By the Committee on Banking and Insurance; and Senators Bean, Lee, and Mayfield

597-02144-17 2017670c1

1 A bill to be entitled
2 An act relating to managed care plans' provider
3 networks; amending s. 409.975, F.S.; prohibiting a
4 managed care plan from excluding a pharmacy that meets
5 the credentialing requirements and standards
6 established by the Agency for Health Care
7 Administration and that accepts the terms of the plan;
8 requiring a managed care plan to offer the same rate
9 of reimbursement to all pharmacies in the plan's
10 network; authorizing rulemaking; providing an
11 effective date.
12
13 Be It Enacted by the Legislature of the State of Florida:
14
15 Section 1. Subsection (1) of section 409.975, Florida
16 Statutes, is amended to read:
17 409.975 Managed care plan accountability.—In addition to
18 the requirements of s. 409.967, plans and providers
19 participating in the managed medical assistance program shall
20 comply with the requirements of this section.
21 (1) PROVIDER NETWORKS.—Managed care plans must develop and
22 maintain provider networks that meet the medical needs of their
23 enrollees in accordance with standards established pursuant to
24 s. 409.967(2)(c). Except as provided in this section, managed
25 care plans may limit the providers in their networks based on
26 credentials, quality indicators, and price.
27 (a) <u>A managed care plan may not exclude any pharmacy that</u>
28 <u>meets the credentialing requirements, complies with agency</u>
29 <u>standards, and accepts the terms of the plan. The managed care</u>

CODING: Words ~~stricken~~ are deletions; words <u>underlined</u> are additions.

597-02144-17 2017670c1

30 plan must offer the same rate of reimbursement to all pharmacies
31 in the plan's network.
32 (b) Plans must include all providers in the region which
33 that are classified by the agency as essential Medicaid
34 providers, unless the agency approves, in writing, an
35 alternative arrangement for securing the types of services
36 offered by the essential providers. Providers are essential for
37 serving Medicaid enrollees if they offer services that are not
38 available from any other provider within a reasonable access
39 standard, or if they provided a substantial share of the total
40 units of a particular service used by Medicaid patients within
41 the region during the last 3 years and the combined capacity of
42 other service providers in the region is insufficient to meet
43 the total needs of the Medicaid patients. The agency may not
44 classify physicians and other practitioners as essential
45 providers. The agency, at a minimum, shall determine which
46 providers in the following categories are essential Medicaid
47 providers:
48 1. Federally qualified health centers.
49 2. Statutory teaching hospitals as defined in s.
50 408.07(45).
51 3. Hospitals that are trauma centers as defined in s.
52 395.4001(14).
53 4. Hospitals located at least 25 miles from any other
54 hospital with similar services.
55
56 Managed care plans that have not contracted with all essential
57 providers in the region as of the first date of recipient
58 enrollment, or with whom an essential provider has terminated

59 its contract, must negotiate in good faith with such essential
60 providers for 1 year or until an agreement is reached, whichever
61 is first. Payments for services rendered by a nonparticipating
62 essential provider shall be made at the applicable Medicaid rate
63 as of the first day of the contract between the agency and the
64 plan. A rate schedule for all essential providers shall be
65 attached to the contract between the agency and the plan. After
66 1 year, managed care plans that are unable to contract with
67 essential providers shall notify the agency and propose an
68 alternative arrangement for securing the essential services for
69 Medicaid enrollees. The arrangement must rely on contracts with
70 other participating providers, regardless of whether those
71 providers are located within the same region as the
72 nonparticipating essential service provider. If the alternative
73 arrangement is approved by the agency, payments to
74 nonparticipating essential providers after the date of the
75 agency's approval shall equal 90 percent of the applicable
76 Medicaid rate. Except for payment for emergency services, if the
77 alternative arrangement is not approved by the agency, payment
78 to nonparticipating essential providers shall equal 110 percent
79 of the applicable Medicaid rate.
80 (c)~~(b)~~ Certain providers are statewide resources and
81 essential providers for all managed care plans in all regions.
82 All managed care plans must include these essential providers in
83 their networks. Statewide essential providers include:
84 1. Faculty plans of Florida medical schools.
85 2. Regional perinatal intensive care centers as defined in
86 s. 383.16(2).
87 3. Hospitals licensed as specialty children's hospitals as

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

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 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

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

597-02144-17 2017670c1

117 under paragraph (b) ~~(a)~~ and the statewide essential providers
118 specified in paragraph (c) ~~(b)~~.
119 (e) ~~(d)~~ The applicable Medicaid rates for emergency services
120 paid by a plan under this section to a provider with which the
121 plan does not have an active contract shall be determined
122 according to s. 409.967(2)(b).
123 (f) ~~(e)~~ Each managed care plan must offer a network contract
124 to each home medical equipment and supplies provider in the
125 region which meets quality and fraud prevention and detection
126 standards established by the plan and which agrees to accept the
127 lowest price previously negotiated between the plan and another
128 such provider.
129 (g) The agency may adopt rules necessary to administer this
130 section, including rules establishing credentialing requirements
131 and quality standards for pharmacies.
132 Section 2. This act shall take effect October 1, 2017.
133