A bill to be entitled

An act relating to managed care plan network access; amending s. 409.967, F.S.; requiring that the Agency for Health Care Administration include specified requirements in its contracts with Medicaid managed care plans; amending s. 409.975, F.S.; authorizing enrollees of Medicaid managed care plans to receive care from Medicaid providers not under contract with the plan under certain circumstances; requiring the plans to reimburse such providers at the applicable rates paid for such services under the plan; providing an effective date.

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

Section 1. Paragraph (c) of subsection (2) of section 409.967, Florida Statutes, is 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. Plans must allow enrollees to receive care from Medicaid providers not under contract with the plan if an enrollee is unable to receive care from a participating provider under the plan in a timely manner consistent with a reasonable access standard, as determined by agency rule, or there is another appropriate Medicaid provider in a location more geographically accessible to the enrollee's residence than those under the plan. The plan must reimburse the nonparticipating Medicaid providers for such services at the applicable Medicaid rate for such services under 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. Each plan must ~~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 must ~~shall~~ submit quarterly reports to the agency identifying the number of enrollees assigned to each primary care provider. The agency shall conduct, or contract for, systematic and continuous testing of the provider network databases maintained by each plan to confirm accuracy, confirm that behavioral health providers are accepting enrollees, and confirm that enrollees have access to behavioral health services.

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 serving children in the care and custody of the Department of Children and Families must maintain complete medical, dental, and behavioral health encounter information and participate in making such information available to the department or the applicable contracted community-based care lead agency for use in providing comprehensive and coordinated case management. The agency and the department shall establish an interagency agreement to provide guidance for the format, confidentiality, recipient, scope, and method of information to be made available and the deadlines for submission of the data. The scope of information available to the department is ~~shall be~~ the data that managed care plans are required to submit to the agency. The agency shall determine the plan's compliance with standards for access to medical, dental, and behavioral health services; the use of medications; and follow-up ~~followup~~ on all medically necessary services recommended as a result of early and periodic screening, diagnosis, and treatment.

Section 2. Paragraph (f) is added to subsection (1) of 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.

(1) PROVIDER NETWORKS.—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). Except as provided in this section, managed care plans may limit the providers in their networks based on credentials, quality indicators, and price.

(f) If an enrollee is unable to receive care from a participating provider under the managed care plan in a timely manner consistent with a reasonable access standard, as determined by agency rule, or there is another appropriate Medicaid provider in a location more geographically accessible to the enrollee's residence than those under the plan, an enrollee may receive such care from a Medicaid provider not under contract with the plan. Plans must reimburse a nonparticipating Medicaid provider for services rendered under this paragraph at the applicable Medicaid rate for such services under the plan.

Section 3. This act shall take effect July 1, 2025.