1 A bill to be entitled
2 An act relating to Medicaid managed care; amending s.
3 409.908, F.S.; requiring that the rental and purchase
4 of durable medical equipment and complex
5 rehabilitation technology be reimbursed by the Agency
6 for Health Care Administration, managed care plans,
7 and subcontractors at a specified amount; amending s.
8 409.967, F.S.; requiring that Medicaid enrollees be
9 allowed their choice of certain qualified Medicaid
10 providers; requiring the agency to adopt rules;
11 prohibiting a managed care plan from referring its
12 members to, or entering into a contract or an
13 arrangement to provide services with, a subcontractor
14 under certain circumstances; requiring that a
15 subcontractor of a managed care plan provide all
16 services in compliance with such contract or
17 arrangement and applicable federal waivers;
18 prohibiting a managed care plan from referring its
19 members to a subcontractor for covered services if the
20 subcontractor has an ownership interest or a profit-
21 sharing arrangement with certain entities; providing
22 an effective date.
23
24 Be It Enacted by the Legislature of the State of Florida:
25

26 Section 1. Subsection (9) of section 409.908, Florida
27 Statutes, is amended to read:
28 409.908 Reimbursement of Medicaid providers.—Subject to
29 specific appropriations, the agency shall reimburse Medicaid
30 providers, in accordance with state and federal law, according
31 to methodologies set forth in the rules of the agency and in
32 policy manuals and handbooks incorporated by reference therein.
33 These methodologies may include fee schedules, reimbursement
34 methods based on cost reporting, negotiated fees, competitive
35 bidding pursuant to s. 287.057, and other mechanisms the agency
36 considers efficient and effective for purchasing services or
37 goods on behalf of recipients. If a provider is reimbursed based
38 on cost reporting and submits a cost report late and that cost
39 report would have been used to set a lower reimbursement rate
40 for a rate semester, then the provider's rate for that semester
41 shall be retroactively calculated using the new cost report, and
42 full payment at the recalculated rate shall be effected
43 retroactively. Medicare-granted extensions for filing cost
44 reports, if applicable, shall also apply to Medicaid cost
45 reports. Payment for Medicaid compensable services made on
46 behalf of Medicaid-eligible persons is subject to the
47 availability of moneys and any limitations or directions
48 provided for in the General Appropriations Act or chapter 216.
49 Further, nothing in this section shall be construed to prevent
50 or limit the agency from adjusting fees, reimbursement rates,

CODING: Words stricken are deletions; words underlined are additions.

51 lengths of stay, number of visits, or number of services, or
52 making any other adjustments necessary to comply with the
53 availability of moneys and any limitations or directions
54 provided for in the General Appropriations Act, provided the
55 adjustment is consistent with legislative intent.
56 (9) A provider of home health care services or of medical
57 supplies and appliances must ~~shall~~ be reimbursed on the basis of
58 competitive bidding or for the lesser of the amount billed by
59 the provider or the agency's established maximum allowable
60 amount, except that, in the case of the rental or purchase of
61 durable medical equipment and complex rehabilitation technology,
62 the provider must be reimbursed by the agency, managed care
63 plans, and any subcontractors at an amount equal to 100 percent
64 of ~~the total rental payments may not exceed the purchase price~~
65 ~~of the equipment over its expected useful life or~~ the agency's
66 established maximum allowable amount~~, whichever amount is less~~.
67 Section 2. Paragraph (c) of subsection (2) of section
68 409.967, Florida Statutes, is amended, and paragraph (p) is
69 added to that subsection, to read:
70 409.967 Managed care plan accountability.—
71 (2) The agency shall establish such contract requirements
72 as are necessary for the operation of the statewide managed care
73 program. In addition to any other provisions the agency may deem
74 necessary, the contract must require:
75 (c) *Access.*—

76 1. The agency shall establish specific standards for the
77 number, type, and regional distribution of providers in managed
78 care plan networks to ensure access to care for both adults and
79 children. Each plan must maintain a regionwide network of
80 providers in sufficient numbers to meet the access standards for
81 specific medical services for all recipients enrolled in the
82 plan. The exclusive use of mail-order pharmacies may not be
83 sufficient to meet network access standards. Consistent with the
84 standards established by the agency, provider networks may
85 include providers located outside the region. A plan may
86 contract with a new hospital facility before the date the
87 hospital becomes operational if the hospital has commenced
88 construction, will be licensed and operational by January 1,
89 2013, and a final order has issued in any civil or
90 administrative challenge. Each plan shall establish and maintain
91 an accurate and complete electronic database of contracted
92 providers, including information about licensure or
93 registration, locations and hours of operation, specialty
94 credentials and other certifications, specific performance
95 indicators, and such other information as the agency deems
96 necessary. The database must be available online to both the
97 agency and the public and have the capability to compare the
98 availability of providers to network adequacy standards and to
99 accept and display feedback from each provider's patients. Each
100 plan shall submit quarterly reports to the agency identifying

101 the number of enrollees assigned to each primary care provider.
102 The agency shall conduct, or contract for, systematic and
103 continuous testing of the provider network databases maintained
104 by each plan to confirm accuracy, confirm that behavioral health
105 providers are accepting enrollees, and confirm that enrollees
106 have access to behavioral health services.
107 2. Each managed care plan must publish any prescribed drug
108 formulary or preferred drug list on the plan's website in a
109 manner that is accessible to and searchable by enrollees and
110 providers. The plan must update the list within 24 hours after
111 making a change. Each plan must ensure that the prior
112 authorization process for prescribed drugs is readily accessible
113 to health care providers, including posting appropriate contact
114 information on its website and providing timely responses to
115 providers. For Medicaid recipients diagnosed with hemophilia who
116 have been prescribed anti-hemophilic-factor replacement
117 products, the agency shall provide for those products and
118 hemophilia overlay services through the agency's hemophilia
119 disease management program.
120 3. Managed care plans, and their fiscal agents or
121 intermediaries, must accept prior authorization requests for any
122 service electronically.
123 4. Managed care plans serving children in the care and
124 custody of the Department of Children and Families must maintain
125 complete medical, dental, and behavioral health encounter

126 information and participate in making such information available
127 to the department or the applicable contracted community-based
128 care lead agency for use in providing comprehensive and
129 coordinated case management. The agency and the department shall
130 establish an interagency agreement to provide guidance for the
131 format, confidentiality, recipient, scope, and method of
132 information to be made available and the deadlines for
133 submission of the data. The scope of information available to
134 the department shall be the data that managed care plans are
135 required to submit to the agency. The agency shall determine the
136 plan's compliance with standards for access to medical, dental,
137 and behavioral health services; the use of medications; and
138 follow up ~~followup~~ on all medically necessary services
139 recommended as a result of early and periodic screening,
140 diagnosis, and treatment.
141 5. Notwithstanding any other law, Medicaid enrollees,
142 including those enrolled in Medicaid managed care plans, must be
143 allowed their choice of any qualified Medicaid durable medical
144 equipment or complex rehabilitation technology provider. The
145 agency shall adopt rules to implement this subparagraph.
146 (p) *Subcontractors.*—A managed care plan may not refer its
147 members to or enter into a contract or an arrangement with a
148 subcontractor to provide services if the managed care plan or
149 the principal of the managed care plan has a common ownership
150 interest. A subcontractor of a managed care plan shall provide

151 all services in compliance with the contract or arrangement and
152 the applicable federal waivers as reasonably necessary to
153 achieve the purpose for which such services are to be provided.
154 A managed care plan may not refer its members to a subcontractor
155 for covered services if the subcontractor has an ownership
156 interest or a profit-sharing arrangement with a provider,
157 another subcontractor, a third-party administrator, or a third-
158 party entity.
159 Section 3. This act shall take effect July 1, 2022.