A bill to be entitled

An act relating to Medicaid provider networks; amending s. 409.908, F.S.; requiring Medicaid managed care plans and providers to negotiate mutually acceptable rates, methods, and terms of payment for purposes of Medicaid reimbursements; requiring plans to pay dentists at certain rates; amending s. 409.967, F.S.; specifying additional requirements for the provider network contracts under the statewide managed care program; amending ss. 409.9071, 427.0135, and 1011.70, F.S.; conforming cross-references; reenacting ss. 409.966(3)(c), 409.975(1), and 409.9855(4)(b), F.S., relating to eligible managed care plans, managed care plan accountability, and the pilot program for individuals with developmental disabilities, respectively, to incorporate the amendment made to s. 409.967, F.S., in references thereto; providing an effective date.

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

Section 1. Present subsections (11) through (26) of section 409.908, Florida Statutes, are redesignated as subsections (12) through (27), respectively, and a new subsection (11) is added to that section, 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.

(11) Managed care plans and providers shall negotiate mutually acceptable rates, methods, and terms of payment. Plans shall pay dentists an amount equal to or higher than the dental payment rates set by the agency.

Section 2. Paragraph (c) of subsection (2) of section 409.967, Florida Statutes, is amended 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. 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.

a. A dentist may appear on the provider network database as an active Medicaid provider only if he or she devotes a minimum average of 20 hours per week of direct patient care at the location where he or she is listed as an active Medicaid provider.

b. A secondary provider network may be published on the database for those providers who offer less than the minimum average of 20 hours per week of direct patient care at the location where they are listed as a provider.

c. A provider may not be listed on the network provider database if he or she offers less than 4 hours per week of direct patient care to beneficiaries of the Medicaid program at the indicated location.

d. Specialty care providers must be listed separately from general dentists on the network provider database and must be listed under the specialty they provide.

e. If a group practice or university employs or uses multiple dental providers, each working less than the parameters established in sub-subparagraphs a.-c., that group practice or university must be listed on the network provider database as a single entity provider and may not have each dental provider listed individually.

f. Each provider in the network provider database must indicate what services he or she provides and whether the practice is accepting new patients for each of those services. This information must also specify the location at which the services are provided. Endodontists, oral surgeons, and periodontists must specify the age range for each of the services they provide.

g. To ensure true adequacy and access of care, dental plans must categorize and report provider availability more specifically, listing which of the following services is provided by each provider, including specialists:

(I) Preventive care.

(II) Restorative care.

(III) Conscious sedation, specifying whether nitrous oxide or oral sedation, or both, are offered.

(IV) In-office anesthesia, specifying whether intravenous sedation or general anesthesia, or both, are offered.

(V) Access to emergent care, specifying whether the provider has access to an ambulatory surgical center, a general hospital, or a children's hospital.

If a provider provides any of the services specified in this sub-subparagraph, the dental plan must disclose whether the provider is experienced in and willing to provide such care to patients with intellectual or developmental disabilities and whether there are any age or other limitations on such 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 care ~~followup~~ on all medically necessary services recommended as a result of early and periodic screening, diagnosis, and treatment.

Section 3. Subsection (1) of section 409.9071, Florida Statutes, is amended to read:

409.9071 Medicaid provider agreements for school districts certifying state match.—

(1) The agency shall reimburse school-based services as provided in ss. 409.908(22) and 1011.70 ~~ss. 409.908(21) and 1011.70~~ pursuant to the rehabilitative services option provided under 42 U.S.C. s. 1396d(a)(13). For purposes of this section, billing agent consulting services are considered billing agent services, as that term is used in s. 409.913(10), and, as such, payments to such persons may not be based on amounts for which they bill nor based on the amount a provider receives from the Medicaid program. This provision may not restrict privatization of Medicaid school-based services. Subject to any limitations provided for in the General Appropriations Act, the agency, in compliance with appropriate federal authorization, shall develop policies and procedures and shall allow for certification of state and local education funds that have been provided for school-based services as specified in s. 1011.70 and authorized by a physician's order where required by federal Medicaid law.

Section 4. Subsection (3) of section 427.0135, Florida Statutes, is amended to read:

427.0135 Purchasing agencies; duties and responsibilities.—Each purchasing agency, in carrying out the policies and procedures of the commission, shall:

(3) Not procure transportation disadvantaged services without initially negotiating with the commission, as provided

in s. 287.057(3)(e)12., or unless otherwise authorized by statute. If the purchasing agency, after consultation with the commission, determines that it cannot reach mutually acceptable contract terms with the commission, the purchasing agency may contract for the same transportation services provided in a more cost-effective manner and of comparable or higher quality and standards. The Medicaid agency shall implement this subsection in a manner consistent with s. 409.908(19) ~~s. 409.908(18)~~ and as otherwise limited or directed by the General Appropriations Act.

Section 5. Subsections (1) and (5) of section 1011.70, Florida Statutes, are amended to read:

1011.70 Medicaid certified school funding maximization.—

(1) Each school district, subject to the provisions of ss. 409.9071 and 409.908(22) ~~ss. 409.9071 and 409.908(21)~~ and this section, is authorized to certify funds provided for a category of required Medicaid services termed "school-based services," which are reimbursable under the federal Medicaid program. Such services shall include, but not be limited to, physical, occupational, and speech therapy services, behavioral health services, mental health services, transportation services, Early Periodic Screening, Diagnosis, and Treatment (EPSDT) administrative outreach for the purpose of determining eligibility for exceptional student education, and any other such services, for the purpose of receiving federal Medicaid financial participation. Certified school funding shall not be

available for the following services:

(a) Family planning.

(b) Immunizations.

(c) Prenatal care.

(5) Lab schools, as authorized under s. 1002.32, shall be authorized to participate in the Medicaid certified school match program on the same basis as school districts subject to the provisions of subsections (1)-(4) and ss. 409.9071 and 409.908(22) ~~ss. 409.9071 and 409.908(21)~~.

Section 6. For the purpose of incorporating the amendment made by this act to section 409.967, Florida Statutes, in a reference thereto, paragraph (c) of subsection (3) of section 409.966, Florida Statutes, is reenacted to read:

409.966 Eligible plans; selection.—

(3) QUALITY SELECTION CRITERIA.—

(c) After negotiations are conducted, the agency shall select the eligible plans that are determined to be responsive and provide the best value to the state. Preference shall be given to plans that:

1. Have signed contracts with primary and specialty physicians in sufficient numbers to meet the specific standards established pursuant to s. 409.967(2)(c).

2. Have well-defined programs for recognizing patient-centered medical homes and providing for increased compensation for recognized medical homes, as defined by the plan.

3. Are organizations that are based in and perform operational functions in this state, in-house or through contractual arrangements, by staff located in this state. Using a tiered approach, the highest number of points shall be awarded to a plan that has all or substantially all of its operational functions performed in the state. The second highest number of points shall be awarded to a plan that has a majority of its operational functions performed in the state. The agency may establish a third tier; however, preference points may not be awarded to plans that perform only community outreach, medical director functions, and state administrative functions in the state. For purposes of this subparagraph, operational functions include corporate headquarters, claims processing, member services, provider relations, utilization and prior authorization, case management, disease and quality functions, and finance and administration. For purposes of this subparagraph, the term "corporate headquarters" means the principal office of the organization, which may not be a subsidiary, directly or indirectly through one or more subsidiaries of, or a joint venture with, any other entity whose principal office is not located in the state.

4. Have contracts or other arrangements for cancer disease management programs that have a proven record of clinical efficiencies and cost savings.

5. Have contracts or other arrangements for diabetes

disease management programs that have a proven record of clinical efficiencies and cost savings.

6. Have a claims payment process that ensures that claims that are not contested or denied will be promptly paid pursuant to s. 641.3155.

Section 7. For the purpose of incorporating the amendment made by this act to section 409.967, Florida Statutes, in a reference thereto, subsection (1) of section 409.975, Florida Statutes, is reenacted 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)(c). 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, 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. The agency, at a minimum, shall determine which providers in the following categories are essential Medicaid providers:

1. Federally qualified health centers.

2. Statutory teaching hospitals as defined in s. 408.07(46).

3. Hospitals that are trauma centers as defined in s. 395.4001(15).

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

Managed care plans that have not contracted with all essential providers in the region as of the first date of recipient enrollment, or with whom an essential provider has terminated its contract, must negotiate in good faith with such essential providers for 1 year or until an agreement is reached, whichever is first. Payments for services rendered by a nonparticipating essential provider 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 providers shall be attached to the contract between the agency and the plan. After 1 year, managed care plans that are unable to contract with essential providers 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 providers after the date of the agency's approval shall equal 90 percent of the applicable Medicaid rate. Except for payment for emergency services, if the alternative arrangement is not approved by the agency, payment to nonparticipating essential providers 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. Statewide essential providers include:

1. Faculty plans of Florida medical schools.

2. Regional perinatal intensive care centers as defined in s. 383.16(2).

3. Hospitals licensed as specialty children's hospitals as

defined in s. 395.002(28).

4. Accredited and integrated systems serving medically complex children which comprise 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.

5. Florida cancer hospitals that meet the criteria in 42 U.S.C. s. 1395ww(d)(1)(B)(v).

Managed care plans that have not contracted with all statewide essential providers in all regions as of the first date of recipient enrollment must continue to negotiate in good faith. Payments to physicians on the faculty of nonparticipating Florida medical schools shall be made at the applicable Medicaid rate. Payments 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. Except for payments for emergency services, payments to nonparticipating specialty children's hospitals, and payments to nonparticipating Florida cancer hospitals that meet the criteria in 42 U.S.C. s. 1395ww(d)(1)(B)(v), 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. For purposes of this paragraph, the term "essential provider" includes providers determined by the agency to be essential Medicaid providers under paragraph (a) and the statewide essential providers specified in paragraph (b).

(d) The applicable Medicaid rates for emergency services paid by a plan under this section to a provider with which the plan does not have an active contract shall be determined according to s. 409.967(2)(b).

(e) Each managed care plan may 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.

Section 8. For the purpose of incorporating the amendment made by this act to section 409.967, Florida Statutes, in a reference thereto, paragraph (b) of subsection (4) of section 409.9855, Florida Statutes, is reenacted to read:

409.9855 Pilot program for individuals with developmental

disabilities.—

(4) ELIGIBLE PLANS; PLAN SELECTION.—

(b) The agency shall select, as provided in s. 287.057(1), one plan to participate in the pilot program for each of the two regions. The director of the Agency for Persons with Disabilities or his or her designee must be a member of the negotiating team.

1. The invitation to negotiate must specify the criteria and the relative weight assigned to each criterion that will be used for determining the acceptability of submitted responses and guiding the selection of the plans with which the agency and the Agency for Persons with Disabilities negotiate. In addition to any other criteria established by the agency, in consultation with the Agency for Persons with Disabilities, the agency shall consider the following factors in the selection of eligible plans:

a. Experience serving similar populations, including the plan's record in achieving specific quality standards with similar populations.

b. Establishment of community partnerships with providers which create opportunities for reinvestment in community-based services.

c. Provision of additional benefits, particularly behavioral health services, the coordination of dental care, and other initiatives that improve overall well-being.

d. Provision of and capacity to provide mental health therapies and analysis designed to meet the needs of individuals with developmental disabilities.

e. Evidence that an eligible plan has written agreements or signed contracts or has made substantial progress in establishing relationships with providers before submitting its response.

f. Experience in the provision of person-centered planning as described in 42 C.F.R. s. 441.301(c)(1).

g. Experience in robust provider development programs that result in increased availability of Medicaid providers to serve the developmental disabilities community.

2. After negotiations are conducted, the agency shall select the eligible plans that are determined to be responsive and provide the best value to the state. Preference must be given to plans that:

a. Have signed contracts in sufficient numbers to meet the specific standards established under s. 409.967(2)(c), including contracts for personal supports, skilled nursing, residential habilitation, adult day training, mental health services, respite care, companion services, and supported employment, as those services are defined in the Florida Medicaid Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook as adopted by reference in rule 59G-13.070, Florida Administrative Code.

b. Have well-defined programs for recognizing patient-centered medical homes and providing increased compensation to recognized medical homes, as defined by the plan.

c. Have well-defined programs related to person-centered planning as described in 42 C.F.R. s. 441.301(c)(1).

d. Have robust and innovative programs for provider development and collaboration with the Agency for Persons with Disabilities.

Section 9. This act shall take effect July 1, 2026.