A bill to be entitled

An act relating to the state Medicaid program; amending s. 409.904, F.S.; authorizing the Agency for Health Care Administration to conduct retrospective reviews and audits of certain claims under the state Medicaid program for a specified purpose; creating s. 409.9041, F.S.; providing legislative findings; requiring the agency, in coordination with the Department of Children and Families, to implement mandatory work and community engagement requirements for able-bodied adults as a condition of obtaining and maintaining Medicaid coverage; requiring the agency to seek federal approval to implement such requirements for certain populations; specifying populations that are subject to such work and community engagement requirements; providing exceptions; defining the term "family caregiver"; specifying the types of activities which may satisfy the work and community engagement requirements; providing that a certain population is required to engage in work or community engagement activities only during standard school hours; requiring persons eligible for Medicaid to demonstrate compliance with the work and community engagement requirements at specified times as a condition of maintaining Medicaid coverage; requiring the agency to

develop a process for ensuring compliance with the work and community engagement requirements; requiring that such process align, to the extent possible, with certain existing processes; requiring the department to verify compliance with the work and community engagement requirements at specified intervals; requiring the agency, in coordination with the department, to conduct outreach regarding implementation of the work and community engagement requirements; specifying requirements for such outreach; specifying procedures in the event of noncompliance; requiring the agency, in coordination with the department, to notify a Medicaid recipient of a finding of noncompliance and the impact to eligibility for continued receipt of services; specifying requirements for such notice; amending s. 409.905, F.S.; requiring the agency to maintain cost-effective purchasing practices in its coverage of hospital inpatient services rendered to Medicaid recipients; amending 409.906, F.S.; requiring the agency to seek federal approval to implement a program for expanded coverage of home- and community-based behavioral health services for a specified population; specifying the goal of the program; requiring the agency to work in coordination with the department to

develop and implement the program upon federal approval; amending s. 409.91195, F.S.; revising the purpose of the Medicaid Pharmaceutical and Therapeutics Committee to include creation of a Medicaid preferred physician-administered drug list, a Medicaid preferred product list, and a high-cost drug list; requiring the agency to adopt such lists upon recommendation of the committee; specifying the frequency with which the committee must review such lists for any recommended additions or deletions; specifying parameters for such recommended additions and deletions; providing that reimbursement for drugs not included on such lists is subject to prior authorization, with an exception; requiring the agency to publish and disseminate such lists to all Medicaid providers in the state by posting on the agency's website or in other media; providing requirements for public testimony related to proposed inclusions on or exclusions from certain lists; requiring the committee to consider certain factors when developing such recommended additions and deletions; amending s. 409.912, F.S.; revising the components of the Medicaid prescribed-drug spending-control program to include the preferred physician-administered drug list, the preferred product list, and the high-cost drug list;

providing requirements for such lists; providing that the agency does not need to follow rulemaking procedures of ch. 120, F.S., when posting updates to such lists; establishing an alternative reimbursement methodology for long-acting injectables administered in a hospital facility setting for severe mental illness; requiring the agency to contract with a vendor to perform a fiscal impact study of the federal 340B Drug Pricing Program; providing requirements for the study; requiring specified entities to submit certain data to the agency for purposes of the study; providing that noncompliance with such requirement may result in sanctions from the agency or the Board of Pharmacy, as applicable; requiring the agency to submit the results of the study to the Governor and the Legislature by a specified date; providing construction; amending s. 409.9122, F.S.; revising requirements for managed care plan encounter data submission and analysis under the Medicaid Encounter Data System; amending s. 409.913, F.S.; revising the definition of the term "overpayment"; providing that determinations of an overpayment under the Medicaid program may be based upon retrospective reviews, investigations, analyses, or audits conducted by the agency to determine possible fraud, abuse,

overpayment, or recipient neglect; providing that certain notices may be provided using other common carriers, as well as through the United States Postal Service; amending s. 409.962, F.S.; defining the term "affiliate"; amending s. 409.967, F.S.; requiring that managed care plan contracts require any third-party administrative entity contracted with the plan to adhere to specified requirements; specifying additional types of payments which may not be included in calculating income for purposes of the achieved savings rebate; requiring the agency to ensure oversight of affiliated entities and related parties within the Statewide Medicaid Managed Care program; requiring the agency to examine specified records and data related to such entities and parties; requiring the agency to consider certain data and findings when determining its final medical loss ratio and during the rate setting process under the program; creating s. 409.9675, F.S.; defining the term "control"; requiring managed care plans to report to the agency and the Office of Insurance Regulation the existence of and details relating to certain affiliations by a specified date and annually thereafter; requiring managed care plans to report any change in such information to the agency and the office in writing

within a specified timeframe; requiring the agency to calculate, analyze, and publicly report on the agency's website an assessment of affiliated entity payment transactions in the Medicaid program and certain administrative costs by a specified date and annually thereafter; providing requirements for the assessment; amending s. 409.973, F.S.; requiring the agency to implement an Integrated Managed Care Pilot Program in designated regions by a specified date; requiring the agency to submit a request for federal approval for the program by a specified date; requiring the agency to implement the program in specified regions by a specified date, contingent on federal approval; providing requirements for implementing the program, including requirements for plan contracts, service delivery, and provider credentialing; providing for the termination of plan contracts under certain circumstances; requiring the agency to establish measures for evaluating the program; requiring the agency to contract with an independent evaluator to conduct the evaluations; specifying requirements for the evaluations; requiring the agency to submit a report on the performance of the pilot program to the Governor and the Legislature beginning on a specified date and annually thereafter;

amending ss. 409.91196 and 627.42392, F.S.; conforming cross-references; providing an effective date.

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

Section 1. Subsection (4) of section 409.904, Florida Statutes, is amended to read:

409.904 Optional payments for eligible persons.—The agency may make payments for medical assistance and related services on behalf of the following persons who are determined to be eligible subject to the income, assets, and categorical eligibility tests set forth in federal and state law. Payment on behalf of these Medicaid eligible persons is subject to the availability of moneys and any limitations established by the General Appropriations Act or chapter 216.

(4) A low-income person who meets all other requirements for Medicaid eligibility except citizenship and who is in need of emergency medical services. The eligibility of such a recipient is limited to the period of the emergency, in accordance with federal regulations. The agency may conduct retrospective reviews or audits of services rendered to the individual and claims submitted by the provider to validate the existence and duration of the emergency medical condition and whether the services rendered were necessary to treat the emergency medical condition regardless of whether the provider

obtained prior authorization for the services.

Section 2. Section 409.9041, Florida Statutes, is created to read:

409.9041 Medicaid work and community engagement requirements.—

(1)(a) The Legislature finds that assisting able-bodied adult Medicaid recipients in achieving self-sufficiency through meaningful work and community engagement is essential to ensuring that the state Medicaid program remains a sustainable resource for residents who are most in need of such assistance.

(b) The agency, in coordination with the department, shall implement mandatory work and community engagement requirements for able-bodied adults as a condition of obtaining and maintaining coverage under the state Medicaid program.

(2) The agency shall seek federal approval to implement mandatory work and community engagement requirements for certain populations, as specified in this section, as a condition of obtaining and maintaining coverage under the state Medicaid program.

(3)(a) Medicaid recipients between the ages of 18 and 64 years must meet the work or community engagement requirements of this section, unless they are one of the following:

1. Indian as defined under 42 C.F.R. s. 438.14(a).

2. A parent, guardian, caretaker relative, or family caregiver of a dependent child younger than 6 years of age or of

a disabled individual. For purposes of this paragraph, the term "family caregiver" means an adult family member or other individual who has a significant relationship with, and who provides a broad range of assistance to, an individual with a chronic or other health condition, disability, or functional limitation.

3. Former foster youth younger than 23 years of age.

4. A veteran with a total disability, as specified under 38 C.F.R. s. 3.340 or as specified by a Veteran Affairs Disability Ratings Letter issued by the United States Department of Veterans Affairs.

5. An individual classified as medically frail under the Medicaid Institutionalized Care Program; categorized as aged, blind, or disabled under the state Medicaid program; or who has a developmental disability as defined in s. 393.063.

6. An individual living in a household that receives Supplemental Nutrition Assistance Program benefits and who is already in compliance with work requirements pursuant to s. 445.024.

7. An individual participating in a residential substance use disorder treatment program.

8. An inmate of a public institution.

9. A woman eligible for Medicaid coverage in a pregnancy-related or postpartum care category.

(b) A person may satisfy the work or community engagement

requirements of this section by participating in one or more of the following activities for at least 80 hours per month:

1. Paid employment.

2. On-the-job-training.

3. Vocational educational training.

4. Job skills training directly related to employment.

5. Education directly related to employment.

6. Satisfactory attendance at a secondary school or in a course of study leading to a high school equivalency diploma.

7. Enrollment at least half-time as defined in 34 C.F.R. s. 668.2(b) in a postsecondary education program to obtain a credential on the Master Credentials List as maintained pursuant to s. 445.004(6)(e).

8. Any other work activity designated as such by the Department of Commerce and provided by a local workforce development board pursuant to s. 445.024.

(c) Parents with children ages 6 through 18 are required to engage in work or community engagement activities only during standard school hours.

(4)(a) Notwithstanding any other statutory provision, in order to maintain Medicaid coverage, an eligible Medicaid recipient must, before enrollment and upon any redetermination for coverage, demonstrate compliance with the work or community engagement requirements of this section.

(b) The agency shall develop a process for ensuring

compliance with this section which aligns, to the extent possible, with the processes currently in place relating to work and community engagement requirements authorized under the state's Supplemental Nutrition Assistance Program, including, but not limited to, participant registration with a local CareerSource center, employment and training programs, and collaboration with the state's local workforce boards.

(c) The department shall verify, in accordance with its procedures, that an individual subject to the work and community engagement requirements of this section demonstrates compliance during the individual's regularly scheduled redetermination of eligibility, or more frequently as determined by the department.

(5) The agency, in coordination with the department, shall conduct outreach regarding the implementation of the work and community engagement requirements of this section. The outreach much include, at a minimum, notification to impacted individuals, including timelines for implementation, requirements for compliance, penalties for noncompliance, and information on how to request an exemption.

(6) If a recipient subject to the work and community engagement requirements of this section is determined to be in noncompliance with such requirements, the agency, in coordination with the department, must notify the recipient of the finding of noncompliance and the impact to his or her eligibility for continued receipt of Medicaid services. The

notice must include, at a minimum, notification of all of the following:

(a) That the recipient is eligible for a grace period of 30 days to either come into compliance with the requirements or request an exemption from the requirements and that Medicaid coverage of services will continue during the grace period.

(b) That if, following the 30-day period, the individual has not come into compliance with or requested an exemption from the work and community engagement requirements, his or her application for assistance will be denied and services terminated at the end of the month following the month in which such 30-calendar-day period ends.

(c) The right of the individual to request a fair hearing if he or she is determined to be noncompliant with program requirements and disenrolled from the state Medicaid program.

(d) How he or she can reapply for medical assistance under the state Medicaid program.

Section 3. Paragraph (f) is added to subsection (5) of section 409.905, Florida Statutes, to read:

409.905 Mandatory Medicaid services.—The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically

necessary and in accordance with state and federal law. Mandatory services rendered by providers in mobile units to Medicaid recipients may be restricted by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.

(5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for all covered services provided for the medical care and treatment of a recipient who is admitted as an inpatient by a licensed physician or dentist to a hospital licensed under part I of chapter 395. However, the agency shall limit the payment for inpatient hospital services for a Medicaid recipient 21 years of age or older to 45 days or the number of days necessary to comply with the General Appropriations Act.

(f) In its coverage of services under this subsection, the agency shall maintain cost-effective purchasing practices as required by s. 409.912.

Section 4. Present subsections (14) through (29) of section 409.906, Florida Statutes, are redesignated as subsections (15) through (30), respectively, and a new subsection (14) is added to that section, to read:

409.906 Optional Medicaid services.—Subject to specific

appropriations, the agency may make payments for services which are optional to the state under Title XIX of the Social Security Act and are furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any optional service that is provided shall be provided only when medically necessary and in accordance with state and federal law. Optional services rendered by providers in mobile units to Medicaid recipients may be restricted or prohibited by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. If necessary to safeguard the state's systems of providing services to elderly and disabled persons and subject to the notice and review provisions of s. 216.177, the Governor may direct the Agency for Health Care Administration to amend the Medicaid state plan to delete the optional Medicaid service known as "Intermediate Care Facilities for the Developmentally Disabled." Optional services may include:

(14) HOME- AND COMMUNITY-BASED BEHAVIORAL HEALTH SERVICES.—The agency shall seek federal approval to implement a program that covers an expanded array of home- and community-based services for adults 18 years of age and older diagnosed

with a serious mental illness who are high utilizers of behavioral health services in an institutional setting. The program must be designed to reduce the need for institutional levels of care for adults with a serious mental illness. The agency shall work in coordination with the Department of Children and Families to develop and implement the program upon receiving federal approval.

Section 5. Section 409.91195, Florida Statutes, is amended to read:

409.91195 Medicaid Pharmaceutical and Therapeutics Committee.—There is created a Medicaid Pharmaceutical and Therapeutics Committee within the agency for the purpose of developing a Medicaid preferred drug list, a Medicaid preferred physician-administered drug list, a Medicaid preferred product list, and a high-cost drug list.

(1) The committee shall be composed of 11 members appointed by the Governor. Four members shall be physicians, licensed under chapter 458; one member licensed under chapter 459; five members shall be pharmacists licensed under chapter 465; and one member shall be a consumer representative. The members shall be appointed to serve for terms of 2 years from the date of their appointment. Members may be appointed to more than one term. The agency shall serve as staff for the committee and assist them with all ministerial duties. The Governor shall ensure that at least some of the members of the committee

represent Medicaid participating physicians and pharmacies serving all segments and diversity of the Medicaid population, and have experience in either developing or practicing under a preferred drug list. At least one of the members shall represent the interests of pharmaceutical manufacturers.

(2) Committee members shall select a chairperson and a vice chairperson each year from the committee membership.

(3) The committee shall meet at least quarterly and may meet at other times at the discretion of the chairperson and members. The committee shall comply with rules adopted by the agency, including notice of any meeting of the committee pursuant to the requirements of the Administrative Procedure Act.

(4) Upon recommendation of the committee, the agency shall adopt a preferred drug list, a preferred physician-administered drug list, a preferred product list, and a high-cost drug list as described in s. 409.912(5). To the extent feasible, the committee shall review all drug or product classes included on the preferred drug list, the preferred physician-administered drug list, and the preferred product list every 12 months~~,~~ and the high-cost drug list every 6 months. The committee may recommend additions to and deletions from the lists ~~preferred drug list~~, such that the lists provide ~~preferred drug list provides~~ for medically appropriate drug and product therapies for Medicaid patients which achieve cost savings contained in

the General Appropriations Act.

(5) Except for antiretroviral drugs, reimbursement of drugs not included on the preferred drug list, preferred physician-administered drug list, preferred product list, or high-cost drug list is subject to prior authorization.

(6) The agency shall publish and disseminate the preferred drug list, preferred physician-administered drug list, preferred product list, and high-cost drug list to all Medicaid providers in the state by Internet posting on the agency's website or in other media.

(7) The committee shall ensure that interested parties, including pharmaceutical manufacturers agreeing to provide a supplemental rebate as outlined in this chapter, have an opportunity to present public testimony to the committee with information or evidence supporting inclusion of a drug or product on the preferred drug list, preferred physician-administered drug list, or preferred product list. Such public testimony shall occur before ~~prior to~~ any recommendations made by the committee for inclusion or exclusion from the preferred drug list, preferred physician-administered drug list, or preferred product list. Upon timely notice, the agency shall ensure that any drug that has been approved or had any of its particular uses approved by the United States Food and Drug Administration under a priority review classification will be reviewed by the committee at the next regularly scheduled

meeting following 3 months of distribution of the drug to the general public.

(8) The committee shall develop its preferred drug list, preferred physician-administered drug list, preferred product list, and high-cost drug list recommendations by considering the clinical efficacy, safety, and cost-effectiveness of a product.

(9) The Medicaid Pharmaceutical and Therapeutics Committee may also make recommendations to the agency regarding the prior authorization of any prescribed drug covered by Medicaid.

(10) Medicaid recipients may appeal agency preferred drug formulary decisions using the Medicaid fair hearing process administered by the Agency for Health Care Administration.

Section 6. Paragraph (a) of subsection (5) of section 409.912, Florida Statutes, is amended, and subsection (14) is added to that section, to read:

409.912 Cost-effective purchasing of health care.—The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program. This section does not restrict access to emergency services or poststabilization care services as defined in 42 C.F.R. s. 438.114. Such confirmation or second opinion

shall be rendered in a manner approved by the agency. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency shall contract with a vendor to monitor and evaluate the clinical practice patterns of providers in order to identify trends that are outside the normal practice patterns of a provider's professional peers or the national guidelines of a provider's professional association. The vendor must be able to provide information and counseling to a provider whose practice patterns are outside the norms, in consultation with the agency, to improve patient care and reduce inappropriate utilization. The agency may mandate prior authorization, drug therapy management, or disease management participation for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform

the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization. The agency is authorized to limit the entities it contracts with or enrolls as Medicaid providers by developing a provider network through provider credentialing. The agency may competitively bid single-source-provider contracts if procurement of goods or services results in demonstrated cost savings to the state without limiting access to care. The agency may limit its network based on the 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, clinical and medical record audits, and other factors. Providers are not entitled to enrollment in the Medicaid provider network. The agency shall determine instances in which allowing Medicaid beneficiaries to purchase durable medical equipment and other goods is less expensive to the Medicaid program than long-term rental of the equipment or goods. The agency may establish rules to facilitate purchases in lieu of long-term rentals in order to protect against fraud and abuse in the Medicaid program as

defined in s. 409.913. The agency may seek federal waivers necessary to administer these policies.

(5)(a) The agency shall implement a Medicaid prescribed-drug spending-control program that includes the following components:

1. A Medicaid preferred drug list and a Medicaid physician-administered drug list. The preferred drug list~~, which~~ shall be a listing of cost-effective therapeutic options recommended by the Medicaid Pharmacy and Therapeutics Committee established pursuant to s. 409.91195 and adopted by the agency for each therapeutic class on the preferred drug list. At the discretion of the committee, and when feasible, the preferred drug list should include at least two products in a therapeutic class. The physician-administered drug list shall be a listing of physician-administered drugs covered by the state Medicaid program, based on the United States Food and Drug Administration's approved indications and compendia in 42 U.S.C. s. 1396r-8(g)(1)(B). Within the preferred physician-administered drug list, there must be a section containing a list of preferred physician-administered drugs that are cost-effective therapeutic options recommended by the Medicaid Pharmaceutical and Therapeutics Committee established pursuant to s. 409.91195. The physician-administered drug list must be updated at least twice a year. The agency may post and update the preferred drug list and the preferred physician-administered drug ~~updates to~~

~~the~~ list on an Internet website without following the rulemaking procedures of chapter 120. Antiretroviral agents are excluded from the preferred drug list. The agency shall also limit the amount of a prescribed drug dispensed to no more than a 34-day supply unless the drug products' smallest marketed package is greater than a 34-day supply, or the drug is determined by the agency to be a maintenance drug in which case a 100-day maximum supply may be authorized. The agency may seek any federal waivers necessary to implement these cost-control programs and to continue participation in the federal Medicaid rebate program, or alternatively to negotiate state-only manufacturer rebates. The agency may adopt rules to administer this subparagraph. The agency shall continue to provide unlimited contraceptive drugs and items. The agency must establish procedures to ensure that:

a. There is a response to a request for prior authorization by telephone or other telecommunication device within 24 hours after receipt of a request for prior authorization; and

b. A 72-hour supply of the drug prescribed is provided in an emergency or when the agency does not provide a response within 24 hours as required by sub-subparagraph a.

2. A Medicaid preferred product list, which shall be a listing of cost-effective therapeutic supplies recommended by the Medicaid Pharmaceutical and Therapeutics Committee

established pursuant to s. 409.91195 and adopted by the agency for each product class listed on the preferred product list and reimbursed by the state Medicaid program through the pharmacy point-of-sale. The agency may post the preferred product list and updates to the list on the agency's website without following the rulemaking procedures of chapter 120.

3. A list of high-cost drugs recommended by the Medicaid Pharmaceutical and Therapeutics Committee established pursuant to s. 409.91195 and adopted by the agency, for the purpose of coverage, reimbursement, or billing guidance. The agency may post the high-cost drug list and updates to the list on an Internet website without following the rulemaking procedures of chapter 120.

4. A provider of prescribed drugs is reimbursed in an amount not to exceed the lesser of the actual acquisition cost based on the Centers for Medicare and Medicaid Services National Average Drug Acquisition Cost pricing files plus a professional dispensing fee, the wholesale acquisition cost plus a professional dispensing fee, the state maximum allowable cost plus a professional dispensing fee, or the usual and customary charge billed by the provider.

5. A hospital facility administering long-acting injectables for severe mental illness shall be reimbursed separately from the diagnosis-related group. Long-acting injectables administered for severe mental illness in a hospital

facility setting shall be reimbursed at no less than the actual acquisition cost of the drug.

6. The agency shall contract with a vendor to perform a detailed fiscal impact study to evaluate the 340B Drug Pricing Program administered by the Health Resources and Services Administration. The study must evaluate 340B compliance, 340B drug purchases, and reimbursement methodologies within the fee-for-service program and Statewide Medicaid Managed Care program. Statewide Medicaid Managed Care plans, pharmacy benefit managers, and Medicaid providers shall submit to the agency all data necessary for the completion of the study, including, but not limited to, information related to drug purchasing, reimbursement, billing and coding, and dispensing. Noncompliance with the 340B data submission requirements of this subparagraph may result in sanctions from the agency or the Board of Pharmacy, as applicable. The agency shall submit the results of the study to the Governor, the President of the Senate, and the Speaker of the House of Representatives by June 30, 2027.

7.~~3.~~ The agency shall develop and implement a process for managing the drug therapies of Medicaid recipients who are using significant numbers of prescribed drugs each month. The management process may include, but is not limited to, comprehensive, physician-directed medical-record reviews, claims analyses, and case evaluations to determine the medical necessity and appropriateness of a patient's treatment plan and

drug therapies. The agency may contract with a private organization to provide drug-program-management services. The Medicaid drug benefit management program shall include initiatives to manage drug therapies for HIV/AIDS patients, patients using 20 or more unique prescriptions in a 180-day period, and the top 1,000 patients in annual spending. The agency shall enroll any Medicaid recipient in the drug benefit management program if he or she meets the specifications of this provision and is not enrolled in a Medicaid health maintenance organization.

8.~~4.~~ The agency may limit the size of its pharmacy network based on need, competitive bidding, price negotiations, credentialing, or similar criteria. The agency shall give special consideration to rural areas in determining the size and location of pharmacies included in the Medicaid pharmacy network. A pharmacy credentialing process may include criteria such as a pharmacy's full-service status, location, size, patient educational programs, patient consultation, disease management services, and other characteristics. The agency may impose a moratorium on Medicaid pharmacy enrollment if it is determined that it has a sufficient number of Medicaid-participating providers. The agency must allow dispensing practitioners to participate as a part of the Medicaid pharmacy network regardless of the practitioner's proximity to any other entity that is dispensing prescription drugs under the Medicaid

program. A dispensing practitioner must meet all credentialing requirements applicable to his or her practice, as determined by the agency.

9.~~5.~~ The agency shall develop and implement a program that requires Medicaid practitioners who issue written prescriptions for medicinal drugs to use a counterfeit-proof prescription pad for Medicaid prescriptions. The agency shall require the use of standardized counterfeit-proof prescription pads by prescribers who issue written prescriptions for Medicaid recipients. The agency may implement the program in targeted geographic areas or statewide.

10.~~6.~~ The agency may enter into arrangements that require manufacturers of generic drugs prescribed to Medicaid recipients to provide rebates of at least 15.1 percent of the average manufacturer price for the manufacturer's generic products. These arrangements shall require that if a generic-drug manufacturer pays federal rebates for Medicaid-reimbursed drugs at a level below 15.1 percent, the manufacturer must provide a supplemental rebate to the state in an amount necessary to achieve a 15.1-percent rebate level.

11.~~7.~~ The agency may establish a preferred drug list as described in this subsection, and, pursuant to the establishment of such preferred drug list, negotiate supplemental rebates from manufacturers that are in addition to those required by Title XIX of the Social Security Act and at no less than 14 percent of

the average manufacturer price as defined in 42 U.S.C. s. 1936 on the last day of a quarter unless the federal or supplemental rebate, or both, equals or exceeds 29 percent. There is no upper limit on the supplemental rebates the agency may negotiate. The agency may determine that specific products, brand-name or generic, are competitive at lower rebate percentages. Agreement to pay the minimum supplemental rebate percentage guarantees a manufacturer that the Medicaid Pharmaceutical and Therapeutics Committee will consider a product for inclusion on the preferred drug list. However, a pharmaceutical manufacturer is not guaranteed placement on the preferred drug list by simply paying the minimum supplemental rebate. Agency decisions will be made on the clinical efficacy of a drug and recommendations of the Medicaid Pharmaceutical and Therapeutics Committee, as well as the price of competing products minus federal and state rebates. The agency may contract with an outside agency or contractor to conduct negotiations for supplemental rebates. For the purposes of this section, the term "supplemental rebates" means cash rebates. Value-added programs as a substitution for supplemental rebates are prohibited. The agency may seek any federal waivers to implement this initiative.

12.a.~~8.a.~~ The agency may implement a Medicaid behavioral drug management system. The agency may contract with a vendor that has experience in operating behavioral drug management systems to implement this program. The agency may seek federal

waivers to implement this program.

b. The agency, in conjunction with the Department of Children and Families, may implement the Medicaid behavioral drug management system that is designed to improve the quality of care and behavioral health prescribing practices based on best practice guidelines, improve patient adherence to medication plans, reduce clinical risk, and lower prescribed drug costs and the rate of inappropriate spending on Medicaid behavioral drugs. The program may include the following elements:

(I) Provide for the development and adoption of best practice guidelines for behavioral health-related drugs such as antipsychotics, antidepressants, and medications for treating bipolar disorders and other behavioral conditions; translate them into practice; review behavioral health prescribers and compare their prescribing patterns to a number of indicators that are based on national standards; and determine deviations from best practice guidelines.

(II) Implement processes for providing feedback to and educating prescribers using best practice educational materials and peer-to-peer consultation.

(III) Assess Medicaid beneficiaries who are outliers in their use of behavioral health drugs with regard to the numbers and types of drugs taken, drug dosages, combination drug therapies, and other indicators of improper use of behavioral

health drugs.

(IV) Alert prescribers to patients who fail to refill prescriptions in a timely fashion, are prescribed multiple same-class behavioral health drugs, and may have other potential medication problems.

(V) Track spending trends for behavioral health drugs and deviation from best practice guidelines.

(VI) Use educational and technological approaches to promote best practices, educate consumers, and train prescribers in the use of practice guidelines.

(VII) Disseminate electronic and published materials.

(VIII) Hold statewide and regional conferences.

(IX) Implement a disease management program with a model quality-based medication component for severely mentally ill individuals and emotionally disturbed children who are high users of care.

13.~~9.~~ The agency shall implement a Medicaid prescription drug management system.

a. The agency may contract with a vendor that has experience in operating prescription drug management systems in order to implement this system. Any management system that is implemented in accordance with this subparagraph must rely on cooperation between physicians and pharmacists to determine appropriate practice patterns and clinical guidelines to improve the prescribing, dispensing, and use of drugs in the Medicaid

program. The agency may seek federal waivers to implement this program.

b. The drug management system must be designed to improve the quality of care and prescribing practices based on best practice guidelines, improve patient adherence to medication plans, reduce clinical risk, and lower prescribed drug costs and the rate of inappropriate spending on Medicaid prescription drugs. The program must:

(I) Provide for the adoption of best practice guidelines for the prescribing and use of drugs in the Medicaid program, including translating best practice guidelines into practice; reviewing prescriber patterns and comparing them to indicators that are based on national standards and practice patterns of clinical peers in their community, statewide, and nationally; and determine deviations from best practice guidelines.

(II) Implement processes for providing feedback to and educating prescribers using best practice educational materials and peer-to-peer consultation.

(III) Assess Medicaid recipients who are outliers in their use of a single or multiple prescription drugs with regard to the numbers and types of drugs taken, drug dosages, combination drug therapies, and other indicators of improper use of prescription drugs.

(IV) Alert prescribers to recipients who fail to refill prescriptions in a timely fashion, are prescribed multiple drugs

that may be redundant or contraindicated, or may have other potential medication problems.

14.~~10.~~ The agency may contract for drug rebate administration, including, but not limited to, calculating rebate amounts, invoicing manufacturers, negotiating disputes with manufacturers, and maintaining a database of rebate collections.

15.~~11.~~ The agency may specify the preferred daily dosing form or strength for the purpose of promoting best practices with regard to the prescribing of certain drugs as specified in the General Appropriations Act and ensuring cost-effective prescribing practices.

16.~~12.~~ The agency may require prior authorization for Medicaid-covered prescribed drugs. The agency may prior-authorize the use of a product:

a. For an indication not approved in labeling;

b. To comply with certain clinical guidelines; or

c. If the product has the potential for overuse, misuse, or abuse.

The agency may require the prescribing professional to provide information about the rationale and supporting medical evidence for the use of a drug. The agency shall post prior authorization, step-edit criteria and protocol, and updates to the list of drugs that are subject to prior authorization on the

agency's Internet website within 21 days after the prior authorization and step-edit criteria and protocol and updates are approved by the agency. For purposes of this subparagraph, the term "step-edit" means an automatic electronic review of certain medications subject to prior authorization.

17.~~13.~~ The agency, in conjunction with the Pharmaceutical and Therapeutics Committee, may require age-related prior authorizations for certain prescribed drugs. The agency may preauthorize the use of a drug for a recipient who may not meet the age requirement or may exceed the length of therapy for use of this product as recommended by the manufacturer and approved by the Food and Drug Administration. Prior authorization may require the prescribing professional to provide information about the rationale and supporting medical evidence for the use of a drug.

18.~~14.~~ The agency shall implement a step-therapy prior authorization approval process for medications excluded from the preferred drug list. Medications listed on the preferred drug list must be used within the previous 12 months before the alternative medications that are not listed. The step-therapy prior authorization may require the prescriber to use the medications of a similar drug class or for a similar medical indication unless contraindicated in the Food and Drug Administration labeling. The trial period between the specified steps may vary according to the medical indication. The step-

therapy approval process shall be developed in accordance with the committee as stated in s. 409.91195(7) and (8). A drug product may be approved without meeting the step-therapy prior authorization criteria if the prescribing physician provides the agency with additional written medical or clinical documentation that the product is medically necessary because:

a. There is not a drug on the preferred drug list to treat the disease or medical condition which is an acceptable clinical alternative;

b. The alternatives have been ineffective in the treatment of the beneficiary's disease;

c. The drug product or medication of a similar drug class is prescribed for the treatment of schizophrenia or schizotypal or delusional disorders; prior authorization has been granted previously for the prescribed drug; and the medication was dispensed to the patient during the previous 12 months; or

d. Based on historical evidence and known characteristics of the patient and the drug, the drug is likely to be ineffective, or the number of doses have been ineffective.

The agency shall work with the physician to determine the best alternative for the patient. The agency may adopt rules waiving the requirements for written clinical documentation for specific drugs in limited clinical situations.

19.~~15.~~ The agency shall implement a return and reuse

program for drugs dispensed by pharmacies to institutional recipients, which includes payment of a $5 restocking fee for the implementation and operation of the program. The return and reuse program shall be implemented electronically and in a manner that promotes efficiency. The program must permit a pharmacy to exclude drugs from the program if it is not practical or cost-effective for the drug to be included and must provide for the return to inventory of drugs that cannot be credited or returned in a cost-effective manner. The agency shall determine if the program has reduced the amount of Medicaid prescription drugs which are destroyed on an annual basis and if there are additional ways to ensure more prescription drugs are not destroyed which could safely be reused.

(14) Neither this section nor this chapter prevents the agency from conducting retrospective reviews, investigations, analyses, audits, or any combination thereof to determine possible fraud, abuse, overpayment, or recipient neglect in the state Medicaid program pursuant to s. 409.913, including, but not limited to, reviews in which the services were the subject of a utilization review or prior authorization process.

Section 7. Paragraph (a) of subsection (4) and paragraph (b) of subsection (6) of section 409.9122, Florida Statutes, are amended to read:

409.9122 Medicaid managed care enrollment; HIV/AIDS

patients; procedures; data collection; accounting; information system; medical loss ratio.—

(4) The agency shall maintain and operate the Medicaid Encounter Data System to collect, process, store, and report on covered services provided to all Florida Medicaid recipients enrolled in prepaid managed care plans.

(a) ~~Prepaid~~ Managed care plans shall submit encounter data, including denied encounters and encounters resulting from a capitated arrangement, electronically in a format that complies with the Health Insurance Portability and Accountability Act provisions for electronic claims and in accordance with deadlines established by the agency. ~~Prepaid~~ Managed care plans must certify that the data reported is accurate and complete.

(6) The agency shall establish, and managed care plans shall use, a uniform method of accounting for and reporting medical and nonmedical costs.

(b) The agency is responsible for validating the financial data submitted by the plans. The agency shall develop methods and protocols for ongoing analysis of data that adjusts for differences in characteristics of plan enrollees to allow comparison among plans and against expected levels of expenditures. The analysis shall be used to identify possible cases of overspending on administrative costs, payment amounts in excess of market rates, ~~or~~ underspending on medical services,

or potential managed care plan fraud, waste, and abuse. Such analysis shall also be used in the rate setting process.

Section 8. Paragraph (e) of subsection (1) and subsections (2) and (6) of section 409.913, Florida Statutes, are amended to read:

409.913 Oversight of the integrity of the Medicaid program.—The agency shall operate a program to oversee the activities of Florida Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate. Each January 15, the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs shall submit a report to the Legislature documenting the effectiveness of the state's efforts to control Medicaid fraud and abuse and to recover Medicaid overpayments during the previous fiscal year. The report must describe the number of cases opened and investigated each year; the sources of the cases opened; the disposition of the cases closed each year; the amount of overpayments alleged in preliminary and final audit letters; the number and amount of fines or penalties imposed; any reductions in overpayment amounts negotiated in settlement agreements or by other means; the amount of final agency determinations of overpayments; the amount deducted from federal claiming as a result of overpayments; the amount of overpayments recovered

each year; the amount of cost of investigation recovered each year; the average length of time to collect from the time the case was opened until the overpayment is paid in full; the amount determined as uncollectible and the portion of the uncollectible amount subsequently reclaimed from the Federal Government; the number of providers, by type, that are terminated from participation in the Medicaid program as a result of fraud and abuse; and all costs associated with discovering and prosecuting cases of Medicaid overpayments and making recoveries in such cases. The report must also document actions taken to prevent overpayments and the number of providers prevented from enrolling in or reenrolling in the Medicaid program as a result of documented Medicaid fraud and abuse and must include policy recommendations necessary to prevent or recover overpayments and changes necessary to prevent and detect Medicaid fraud. All policy recommendations in the report must include a detailed fiscal analysis, including, but not limited to, implementation costs, estimated savings to the Medicaid program, and the return on investment. The agency must submit the policy recommendations and fiscal analyses in the report to the appropriate estimating conference, pursuant to s. 216.137, by February 15 of each year. The agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs each must include detailed unit-specific performance standards, benchmarks, and metrics in the report, including projected cost

savings to the state Medicaid program during the following fiscal year.

(1) For the purposes of this section, the term:

(e) "Overpayment" includes any amount that is not authorized to be paid by the Medicaid program or that should not have been paid, including payments made ~~whether paid~~ as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake, and may include amounts paid for goods or services that were the subject of a utilization review or prior authorization process.

(2) The agency shall conduct, or cause to be conducted by contract or otherwise, reviews, investigations, analyses, audits, or any combination thereof, to determine possible fraud, abuse, overpayment, or recipient neglect in the Medicaid program and shall report the findings of any overpayments in audit reports as appropriate. An overpayment determination may be based upon retrospective reviews, investigations, analyses, audits, or any combination thereof to determine possible fraud, abuse, overpayment, or recipient neglect in the Medicaid program. At least 5 percent of all audits shall be conducted on a random basis. As part of its ongoing fraud detection activities, the agency shall identify and monitor, by contract or otherwise, patterns of overutilization of Medicaid services based on state averages. The agency shall track Medicaid provider prescription and billing patterns and evaluate them

against Medicaid medical necessity criteria and coverage and limitation guidelines adopted by rule. Medical necessity determination requires that service be consistent with symptoms or confirmed diagnosis of illness or injury under treatment and not in excess of the patient's needs. The agency shall conduct reviews of provider exceptions to peer group norms and shall, using statistical methodologies, provider profiling, and analysis of billing patterns, detect and investigate abnormal or unusual increases in billing or payment of claims for Medicaid services and medically unnecessary provision of services.

(6) Any notice required to be given to a provider under this section is presumed to be sufficient notice if sent to the mailing address last shown on the provider enrollment file. It is the responsibility of the provider to furnish and keep the agency informed of the provider's current mailing and service addresses ~~address~~. United States Postal Service or other common carrier's proof of mailing or certified or registered mailing of such notice to the provider at the address shown on the provider enrollment file constitutes sufficient proof of notice. Any notice required to be given to the agency by this section must be sent to the agency at an address designated by rule.

Section 9. Present subsections (2) through (18) of section 409.962, Florida Statutes, are redesignated as subsections (3) through (19), respectively, and a new subsection (2) is added to that section, to read:

409.962 Definitions.—As used in this part, except as otherwise specifically provided, the term:

(2) "Affiliate," including the terms "affiliated with" and "affiliation," means a person, as construed in s. 1.01(3), who:

(a) Directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with a specified entity or person. The term includes parent and subsidiary entities; or

(b) Is deemed a "related party" according to the standards adopted by the Financial Accounting Standards Board.

Section 10. Subsections (1) and (2) and paragraph (h) of subsection (3) of section 409.967, Florida Statutes, are amended, and subsection (5) is added to that section, to read:

409.967 Managed care plan accountability.—

(1) CONTRACT PROCUREMENT PROCESS.—Beginning with the contract procurement process initiated during the 2023 calendar year, the agency shall establish a 6-year contract with each managed care plan selected through the procurement process described in s. 409.966. A plan contract may not be renewed; however, the agency may extend the term of a plan contract to cover any delays during the transition to a new plan. The agency shall extend until December 31, 2024, the term of existing plan contracts awarded pursuant to the invitation to negotiate published in July 2017.

(2) CONTRACT REQUIREMENTS.—The agency shall establish such

contract requirements as are necessary for the operation of the statewide managed care program. The contracts must require any third-party administrative entity contracted by a plan to adhere to all requirements specific to the state Medicaid program. In addition to any other provisions the agency may deem necessary, the contract must require:

(a) *Physician compensation.*—Managed care plans are expected to coordinate care, manage chronic disease, and prevent the need for more costly services. Effective care management should enable plans to redirect available resources and increase compensation for physicians. Plans achieve this performance standard when physician payment rates equal or exceed Medicare rates for similar services. The agency may impose fines or other sanctions on a plan that fails to meet this performance standard after 2 years of continuous operation.

(b) *Emergency services.*—Managed care plans shall pay for services required by ss. 395.1041 and 401.45 and rendered by a noncontracted provider. The plans must comply with s. 641.3155. Reimbursement for services under this paragraph is the lesser of:

1. The provider's charges;

2. The usual and customary provider charges for similar services in the community where the services were provided;

3. The charge mutually agreed to by the entity and the provider within 60 days after submittal of the claim; or

4. The Medicaid rate, which, for the purposes of this paragraph, means the amount the provider would collect from the agency on a fee-for-service basis, less any amounts for the indirect costs of medical education and the direct costs of graduate medical education that are otherwise included in the agency's fee-for-service payment, as required under 42 U.S.C. s. 1396u-2(b)(2)(D). For the purpose of establishing the amounts specified in this subparagraph, the agency shall publish on its website annually, or more frequently as needed, the applicable fee-for-service fee schedules and their effective dates, less any amounts for indirect costs of medical education and direct costs of graduate medical education that are otherwise included in the agency's fee-for-service payments.

(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. 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. 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 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 followup on all medically necessary services recommended as a result of early and periodic screening, diagnosis, and treatment.

(d) *Quality care.*—Managed care plans shall provide, or

contract for the provision of, care coordination to facilitate the appropriate delivery of behavioral health care services in the least restrictive setting with treatment and recovery capabilities that address the needs of the patient. Services shall be provided in a manner that integrates behavioral health services and primary care. Plans shall be required to achieve specific behavioral health outcome standards, established by the agency in consultation with the department.

(e) *Encounter data.*—The agency shall maintain and operate a Medicaid Encounter Data System to collect, process, store, and report on covered services provided to all Medicaid recipients enrolled in prepaid plans.

1. Each prepaid plan must comply with the agency's reporting requirements for the Medicaid Encounter Data System. Prepaid plans must submit encounter data electronically in a format that complies with the Health Insurance Portability and Accountability Act provisions for electronic claims and in accordance with deadlines established by the agency. Prepaid plans must certify that the data reported is accurate and complete.

2. The agency is responsible for validating the data submitted by the plans. The agency shall develop methods and protocols for ongoing analysis of the encounter data that adjusts for differences in characteristics of prepaid plan enrollees to allow comparison of service utilization among plans

and against expected levels of use. The analysis shall be used to identify possible cases of systemic underutilization or denials of claims and inappropriate service utilization such as higher-than-expected emergency department encounters. The analysis shall provide periodic feedback to the plans and enable the agency to establish corrective action plans when necessary. One of the focus areas for the analysis shall be the use of prescription drugs.

3. The agency shall make encounter data available to those plans accepting enrollees who are assigned to them from other plans leaving a region.

4. The agency shall annually produce a report entitled "Analysis of Potentially Preventable Health Care Events of Florida Medicaid Enrollees." The report must include, but need not be limited to, an analysis of the potentially preventable hospital emergency department visits, hospital admissions, and hospital readmissions that occurred during the previous state fiscal year which may have been prevented with better access to primary care, improved medication management, or better coordination of care, reported by age, eligibility group, managed care plan, and region, including conditions contributing to each potentially preventable event or category of potentially preventable events. The agency may include any other data or analysis parameters to augment the report which it deems pertinent to the analysis. The report must demonstrate trends

using applicable historical data. The agency shall submit the report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by October 1, 2024, and each October 1 thereafter. The agency may contract with a third-party vendor to produce the report required under this subparagraph.

(f) *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.

2. Each managed care plan must collect and report the Healthcare Effectiveness Data and Information Set (HEDIS) measures, the federal Core Set of Children's Health Care Quality measures, and the federal Core Set of Adult Health Care Quality Measures, as specified by the agency. Each plan must collect and report the Adult Core Set behavioral health measures beginning with data reports for the 2025 calendar year. Each plan must stratify reported measures by age, sex, race, ethnicity, primary language, and whether the enrollee received a Social Security Administration determination of disability for purposes of

Supplemental Security Income beginning with data reports for the 2026 calendar year. A plan's performance on 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 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, or another nationally recognized accrediting body, or have initiated the accreditation process, within 1 year after the contract is executed. For any plan not accredited within 18 months after executing the contract, the agency shall suspend automatic assignment under ss. 409.977 and 409.984.

(g) *Program integrity.*—Each managed care plan shall establish program integrity functions and activities to reduce the incidence of fraud and abuse, including, at a minimum:

1. A provider credentialing system and ongoing provider monitoring, including maintenance of written provider credentialing policies and procedures which comply with federal and agency guidelines;

2. An effective prepayment and postpayment review process including, but not limited to, data analysis, system editing, and auditing of network providers;

3. Procedures for reporting instances of fraud and abuse pursuant to chapter 641;

4. Administrative and management arrangements or procedures, including a mandatory compliance plan, designed to prevent fraud and abuse; and

5. Designation of a program integrity compliance officer.

(h) *Grievance resolution.*—Consistent with federal law, each managed care plan shall establish and the agency shall approve an internal process for reviewing and responding to grievances from enrollees. Each plan shall submit quarterly reports on the number, description, and outcome of grievances filed by enrollees.

(i) *Penalties.*—

1. Withdrawal and enrollment reduction.—Managed care plans that reduce enrollment levels or leave a region before the end of the contract term must reimburse the agency for the cost of enrollment changes and other transition activities. If more than one plan leaves a region at the same time, costs must be shared by the departing plans proportionate to their enrollments. In addition to the payment of costs, departing provider services networks must pay a per-enrollee penalty of up to 3 months' payment and continue to provide services to the enrollee for 90 days or until the enrollee is enrolled in another plan, whichever occurs first. In addition to payment of costs, all other departing plans must pay a penalty of 25 percent of that portion of the minimum surplus maintained pursuant to s. 641.225(1) which is attributable to the provision of coverage to

Medicaid enrollees. Plans shall provide at least 180 days' notice to the agency before withdrawing from a region. If a managed care plan leaves a region before the end of the contract term, the agency shall terminate all contracts with that plan in other regions pursuant to the termination procedures in subparagraph 3.

2. Encounter data.—If a plan fails to comply with the encounter data reporting requirements of this section for 30 days, the agency must assess a fine of $5,000 per day for each day of noncompliance beginning on the 31st day. On the 31st day, the agency must notify the plan that the agency will initiate contract termination procedures on the 90th day unless the plan comes into compliance before that date.

3. Termination.—If the agency terminates more than one regional contract with the same managed care plan due to noncompliance with the requirements of this section, the agency shall terminate all the regional contracts held by that plan. When terminating multiple contracts, the agency must develop a plan to provide for the transition of enrollees to other plans, and phase in the terminations over a time period sufficient to ensure a smooth transition.

(j) *Prompt payment.*—Managed care plans shall comply with ss. 641.315, 641.3155, and 641.513.

(k) *Electronic claims.*—Managed care plans, and their fiscal agents or intermediaries, shall accept electronic claims

in compliance with federal standards.

(l) *Fair payment.*—Provider service networks must ensure that no entity licensed under chapter 395 with a controlling interest in the network charges a Medicaid managed care plan more than the amount paid to that provider by the provider service network for the same service.

(m) *Itemized payment.*—Any claims payment to a provider by a managed care plan, or by a fiscal agent or intermediary of the plan, must be accompanied by an itemized accounting of the individual claims included in the payment including, but not limited to, the enrollee's name, the date of service, the procedure code, the amount of reimbursement, and the identification of the plan on whose behalf the payment is made.

(n) *Provider dispute resolution.*—Disputes between a plan and a provider may be resolved as described in s. 408.7057.

(o) *Transparency.*—Managed care plans shall comply with ss. 627.6385(3) and 641.54(7).

(3) ACHIEVED SAVINGS REBATE.—

(h) The following may not be included as allowable expenses in calculating income for determining the achieved savings rebate:

1. Payment of achieved savings rebates.

2. Any financial incentive payments made to the plan outside of the capitation rate.

3. Any financial disincentive payments levied by the state

or Federal Government.

4. Expenses associated with any lobbying or political activities.

5. The cash value or equivalent cash value of bonuses of any type paid or awarded to the plan's executive staff, other than base salary.

6. Reserves and reserve accounts.

7. Administrative costs, including, but not limited to, reinsurance expenses, interest payments, depreciation expenses, bad debt expenses, and outstanding claims expenses in excess of actuarially sound maximum amounts set by the agency.

8. Payments to affiliated entities as defined in s. 409.962 in excess of market rates, as determined by the agency.

The agency shall consider these and other factors in developing contracts that establish shared savings arrangements.

(5) AFFILIATED ENTITIES AND RELATED PARTIES.—

(a) The agency shall ensure oversight of affiliated entities and related parties as defined in s. 409.962 within the Statewide Medicaid Managed Care program. This includes, but is not limited to, examining financial records and self-referral data for any managed care plan providing services within the Statewide Medicaid Managed Care program utilizing affiliated entities and related parties within their business model.

(b) The agency shall consider data obtained pursuant to

paragraph (a) and the findings of the annual assessment required under s. 409.9675(3) when determining the final medical loss ratio as specified in subsection (4) and during the rate setting process.

Section 11. Section 409.9675, Florida Statutes, is created to read:

409.9675 Affiliated entities and controlling interest; reports required.—

(1) As used in this part, the term "control," including the terms "controlling," "controlled by," and "under common control with," means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership or voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. This definition applies regardless of whether such power is affirmative or negative or whether such power is actually used. Control is presumed to exist, but is not limited to, when any affiliate or person, as construed in s. 1.01(3):

(a) Directly or indirectly owns, controls, holds the power to vote, or holds proxies representing 10 percent or more of any class of the voting securities of any other person.

(b) Shares common ownership with any person, has an

investor or is a holder of an ownership interest in any person, exercises control in any manner over the election of a majority of the directors or of individuals exercising similar functions of any person, has the power to exercise controlling influence over the management of any person, or serves as a working majority of the board of directors, managers, or the officers of a person, who is:

1. A provider or a member of a provider group or group practice as defined in s. 456.053 under the managed care plan; or

2. A person responsible for providing any pharmacy services, pharmaceuticals, diagnostics, care coordination, care delivery, health care services, medical equipment, administrative services, or financial services under the managed care plan.

(2) By March 31, 2027, and annually thereafter, each managed care plan shall report to the agency and the Office of Insurance Regulation, in the manner prescribed by the agency, all of the following:

(a) Any person, as construed in s. 1.01(3), controlled by or affiliated with the managed care plan, including, but not limited to, any provider, provider group, group practice as defined in s. 456.053(3), or person responsible for providing any pharmacy services, pharmaceuticals, diagnostics, care coordination, care delivery, health care services, medical

equipment, administrative services, or financial services for, to, or on behalf of the managed care plan.

(b) Any affiliation of any kind or nature with any person, as construed in s. 1.01(3), which, either directly or indirectly, through one or more intermediaries has an investment or ownership interest representing 10 percent or more, shares common ownership, or has an investor or a holder of an ownership interest representing 10 percent or more, with any person providing pharmacy services, diagnostics, care coordination, care delivery, health care services, medical equipment, administrative services, or financial services for, to, or on behalf of the managed care plan.

(c) For any affiliation reported under paragraph (a) or paragraph (b), the report must include all of the following:

1. The percentage of ownership or control of any person or affiliate with whom the managed care plan or prepaid plan has had business transactions during the 12-month period in the annual achieved savings rebate financial reporting required under s. 409.967(3) and identification of the services provided under the contract or contracts involved in such business transactions; and

2. Any significant business transactions between the managed care plan and any affiliated person during the 12-month period in the annual financial reporting required under s. 409.967(3).

(3) Each managed care plan shall report any change in information required by subsection (1) to the agency and the Office of Insurance Regulation in writing within 60 days after such change occurs.

(4) By December 31, 2026, and annually thereafter, the agency shall calculate, analyze, and publicly report on the agency's website an assessment of affiliated entity payment transactions in the Medicaid program for medical benefit and administrative costs as reported for purposes of the achieved savings rebate. The baseline assessment, at a minimum, must include achieved savings rebate transactions for the years 2021, 2022, and 2023; the amount and associated percentage of affiliated entity payments within the medical loss ratio; and the payment deviation percentages and associated amounts at the Healthcare Common Procedure Coding System level for affiliated entities as compared to nonaffiliated entities. The assessment must also compare payment amounts for value-based or alternative payment arrangements.

Section 12. Paragraph (c) is added to subsection (5) of section 409.973, Florida Statutes, to read:

409.973 Benefits.—

(5) PROVISION OF DENTAL SERVICES.—

(c) By July 1, 2027, the agency shall implement an Integrated Managed Care Pilot Program in which Medicaid recipients in designated regions of this state shall receive

both medical and dental covered benefits through the same managed medical assistance plan.

1. The agency shall submit a request for federal approval for the pilot program by August 1, 2026, and to implement the pilot program in Statewide Medicaid Managed Care Regions A and B by July 1, 2027, contingent upon federal approval.

2. The agency is directed to amend contracts awarded to managed care plans for the provision of managed medical assistance services in Statewide Medicaid Managed Care Regions A and B to include coverage of state plan dental services effective upon implementation of the pilot program. Managed care plans providing managed medical assistance services in Regions A and B must begin providing dental services by July 1, 2027, for all Medicaid recipients in their region previously eligible for services under the statewide prepaid dental program and must comply with contractual continuity of care requirements. Managed care plans must also agree to provide the same level of service as the prepaid dental plans in their region, including expanded benefits offered by those plans at no cost to the state. Managed care plans that provide dental services in Regions A and B must maintain a minimum dental medical loss ratio of 85 percent, calculated in accordance with 42 C.F.R. 438.8. The agency shall separately identify the amounts included in the capitation rates for dental services. The managed care plans shall recognize existing provider credentialing performed by the prepaid dental

plans for providers who remain in good standing with the state Medicaid program for a period not to exceed 12 months after the effective date of implementation of the pilot program. If a managed care plan fails to execute contracts or contract amendments needed to implement the pilot program, the agency must terminate all contracts with that plan. Contracts in Statewide Medicaid Managed Care Regions A and B which provide services under the statewide prepaid Medicaid dental health program authorized by paragraph (b) terminate upon implementation of the pilot program in these regions.

3. The agency shall establish specific measures of access, quality, and costs for evaluations of the pilot program. The agency shall contract with an independent evaluator to conduct the program evaluations. The evaluations must compare the experience in the regions participating in the pilot program with the experience in the regions not participating in the pilot program. The evaluations must include consideration of all of the following, at a minimum:

a. Utilization of routine preventive dental care, including routine preventive dental care provided as expanded benefits, and avoidable emergency or surgical dental services.

b. Dental health outcomes and other associated health outcomes impacted by dental health.

c. Recipient satisfaction and continuity of care.

d. Impact on the provider network, including any increase

in the number of dental practitioners willing to accept Medicaid.

e. Costs of Medicaid services for the pilot program population with specific focus on utilization, outcomes, and costs associated with children and disabled populations.

4. The agency shall submit a report on the performance of the pilot program to the Governor, the President of the Senate, and the Speaker of the House of Representatives beginning on December 1, 2028, and annually thereafter.

Section 13. Subsection (1) of section 409.91196, Florida Statutes, is amended to read:

409.91196 Supplemental rebate agreements; public records and public meetings exemption.—

(1) The rebate amount, percent of rebate, manufacturer's pricing, and supplemental rebate, and other trade secrets as defined in s. 688.002 that the agency has identified for use in negotiations, held by the Agency for Health Care Administration under s. 409.912(5)(a)11. ~~s. 409.912(5)(a)7.~~ are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

Section 14. Subsection (1) of section 627.42392, Florida Statutes, is amended to read:

627.42392 Prior authorization.—

(1) As used in this section, the term "health insurer" means an authorized insurer offering health insurance as defined

in s. 624.603, a managed care plan as defined in s. 409.962(12) ~~s. 409.962(10)~~, or a health maintenance organization as defined in s. 641.19(12).

Section 15. This act shall take effect July 1, 2026.