid premium revenue.

(c) Plans that spend more than 92 percent of Medicaid premium revenue shall be evaluated by the agency to determine whether higher expenditures are the result of failures in care management. Such a determination may result in the plan being excluded from automatic enrollments.

(2) SELECT PROVIDER PARTICIPATION.—Providers may not be required to participate in any qualified plan selected by the agency except as provided in this subsection. The following providers must agree to participate with each qualified plan selected by the agency in the regions where they are located:

(a) Statutory teaching hospitals as defined in s. 408.07(45).

(b) Hospitals that are trauma centers as defined in s. 395.4001(14).

(c) Hospitals that are regional perinatal intensive care centers as defined in s. 383.16(2).

(d) Hospitals licensed as specialty children's hospitals as defined in s. 395.002(28).

(e) Hospitals with both an active Medicaid provider agreement under s. 409.907 and a certificate of need.

To the extent that the contracts between the hospitals described in paragraphs (a)-(d) and the qualified plans require the services of the hospital's medical staff who are employees or under contract with the hospital to meet the hospital's contractual obligations, such staff is also required to contract with the plans selected by the agency. Any services provided by the medical staff independent of their employment or contractual

obligations to the hospital are not covered by this subsection.

(3) PERFORMANCE MEASUREMENT.—Each plan shall monitor the quality and performance of each participating provider. At the beginning of the contract period, each plan shall notify all its network providers of the metrics used by the plan for evaluating the provider's performance and determining continued participation in the network.

(4) PREGNANCY AND INFANT HEALTH.—Each plan shall establish specific programs and procedures to improve pregnancy outcomes and infant health, including, but not limited to, coordination with the Healthy Start program, immunization programs, and referral to the Special Supplemental Nutrition Program for Women, Infants, and Children, and the Children's Medical Services program for children with special health care needs.

(5) SCREENING RATE.—Each plan shall achieve an annual Early and Periodic Screening, Diagnosis, and Treatment Service screening rate of at least 60 percent for those recipients continuously enrolled for at least 8 months.

(6) PROVIDER PAYMENT.—Plans and hospitals shall negotiate mutually acceptable rates, methods, and terms of payment. At a minimum, plans shall pay hospitals the Medicaid rate. Payments to hospitals shall not exceed 150 percent of the Medicaid rate, unless specifically approved by the agency. For purposes of this subsection, the Medicaid rate is the rate the agency would have paid on the first day of the contract between the provider and the plan. Payment rates may be updated periodically.

(7) CONFLICT RESOLUTION.—The agency shall establish a process for resolving disputes between qualified plans Medicaid

inpatient hospital providers or the medical staff of the providers listed in paragraphs (2)(a)-(d) when the agency is notified by either party of irreconcilable differences and the agency determines that the dispute jeopardizes access to or quality of services for Medicaid recipients. The agency may contract with an outside entity for any portion of this process. When this process is invoked by one or both of the parties, the agency is authorized to establish payment rates, contract terms, and other conditions on either or both parties. This process may not be used to review and reverse any plan decision to exclude any provider that fails to meet quality standards. Administration costs of each instance of conflict resolution shall be paid by the entities which invoke it, in equal parts.

(8) MEDICALLY NEEDY ENROLLEES.—Each selected plan shall

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

Remove lines 76-80 and insert:

qualified plan; creating s. 409.975, F.S.; establishing managed care plan accountability; creating a medical loss ratio requirement; requiring certain provider types to