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LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
03/22/2017	.	
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Appropriations Subcommittee on Health and Human Services (Bean) recommended the following:

Senate Amendment (with title amendment)

Delete lines 27 - 131
and insert:
(a) A managed care plan may not enter into a contract with a pharmacy benefits manager (PBM) to manage the prescription drug coverage provided under the plan or to control the costs of the prescription drug coverage under such plan unless:
1. The contract prevents the PBM from requiring that a plan enrollee use a retail pharmacy or other pharmacy entity

providing pharmacy services in which the PBM has an ownership interest or which has an ownership interest in the PBM, or the contract provides an incentive to a plan enrollee to encourage the enrollee to use a retail pharmacy, mail order pharmacy, specialty pharmacy, or other pharmacy entity providing pharmacy services in which the PBM has an ownership interest or which has an ownership interest in the PBM, if the incentive is applicable only to such pharmacies; and

2. The contract requires the PBM to update the maximum allowable cost as defined by s. 465.1862(1)(a) every 7 calendar days beginning on January 1 of each year, to accurately reflect the market price of acquiring the drug.

(b) Plans must include all providers in the region which ~~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.

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

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

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.

(c) ~~(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.

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 shall equal the highest rate established by contract between that provider

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and any other Medicaid managed care plan.

(d) ~~(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 (b) ~~(a)~~ and the statewide essential providers specified in paragraph (c) ~~(b)~~.

(e) ~~(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).

(f) ~~(e)~~ 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.

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

And the title is amended as follows:

Delete lines 3 - 10

and insert:

networks; amending s. 409.975, F.S.; prohibiting a managed care plan from contracting with a pharmacy

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benefits manager to manage the prescription drug coverage provided under the plan unless certain requirements are met; providing an