A bill to be entitled

An act relating to health insurer accountability; amending s. 408.7057, F.S.; requiring a health plan to participate in a filed claim dispute; providing penalties for failure to respond to a claim; requiring the Agency for Health Care Administration to notify a certain entity within a specified timeframe when a health plan fails to pay a provider under certain circumstances; requiring a health plan to pay a provider within a specified timeframe after the agency's order; providing penalties; amending s. 409.967, F.S.; providing credentialing requirements for a managed care plan; requiring each managed care plan to identify to the agency and the Office of Insurance Regulation any ownership interest or affiliation of any kind with certain entities; providing requirements for the identification of such information; requiring each managed care plan to report specified information to the agency and the office in writing within a specified timeframe; removing a provision requiring the results of certain audit reports to be dispositive; amending s. 409.975, F.S.; requiring managed care contracts to include provider notifications regarding certain denials of coverage; amending ss. 627.6131 and 641.315, F.S.;

prohibiting an insurer from denying certain claims under certain circumstances; providing notification requirements and penalties; amending ss. 409.973 and 409.9855, F.S.; conforming cross-references; providing an effective date.

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

Section 1. Subsection (7) of section 408.7057, Florida Statutes, is renumbered as subsection (8), subsection (5) is amended, paragraph (i) is added to subsection (2), and a new subsection (7) is added to that section, to read:

408.7057 Statewide provider and health plan claim dispute resolution program.—

(2)

(i) A health plan must participate in a filed claim dispute. Failure to respond as provided in paragraph (f) shall result in a default against the health plan.

(5) The agency shall notify within 7 days the appropriate licensure or certification entity whenever there is:

(a) A failure to pay as provided in subsection (7); or

(b) A violation of a final order issued by the agency pursuant to this section.

(7) A health plan that does not prevail in the agency's order shall pay the provider the amount provided in the order

within 35 days after the order is entered. A health plan that does not pay the required amount within the required timeframe is subject to a penalty of up to $500 per day until the amount is paid.

Section 2. Subsections (3) and (4) of section 409.967, Florida Statutes, are renumbered as subsections (4) and (5), respectively, paragraph (e) of present subsection (3) is amended, paragraphs (p) and (q) are added to subsection (2), and a new subsection (3) is added to that section, 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:

(p) Credentialing.—

1. A managed care plan shall determine whether it will contract with a provider within 30 calendar days after receipt of the verified credentialing information from a credentialing verification organization either designated by the agency or contracted by managed care organizations as part of a credentialing alliance. Within 15 days after a contract is executed, a managed care plan shall ensure that any internal processing systems of the managed care plan have been updated to include:

a. The accepted provider contract.

b. The provider as a participating provider.

2. For the purpose of reimbursement of claims, once a provider has met the terms and conditions for credentialing and enrollment, the provider's credentialing application date shall be the date from which the provider's claims become eligible for payment.

3. A managed care plan may not require a provider to appeal or resubmit any clean claim submitted during the time period between the provider's credentialing application date and the completion of the credentialing process.

(q) Ownership interest or affiliation.—

1. Each managed care plan shall identify to the agency and the Office of Insurance Regulation any ownership interest or affiliation of any kind with any provider, provider group, or company responsible for providing any pharmacy, diagnostics, care coordination, care delivery, direct health care services, administrative services, or financial services.

2. Each managed care plan shall also identify to the agency and the Office of Insurance Regulation any ownership affiliation of any kind with any entity which, either directly or indirectly, through one or more intermediaries:

a. Has an investment or ownership interest of any kind with any entity providing pharmacy, diagnostics, care coordination, care delivery, direct health care services, or administrative services;

b. Shares common ownership with any entity providing pharmacy, diagnostics, care coordination, care delivery, direct health care services, or administrative services; or

c. Has an investor or a holder of an ownership interest of any kind with any entity providing pharmacy, diagnostics, care coordination, care delivery, direct health care services, or administrative services.

(3) Each managed care plan shall report any change in information in subsection (2) to the agency and the Office of Insurance Regulation in writing within 60 days after the change occurs.

(4) ~~(3)~~ ACHIEVED SAVINGS REBATE.—

(e) Once the certified public accountant completes the audit, the certified public accountant shall submit an audit report to the agency attesting to the achieved savings of the plan. The agency shall review the report to determine compliance with the requirements of this subsection. The agency shall notify the certified public accountant of any deficiencies in the audit report. The certified public accountant must correct such deficiencies in the audit report and resubmit the revised audit report to the agency before the report is considered final. ~~Once finalized, the results of the audit report are dispositive.~~

Section 3. Subsection (7) is added to section 409.975, Florida Statutes, 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.

(7) PROVIDER NOTIFICATION REQUIREMENT.—Each managed care contract with a provider must include provider notifications regarding denials of coverage in accordance with ss. 627.6131(22) and 641.315(15).

Section 4. Subsection (22) is added to section 627.6131, Florida Statutes, to read:

627.6131 Payment of claims.—

(22) For circumstances in subparagraph (21)(a)1. and sub-subparagraphs (21)(a)5.d. and e., an insurer may not deny a claim of a previously authorized health care service unless the insurer has notified both the insured and the treating provider of the insured's change in coverage status or applicable benefit limitation. Notification to the provider must be issued contemporaneously with the notice required to be given to the insured under this section. Failure to provide such notification shall preclude the insurer from denying payment for the authorized service.

Section 5. Subsection (15) is added to section 641.315, Florida Statutes, to read:

641.315 Provider contracts.—

(15) For circumstances in subparagraph (14)(a)1. and sub-

subparagraphs (14)(a)5.d. and e., an insurer may not deny a claim of a previously authorized health care service unless the insurer has notified both the insured and the treating provider of the insured's change in coverage status or applicable benefit limitation. Notification to the provider must be issued contemporaneously with the notice required to be given to the insured under this section. Failure to provide such notification shall preclude the insurer from denying payment for the authorized service.

Section 6. Paragraph (b) of subsection (5) of section 409.973, Florida Statutes, is amended to read:

409.973 Benefits.—

(5) PROVISION OF DENTAL SERVICES.—

(b) In the event the Legislature takes no action before July 1, 2017, with respect to the report findings required under paragraph (a), the agency shall implement a statewide Medicaid prepaid dental health program for children and adults with a choice of at least two licensed dental managed care providers who must have substantial experience in providing dental care to Medicaid enrollees and children eligible for medical assistance under Title XXI of the Social Security Act and who meet all agency standards and requirements. To qualify as a provider under the prepaid dental health program, the entity must be licensed as a prepaid limited health service organization under part I of chapter 636 or as a health maintenance organization

under part I of chapter 641. The contracts for program providers shall be awarded through a competitive procurement process. Beginning with the contract procurement process initiated during the 2023 calendar year, the contracts must be for 6 years and may not be renewed; however, the agency may extend the term of a plan contract to cover delays during a transition to a new plan provider. The agency shall include in the contracts a medical loss ratio provision consistent with s. 409.967(5) ~~s. 409.967(4)~~. The agency is authorized to seek any necessary state plan amendment or federal waiver to commence enrollment in the Medicaid prepaid dental health program no later than March 1, 2019. The agency shall extend until December 31, 2024, the term of existing plan contracts awarded pursuant to the invitation to negotiate published in October 2017.

Section 7. Paragraph (c) of subsection (5) of section 409.9855, Florida Statutes, is amended to read:

409.9855 Pilot program for individuals with developmental disabilities.—

(5) PAYMENT.—

(c) The revenues and expenditures of the selected plan which are associated with the implementation of the pilot program must be included in the reporting and regulatory requirements established in s. 409.967(4) ~~s. 409.967(3)~~.

Section 8. This act shall take effect July 1, 2026.