875574

LEGISLATIVE ACTION

Senate	.	House
	.	
	.	
Floor: 2/F/RM	.	
03/08/2012 06:36 PM	.	
	.	

Senator Garcia moved the following:

Senate Amendment to House Amendment (504515) (with title amendment)

Between lines 470 and 471
insert:

Section 9. Subsection (1) of section 409.975, Florida Statutes, is amended 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) PROVIDER NETWORKS.—Managed care plans must develop and maintain provider networks that meet the medical needs of their

enrollees in accordance with standards established pursuant to s. 409.967(2)(b). Except as provided in this section, managed care plans may limit the providers in their networks based on credentials, quality indicators, and price.

(a) Plans must include all providers in the region that are classified by the agency as essential Medicaid providers for the essential services they provide, unless the agency approves, in writing, an alternative arrangement for securing the types of services offered by the essential providers. Providers are essential for serving Medicaid enrollees if they offer services that are not available from any other provider within a reasonable access standard, or if they provided a substantial share of the total units of a particular service used by Medicaid patients within the region during the last 3 years and the combined capacity of other service providers in the region is insufficient to meet the total needs of the Medicaid patients. The agency may not classify physicians and other practitioners as essential providers.

1. The agency, at a minimum, shall determine which providers in the following categories are essential Medicaid providers:

a.~~1.~~ Federally qualified health centers.

b.~~2.~~ Statutory teaching hospitals as defined in s. 408.07~~(45)~~.

c.~~3.~~ Hospitals that are trauma centers as defined in s. 395.4001~~(14)~~.

d.~~4.~~ Hospitals located at least 25 miles from any other hospital with similar services.

2. Before the selection of managed care plans as specified

875574

in s. 409.966, each essential Medicaid provider and each hospital that is necessary in order for a managed care plan to demonstrate an adequate network, as determined by the agency, are deemed a part of that managed care plan's network for purposes of the plan's enrollment or expansion in the Medicaid program. A hospital that is necessary for a managed care plan to demonstrate an adequate network is an essential hospital. An essential Medicaid provider is deemed a part of a managed care plan's network for the essential services it provides for purposes of the plan's enrollment or expansion in the Medicaid program. The managed care plan, each essential Medicaid provider, and each essential hospital shall negotiate in good faith to enter into a provider network contract. During the plan selection process, the managed care plan is not required to have written agreements or contracts with essential Medicaid providers or essential hospitals.

3. Managed care plans that have not contracted with all essential Medicaid providers or essential hospitals in the region as of the first date of recipient enrollment, or with whom an essential Medicaid provider or essential hospital has terminated its contract, must continue to negotiate in good faith with such essential Medicaid providers or essential hospitals for 1 year, ~~or~~ until an agreement is reached, or a complaint is resolved as provided in paragraph (e), whichever is first. Each essential Medicaid provider must continue to negotiate in good faith during that year to enter into a provider network contract for at least the essential services it provides. Each essential hospital must continue to negotiate in good faith during that year to enter into a provider network

contract. Payments for services rendered by a nonparticipating essential Medicaid provider or essential hospital shall be made at the applicable Medicaid rate as of the first day of the contract between the agency and the plan. A rate schedule for all essential Medicaid providers and essential hospitals must ~~shall~~ be attached to the contract between the agency and the plan.

4. After 1 year, managed care plans that are unable to contract with essential Medicaid providers and essential hospitals shall notify the agency and propose an alternative arrangement for securing the essential services for Medicaid enrollees. The arrangement must rely on contracts with other participating providers~~,~~ regardless of whether those providers are located within the same region as the nonparticipating essential service provider. If the alternative arrangement is approved by the agency, payments to nonparticipating essential Medicaid providers and essential hospitals after the date of the agency's approval must ~~shall~~ equal 90 percent of the applicable Medicaid rate. If the alternative arrangement is not approved by the agency, payment to nonparticipating essential Medicaid providers and essential hospitals must ~~shall~~ equal 110 percent of the applicable Medicaid rate.

(b) Certain providers are statewide resources and essential providers for all managed care plans in all regions. All managed care plans must include these essential providers in their networks for the essential services they provide.

1. Statewide essential providers include:

a.~~1.~~ Faculty plans of Florida medical schools.

b.~~2.~~ Regional perinatal intensive care centers as defined

875574

in s. 383.16~~(2).~~

c.~~3.~~ Hospitals licensed as a specialty hospital for children ~~children's hospitals~~ as defined in s. 395.002~~(28)~~.

d.~~4.~~ Accredited and integrated systems serving medically complex children that are comprised of separately licensed, but commonly owned, health care providers delivering at least the following services: medical group home, in-home and outpatient nursing care and therapies, pharmacy services, durable medical equipment, and Prescribed Pediatric Extended Care.

2. Before the selection of managed care plans as specified in s. 409.966, each statewide essential provider is deemed a part of that managed care plan's network for the essential services they provide and for purposes of the plan's enrollment or expansion in the Medicaid program. The managed care plan and each statewide essential provider shall negotiate in good faith to enter into a provider network contract. During the plan selection process, the managed care plan is not required to have written agreements or contracts with statewide essential providers or essential hospitals.

3. Managed care plans that have not contracted with all statewide essential providers in all regions as of the first date of recipient enrollment and all statewide essential providers that have not entered into a contract with each managed care plan must continue to negotiate in good faith~~.~~ to enter into a provider network contract for at least the essential services. As of the first day of the contract between the agency and the plan, and until a provider network contract is signed, payments:

a. To physicians on the faculty of nonparticipating Florida


875574

medical schools shall be made at the applicable Medicaid rate. ~~Payments~~

b. For services rendered by regional perinatal intensive care centers shall be made at the applicable Medicaid rate ~~as of the first day of the contract between the agency and the plan~~. ~~Payments~~

c. To nonparticipating specialty children's hospitals shall equal the highest rate established by contract between that provider and any other Medicaid managed care plan.

(c) After 12 months of active participation in a plan's network, the plan may exclude any essential provider from the network for failure to meet quality or performance criteria. If the plan excludes an essential provider from the plan, the plan must provide written notice to all recipients who have chosen that provider for care. The notice shall be provided at least 30 days before the effective date of the exclusion.

(d) Each managed care plan must offer a network contract to each home medical equipment and supplies provider in the region which meets quality and fraud prevention and detection standards established by the plan and which agrees to accept the lowest price previously negotiated between the plan and another such provider.

(e) At any time during negotiations a managed care plan, an essential Medicaid provider, an essential hospital, or a statewide essential provider may file a complaint with the agency alleging that, in provider network negotiations, the other party is not negotiating in good faith. The agency shall review each complaint and make a determination whether or not one or both parties have failed to negotiate in good faith.

875574

1. If the agency determines that:

a. The managed care plan was not negotiating in good faith, payment to the nonparticipating essential Medicaid provider, essential hospital, or statewide essential provider shall equal 110 percent of the applicable Medicaid rate or the highest contracted rate the provider has with a plan, whichever is higher.

b. The essential Medicaid provider, essential hospital, or statewide essential provider was not negotiating in good faith, payment to the nonparticipating provider shall equal 90 percent of the applicable Medicaid rate or the lowest contracted rate the provider has with a plan, whichever is lower.

c. Both parties were not negotiating in good faith, payment to the nonparticipating provider shall be made at the applicable Medicaid rate.

2. In making a determination under this paragraph regarding a managed care plan's good faith efforts to negotiate, the agency, at a minimum, shall consider whether the managed care plan has:

a. Offered payment rates that are comparable to other managed care plan rates to the provider or that are comparable to fee-for-service rates for the provider.

b. Proposed its prepayment edits and audits and prior authorizations in a manner comparable to other managed care plans or comparable to current fee for service utilization management and prior authorization procedures for non-emergent services.

c. Offered to pay the provider's undisputed claims faster or equal to existing Medicaid managed care plan contract

875574

standards and, if the managed care plan's claims payment system has been used in other markets, has it failed to meet these standards.

d. Offered a provider dispute resolution system that meets or exceeds existing Medicaid managed care plan contract requirements.

e. If the provider is a hospital essential provider, offered a reasonable payment amount for use of the hospital emergency room for non-emergent care, developed referral arrangements with the hospital for non-emergent care, and offered reasonable prior or post authorization requirements for non-emergent care in the emergency room.

f. Attempted to work with the provider to assist the provider with any patient volume arrangements and whether patient volume arrangements benefit the provider.

g. Demonstrated its financial viability and commitment to meeting its financial obligations.

h. Demonstrated its ability to support HIPAA-compliant electronic data interchange transactions.

3. In making a determination under this paragraph regarding a provider's good faith efforts to negotiate, the agency shall, at a minimum, consider whether the provider has:

a. Met with the managed care plan at a reasonable frequency and involved empowered decision makers in the meetings.

b. Offered reasonable rates that are comparable to other managed care plan rates to the provider or comparable to fee-for-service rates to the provider.

c. Negotiated managed care plan prepayment edits and audits and prior authorizations in a manner comparable to other managed

875574

care plans or comparable to fee for service utilization management and prior authorization procedures for non-emergent services.

d. Negotiated reasonable payment timeframes for payment of undisputed claims that are comparable to existing Medicaid managed care plan standards or comparable to fee-for-service experience.

e. Researched other providers' experience with the managed care plan's claims payment system for timeliness of payment.

f. Negotiated with the managed care plan regarding a provider dispute resolution system that meets or exceeds the managed care plan's Medicaid contract requirements.

g. If the provider is an essential hospital, negotiated with the managed care plan regarding primary care alternatives to non-emergent use of the emergency room.

h. Negotiated patient volume arrangements with the managed care plan.

i. Developed, or is developing, a hospital-based provider service network.

j. Already contracted with other Medicaid managed care plans.

4. Either party may appeal a determination by the agency under this paragraph pursuant to chapter 120. The party appealing the agency's determination shall pay the appellee's attorney's fees and costs, in an amount up to $1 million, from the beginning of the agency's review of the complaint if the appealing party loses the appeal.

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

And the title is amended as follows:

Delete line 529

and insert:

standards; setting enrollment requirements; amending s. 409.975, F.S.; providing that an essential provider and a hospital that is necessary for a managed care plan to demonstrate an adequate network as determined by the Agency for Health Care Administration are deemed part of that managed care plan’s network for purposes of the provider’s or hospital’s application for enrollment or expansion in Medicaid; requiring good faith negotiations between Medicaid managed care plans and essential Medicaid providers; providing that a statewide essential provider is part of a Medicaid managed care plan’s network for purposes of the managed care plan’s application for enrollment or expansion in the Medicaid program; requiring good faith negotiations between Medicaid managed care plans and statewide essential providers; authorizing Medicaid managed care plans and certain Medicaid providers to file a complaint alleging that, in provider network negotiations, the other party is not negotiating in good faith; requiring the agency to review such complaints and make a determination whether or not one or both parties have failed to negotiate in good faith; providing criteria for the agency to consider in making a determination about good faith negotiations; providing financial penalties for parties that do not negotiate in good faith;

providing for appeal of the agency's determination pursuant to ch. 120, F.S.; providing for payment of attorney fees and costs; amending