By Senator Jones

35-00194B-22 20221540__

A bill to be entitled

An act relating to Medicaid managed care; amending s. 409.908, F.S.; requiring that the rental and purchase of durable medical equipment and complex rehabilitation technology by providers of home health care services or medical supplies and appliances be reimbursed by the Agency for Health Care Administration, managed care plans, and subcontractors at a specified amount; amending s. 409.967, F.S.; requiring that Medicaid enrollees be allowed their choice of certain qualified Medicaid providers; requiring the agency to adopt rules; prohibiting a managed care plan from referring its members to, or entering into a contract or an arrangement to provide services with, a subcontractor under certain circumstances; requiring that a subcontractor of a managed care plan provide all services in compliance with such contract or arrangement and applicable federal waivers; prohibiting a managed care plan from referring its members to a subcontractor for covered services if the subcontractor has an ownership interest or a profit-sharing arrangement with certain entities; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (9) of section 409.908, Florida Statutes, is amended to read:

409.908 Reimbursement of Medicaid providers.—Subject to

specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid-eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(9) A provider of home health care services or of medical supplies and appliances must ~~shall~~ be reimbursed on the basis of

competitive bidding or for the lesser of the amount billed by the provider or the agency's established maximum allowable amount, except that, in the case of the rental or purchase of durable medical equipment and complex rehabilitation technology, the provider must be reimbursed by the agency, managed care plans, and any subcontractors at an amount equal to 100 percent of ~~the total rental payments may not exceed the purchase price of the equipment over its expected useful life or~~ the agency's established maximum allowable amount~~, whichever amount is less~~.

Section 2. Paragraph (c) of subsection (2) of section 409.967, Florida Statutes, is amended, and paragraph (p) is added to that subsection, to read:

409.967 Managed care plan accountability.—

(2) The agency shall establish such contract requirements as are necessary for the operation of the statewide managed care program. In addition to any other provisions the agency may deem necessary, the contract must require:

(c) *Access.*—

1. The agency shall establish specific standards for the number, type, and regional distribution of providers in managed care plan networks to ensure access to care for both adults and children. Each plan must maintain a regionwide network of providers in sufficient numbers to meet the access standards for specific medical services for all recipients enrolled in the plan. The exclusive use of mail-order pharmacies may not be sufficient to meet network access standards. Consistent with the standards established by the agency, provider networks may include providers located outside the region. A plan may contract with a new hospital facility before the date the

hospital becomes operational if the hospital has commenced construction, will be licensed and operational by January 1, 2013, and a final order has issued in any civil or administrative challenge. Each plan shall establish and maintain an accurate and complete electronic database of contracted providers, including information about licensure or registration, locations and hours of operation, specialty credentials and other certifications, specific performance indicators, and such other information as the agency deems necessary. The database must be available online to both the agency and the public and have the capability to compare the availability of providers to network adequacy standards and to accept and display feedback from each provider's patients. Each plan shall submit quarterly reports to the agency identifying the number of enrollees assigned to each primary care provider. The agency shall conduct, or contract for, systematic and continuous testing of the provider network databases maintained by each plan to confirm accuracy, confirm that behavioral health providers are accepting enrollees, and confirm that enrollees have access to behavioral health services.

2. Each managed care plan must publish any prescribed drug formulary or preferred drug list on the plan's website in a manner that is accessible to and searchable by enrollees and providers. The plan must update the list within 24 hours after making a change. Each plan must ensure that the prior authorization process for prescribed drugs is readily accessible to health care providers, including posting appropriate contact information on its website and providing timely responses to providers. For Medicaid recipients diagnosed with hemophilia who

have been prescribed anti-hemophilic-factor replacement products, the agency shall provide for those products and hemophilia overlay services through the agency's hemophilia disease management program.

3. Managed care plans, and their fiscal agents or intermediaries, must accept prior authorization requests for any service electronically.

4. Managed care plans serving children in the care and custody of the Department of Children and Families must maintain complete medical, dental, and behavioral health encounter information and participate in making such information available to the department or the applicable contracted community-based care lead agency for use in providing comprehensive and coordinated case management. The agency and the department shall establish an interagency agreement to provide guidance for the format, confidentiality, recipient, scope, and method of information to be made available and the deadlines for submission of the data. The scope of information available to the department shall be the data that managed care plans are required to submit to the agency. The agency shall determine the plan's compliance with standards for access to medical, dental, and behavioral health services; the use of medications; and follow up ~~followup~~ on all medically necessary services recommended as a result of early and periodic screening, diagnosis, and treatment.

5. Notwithstanding any other law, Medicaid enrollees, including those enrolled in Medicaid managed care plans, must be allowed their choice of any qualified Medicaid durable medical equipment or complex rehabilitation technology provider. The

agency shall adopt rules to implement this subparagraph.

(p) *Subcontractors.*—A managed care plan may not refer its members to or enter into a contract or an arrangement with a subcontractor to provide services if the managed care plan or the principal of the managed care plan has a common ownership interest. A subcontractor of a managed care plan shall provide all services in compliance with the contract or arrangement and the applicable federal waivers as reasonably necessary to achieve the purpose for which such services are to be provided. A managed care plan may not refer its members to a subcontractor for covered services if the subcontractor has an ownership interest or a profit-sharing arrangement with a provider, another subcontractor, a third-party administrator, or a third-party entity.

Section 3. This act shall take effect July 1, 2022.