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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/22/2013	.	
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The Committee on Appropriations (Bean) recommended the following:

Senate Amendment to Amendment (342762) (with title amendment)

Delete lines 1861 - 1900
and insert:

Section 56. Paragraphs (c) and (e) of subsection (2) of section 409.967, Florida Statutes, are 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. A plan may contract with a new hospital facility before the date the hospital becomes operational if the hospital has commenced construction, will be licensed and operational by January 1, 2013, and a final order has issued in any civil or administrative challenge. 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.

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 must permit an enrollee who was receiving a prescription drug and was on the plan's formulary and subsequently removed or changed, to continue receiving that drug if the provider submits a written request demonstrating that the drug is medically necessary, and the enrollee meets clinical criteria to receive the drug.

(e) *Continuous improvement.*—The agency shall establish specific performance standards and expected milestones or timelines for improving performance over the term of the contract.

1. Each managed care plan shall establish an internal health care quality improvement system, including enrollee satisfaction and disenrollment surveys. The quality improvement system must include incentives and disincentives for network providers.

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2. Each plan must collect and report the Health Plan Employer Data and Information Set (HEDIS) measures, as specified by the agency. These measures must be published on the plan's website in a manner that allows recipients to reliably compare the performance of plans. The agency shall use the HEDIS measures as a tool to monitor plan performance.

3. Each managed care plan must be accredited by the National Committee for Quality Assurance, the Joint Commission, a national accrediting organization that is approved by the Centers for Medicare and Medicaid Services and whose standards incorporate comparable licensure regulations required by the state, or another nationally recognized accrediting body, or have initiated the accreditation process, within 1 year after the contract is executed. The agency shall suspend automatic assignment under ss. 409.977 and 409.984 for a ~~any~~ plan not accredited within 18 months after executing the contract~~, the agency shall suspend automatic assignment under s. 409.977 and 409.984~~.

4. By the end of the fourth year of the first contract term, the agency shall issue a request for information to determine whether cost savings could be achieved by contracting for plan oversight and monitoring, including analysis of encounter data, assessment of performance measures, and compliance with other contractual requirements.

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

And the title is amended as follows:

Delete lines 3520 - 3523

and insert:

treating individuals with HIV/AIDS; amending s. 409.966; F.S.; revising references to certain accrediting organizations to conform to changes made by the act; amending s. 409.967, F.S.; requiring a managed care plan to permit enrollees to continue receiving certain drugs that are removed from the plan's formulary; revising references to certain accrediting organizations to conform to changes made by the act; amending s. 429.07, F.S.;