The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Appropriations Subcommittee on Health and Human Services

BILL:	CS/SB 670
INTRODUCER:	Banking and Insurance Committee and Senator Bean and others
SUBJECT:	Managed Care Plans' Provider Networks
DATE:	March 20, 2017 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Fav/CS**
2.	Forbes	Williams	AHS	**Recommend: Favorable**
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 670 prohibits a Medicaid managed care plan from excluding any pharmacy from its provider network if the pharmacy meets the credentialing requirements, complies with the Agency for Health Care Administration (agency) standards, and accepts the terms of the plan. The bill requires the managed care plan to offer the same rate of reimbursement to all pharmacies in the plan's network. The bill also authorizes the agency to adopt rules necessary to administer the provisions of the bill, including rules establishing credentialing requirements and quality standards for pharmacies. This bill will allow Medicaid enrollees to access additional pharmacies.

According to the agency, the bill will have an indeterminate fiscal impact on the Medicaid Program.

This bill is effective October 1, 2017.

II. Present Situation:

Many public and private employers and health plans contract with a pharmacy benefit manager (PBM) to help control drug costs. The PBM may provide the employer or plan with access to a nationwide network of pharmacies that will provide services and drugs at a discounted contracted price. The PBMs may negotiate drug prices with retail pharmacies and drug

manufacturers on behalf of health plans or employers and, in addition to other administrative, clinical, and cost containment services, process drug claims for the plans.

Historically, independent pharmacies were anchors in the business community and their pharmacists had long-term relationships with their patients.[1] However, many independent pharmacies have closed in recent years because of the competition resulting from the proliferation of big box and chain retail pharmacies[2] that can negotiate with PBMs at deeply discounted reimbursement levels based on large volume sales. While the big-box and chain retail pharmacies may be able to offset lower prescription reimbursements with other retail sales, it can be difficult for a local independent pharmacy to compete since they derive 90 percent or more of their revenue from prescription sales.[3]

Florida's Statewide Medicaid Managed Care Program

The Florida Medicaid program is a partnership between the federal and state governments. In Florida, the Agency for Health Care Administration (agency) oversees the Medicaid program.[4] The Statewide Medicaid Managed Care (SMMC) program is comprised of the Managed Medical Assistance (MMA) program and the Long-term Care (LTC) managed care program. The agency contracts with managed care plans to provide services to eligible recipients.

Accreditation of Medicaid Managed Care Plans

A managed care plan that is eligible to provide services under the SMMC program must have a contract with the agency to provide services under the Medicaid program. The plan must be a health insurer, an exclusive provider organization, a health maintenance organization (HMO), a provider service network, or an accountable care organization.[5]

Additionally, Medicaid managed care plans are required to be accredited by a nationally recognized accreditation organization or have initiated the accreditation process within 1 year after contract execution.[6] Accreditation is a process of review that healthcare organizations participate in to demonstrate the ability to meet predetermined standards.

Currently, all Florida Medicaid managed care plans are certified by one of three accreditation bodies,[7] which has its own credentialing standards. Each managed care plan must comply with these standards in order to maintain their accreditation. These standards address areas such as quality management and improvement, utilization management, and credentialing. Therefore, in addition to the agency's enrollment and contractually required credentialing requirements,

[1] Independent pharmacies are a type of retail pharmacy with a store-based location—often in rural and underserved areas—that dispense medications to consumers, including both prescription and over-the-counter drugs. See http://www.gao.gov/assets/660/651631.pdf (last viewed Mar. 1, 2017).
[2] Such as Walmart, CVS, Walgreens, Publix or Kroger.
[3] Modern Medicine, *The PBM Squeeze* (Apr. 15, 2013) available at http://drugtopics.modernmedicine.com/drug-topics/news/tags/mac/pbm-squeeze (last viewed Mar. 1, 2017).
[4] Part III of ch. 409, F.S., governs the Medicaid program.
[5] Section 409.962, F.S.
[6] Section 409.967(2)(f)3., F.S.
[7] National Committee for Quality Assurance (NCQA), Joint Commission (JCAHO), or the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC).

managed care plans are responsible for credentialing their providers in accordance with their accreditation standards. A Medicaid managed care plan that fails to attain and maintain accreditation may be subject to liquidated damages for each day of noncompliance.[8]

Provider Credentialing Requirements

Medicaid managed care plans are required by the SMMC contract to conduct credentialing activities of health care providers in accordance with their accreditation requirements to verify a provider's professional qualifications. The process of verifying the credentials of health care providers and facilities helps protect consumers from fraud and poor quality health care by ensuring that providers and facilities have the proper qualifications and licensure to deliver health care services. Most accrediting bodies require health plans to re-credential providers at least every 3 years. Many stakeholders share responsibility for credentialing, and most states and the federal government have laws that affect how credentialing is performed. For example, plans verify with a state or designated certification body that a provider is licensed to practice medicine. Plans also verify a practitioner's Drug Enforcement Agency or Controlled Dangerous Substances certificate, education, and training (including board certification), work history and history of professional liability claims.

Minimum Medicaid Enrollment Requirements

Section 409.912, F.S., authorizes the agency to limit the entities it contracts with or enrolls as Medicaid providers by developing a provider network through provider credentialing. The statute also states that providers are not entitled to enroll in the Medicaid provider network. The agency may limit its provider network based on the following factors:

- Assessment of beneficiary access to care,
- Provider availability,
- Provider quality standards,
- Time and distance standards for access to care,
- The cultural competence of the provider network,
- Demographic characteristics of Medicaid beneficiaries,
- Practice and provider-to-beneficiary standards,
- Appointment wait times,
- Beneficiary use of services,
- Provider turnover,
- Provider profiling,
- Provider licensure history,
- Previous program integrity investigations and findings,
- Peer review,
- Provider Medicaid policy and billing compliance records, and
- Clinical and medical record audits, and other factors.

[8] See http://www.fdhc.state.fl.us/medicaid/statewide_mc/plans.shtml for Florida Medicaid contract provisions (last viewed Mar. 1, 2017).

To receive Medicaid reimbursement, a provider must be enrolled in Medicaid, meet the provider qualifications at the time the service is rendered, and be in compliance with all applicable local, state, and federal laws, rules, regulations, Medicaid bulletins, manuals, handbooks, and statements of policy.[9] Providers rendering services to enrollees through managed care plan contracts currently have several enrollment options including registration only, limited provider enrollment, and full provider enrollment. The registration and limited provider enrollment options do not entitle the provider to serve recipients in the fee-for-service delivery system, but they do meet the federal and state screening standards and allow the issuance of a Medicaid provider identification number. Full provider enrollment allows a provider to serve recipients in the Medicaid fee-for-service delivery system or enrollees in a Medicaid managed care plan, if authorized by the managed care plan of the enrollee. Further, providers seeking limited provider enrollment or full enrollment must execute an agreement with the agency upon successful conclusion of the background screening requirements.[10]

Medicaid Prescription Drug Benefit

The agency maintains coverage policies for most Florida Medicaid services, which are incorporated by reference into ch. 59G-4, F.A.C. Medicaid managed care plans cannot be more restrictive than these policies or the Florida Medicaid State Plan (which is approved by the federal Centers for Medicare and Medicaid Services) in providing services to their enrollees. In addition to prescribing coverage requirements, the coverage policies also set minimum provider qualifications for who may render services to Medicaid recipients.

Florida Medicaid managed care plans serving MMA enrollees are required to provide all prescription drugs listed on the agency's Preferred Drug List (PDL) for at least the first year of operation. At this time, Medicaid managed care plans have not implemented their own plan-specific formulary or PDL. The prior authorization criteria and protocols related to prescription drugs of a Medicaid managed care plan must not be more restrictive than the criteria established by the agency.

The Medicaid fee-for-service system reimburses all Florida Medicaid pharmacy providers at the same rate. Florida Medicaid contracts with a pharmacy benefits manager (PBM) entity to pay for prescription claims. Managed care plans also have a PBM to process their pharmacy claims for all the pharmacies in their networks. For Medicaid managed care plans, the reimbursement of prescribed drugs is based upon negotiated prices between the managed care plan and the pharmacy provider.

Pharmacy Provider Networks in Medicaid Managed Care

Medicaid beneficiaries generally have the right to obtain medical services from any willing provider.[11] However, there is an exception for beneficiaries enrolled in certain managed care

[9] See Rules 59G-5.010 Provider Enrollment and 59G-5.020, F.A.C.
[10] For both limited provider enrollment and full provider enrollment, the agency conducts several basic credentialing functions, including licensure verification, background screening history, criminal history, and federal exclusion database checks. In the case of registered-only providers, the managed care plan is responsible for conducting all credential verifications and background checks.
[11] See CMS Guidance to State Medicaid Directors (Apr. 19, 2016) (on file with Banking and Insurance Committee).

plans (to permit such plans to restrict beneficiaries to providers in the managed care plan networks), except such plans cannot restrict the choice of family planning providers.[12]

Pursuant to s. 409.975(1), F.S., Medicaid managed care plans must develop and maintain provider networks that meet the medical needs of their enrollees in accordance with standards established pursuant to s. 409.967(2)(c), F.S. Managed care plans may limit the providers in their networks based on credentials, quality indicators and price, except as specified in the law, and may negotiate rates with pharmacy providers.

Managed care plans must maintain a region-wide network of pharmacy providers in sufficient numbers to meet the access standards for pharmacy and 24-hour pharmacy services for all recipients enrolled in the plan.[13] At a minimum, managed care plans must have pharmacy providers available to enrollees within 30 minutes and 20 miles and 24-hour pharmacy providers available within 60 minutes and 45 miles, regardless of whether in an urban or rural area.[14] At this time, the agency is amending contracts to revise pharmacy network standards to require managed care plans to have pharmacy providers available to the managed care plan's enrollees within 15 minutes and 10 miles, regardless of whether in an urban or rural area. The agency anticipates that this new network standard will be effective upon execution of the June 2017 plan contract amendment.[15]

Managed care plans may assign an enrollee to a specialty pharmacy for specialty medications; however, managed care plans must ensure that members have a choice of available providers in the network of the managed care plan, and members must be notified of this provision.[16] Prior to assigning an enrollee to a specialty pharmacy, the managed care plan must notify the enrollee how to change specialty pharmacies and "opt out" of the assignment, notify the enrollee of their freedom of choice among network providers, and notify the enrollee of rights and protections.[17]

If only one pharmacy distributes a specific product and the provider is not in the plan's network, the managed care plan must take necessary action to provide all medically necessary covered services to enrollees with reasonable promptness, including, but not limited to, the following:

- Utilizing out-of-network providers; and
- Using financial incentives to induce network or out-of-network providers to accept an enrollee as a patient/client and provide all medically necessary covered services with reasonable promptness to the enrollee.[18]

[12] See s. 1902(a)(23(B) of the Social Security Act, 42 C.F.R. s. 431.51(b)(1) and 42 C.F.R. Part 438.
[13] Section 409.967(2)(c)1., F.S.
[14] Pursuant to s. 409.967(2)(c)1., F.S., the managed care plan may use mail-order pharmacies; however, mail-order pharmacies do not count towards the plan's pharmacy network access standards.
[15] Agency for Health Care Administration, 2017 Agency Legislative Bill Analysis of SB 670 (Feb. 6, 2017) (on file with Senate Banking and Insurance Committee).
[16] 42 C.F.R. s. 438.10(f).
[17] 42 C.F.R. s. 438.100.
[18] 42 C.F.R. s. 438.206(b)(4).

Medicare Part D Any Willing Pharmacy Requirements

Federal regulations require a Part D prescription drug plan or sponsor to contract with any willing pharmacy that meets the particular plan's standard terms and conditions.[19] Federal guidance on this requirement provides that the plans standard terms and conditions establish a floor of minimum requirements that all similarly situated pharmacies must abide by while sponsors may modify some of their standard terms and conditions to encourage participation by particular pharmacies. Therefore, plans may negotiate varying payment rates to attract the network participation of certain pharmacies.[20]

Survey of other States

Based on a limited staff survey, approximately 24 states have enacted legislation requiring any willing pharmacy or pharmacist provisions. It is unclear whether these provisions apply to Medicaid or commercial plans or both. In 2015, the State of Maryland issued a report relating to access to Medicaid pharmacy services.[21] In the report, the state contends that encouraging managed care plans to limit their pharmacy networks is an effective strategy for achieving substantial savings without jeopardizing access to prescription drugs. The report cited studies that concluded that allowing insurers to work with PBMs to limit or restrict their pharmacy networks would result in savings[22] while implementing "any willing provider" (AWP) laws may increase pharmacy drug costs.[23]

III. Effect of Proposed Changes:

Section 1 amends s. 409.975, F.S., to prohibit a Medicaid managed care plan from excluding any pharmacy from its provider network if the pharmacy meets the credentialing requirements, complies with the agency standards, and accepts the terms of the plan. The managed care plan must offer the same rate of reimbursement to all pharmacies in the plan's network.

The bill authorizes the agency to adopt rules necessary to administer the provisions of this bill, which includes rules establishing credentialing requirements and quality standards for pharmacies.

Section 2 provides the act will take effect October 1, 2017.

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[19] 42 C.F.R. s. 423.120(a)(8)(i).
[20] Centers for Medicare and Medicaid Services, *Compliance with Any Willing Pharmacy (AWP) Requirements* (Aug. 13, 2015) (on file with Senate Banking and Insurance Committee).
[21] Maryland Department of Health and Mental Hygiene, *Ensuring Maryland Medical Assistance Program Recipients Enrolled in Managed Care Organizations Have Reasonable Access to Pharmacy Services* (Dec. 2015), available at https://mmcp.dhmh.maryland.gov/Documents/JCRs/MCOpharmacynetworksJCRfinal12-15.pdf (last viewed Mar. 1, 2017).
[22] Joanna Shepard, *Selective Contracting in Prescription Drugs: The Benefits for Pharmacy Networks,* 15 MINN. J.L. SCI. & TECH. 1027 (2014) available at http://scholarship.law.umn.edu/cgi/viewcontent.cgi?article=1031&context=mjlst (last viewed Mar. 1, 2017).
[23] Jonathon Klick and Joshua D. Wright, *The Effect of any Willing Provider and Freedom of Choice Laws on Prescription Drug Expenditures*, 17 AM. LAW ECON. REV. 192-213 (Spring 2015), available at http://scholarship.law.upenn.edu/cgi/viewcontent.cgi?article=1437&context=faculty_scholarship (last viewed Mar. 1, 2017).

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Requiring Medicaid managed care plans to contract with "any willing pharmacy" that meets certain requirements for participation in Medicaid managed care plans may offer patients greater choice and convenience in the selection of pharmacies.

Absent the promise of exclusivity of network providers, the bargaining power of the larger Medicaid managed care plans may be weakened. Providers may have less incentive to offer substantial discounts to plans, possibly resulting in higher costs to the plans, which may be passed through to the capitation rate setting process.

C. Government Sector Impact:

Impacts on the Credentialing Process[24]

The bill will have an operational and fiscal impact on the Medicaid program, in particular the operations of managed care plans contracted to provide services through the SMMC program.

Medicaid managed care plans will be required to determine if existing pharmacy providers meet and maintain the new credentialing and quality standards. Because this change may result in larger provider networks, the plans may need to deploy additional strategies to monitor against fraud, waste, and abuse. These additional responsibilities may have a fiscal impact on the managed care plans. The fiscal impact of the proposed changes will have an indeterminate impact on managed care plans, but if significant, the

[24] Agency for Health Care Administration, *2017 Agency Legislative Bill Analysis* (Feb. 6, 2017) (on file with Senate Banking and Insurance Committee)

additional administrative costs most likely will be passed through to the capitation rate setting process.

Impacts on Payment Strategies

The bill further requires managed care plans to offer the same rate of reimbursement to all pharmacies in the plan's network. The bill reduces the ability of the plans to negotiate rates for services with pharmacy providers. The bill limits the ability of the plans to control the size of provider networks through cost effective purchasing strategies, which also has the potential to reduce savings opportunities. Currently, managed care plans have the ability to achieve savings by contracting with pharmacies at reduced prices in exchange for volume purchasing. The bill may reduce the managed care plans' bargaining power, resulting in increased costs to the Medicaid program through adjustments that would need to be made in the capitation rates.

VI. Technical Deficiencies:

None.

VII. Related Issues:

According to the agency, the bill creates challenges for plans that want to implement value based purchasing or alternative payment methodologies that are tied to certain plan-specific quality improvement strategies.

VIII. Statutes Affected:

This bill substantially amends section 409.975 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Banking and Insurance on March 6, 2017:
The CS clarifies rulemaking authority and changes the effective date from July 1 to October 1, 2017.

B. Amendments:

None.