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LEGISLATIVE ACTION

Senate . House

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The Committee on Health Policy (Brodeur) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Effective upon this act becoming a law, subsection (20) is added to section 1.01, Florida Statutes, to read:

1.01 Definitions.—In construing these statutes and each and every word, phrase, or part hereof, where the context will permit:

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(20) The term "Joint Legislative Committee on Medicaid Oversight" means a committee or committees designated by joint rule of the Legislature, by the President of the Senate or the Speaker of the House of Representatives, or by agreement between the President of the Senate and the Speaker of the House of Representatives.

Section 2. Effective upon this act becoming a law, section 11.405, Florida Statutes, is created to read:

11.405 Joint Legislative Committee on Medicaid Oversight.—The Joint Legislative Committee on Medicaid Oversight is created to ensure that the state Medicaid program is operating in accordance with the Legislature's intent and to promote transparency and efficiency in government spending.

(1) MEMBERSHIP; SUBCOMMITTEES; MEETINGS.—

(a) The committee shall be composed of five members of the Senate appointed by the President of the Senate and five members of the House of Representatives appointed by the Speaker of the House of Representatives, with each member serving a 2-year term. The chair and vice chair shall each be appointed for 1-year terms, with the appointments alternating between the President of the Senate and the Speaker of the House of Representatives. The chair and vice chair may not be members of the same house of the Legislature. If both the chair and vice chair are absent at any meeting, the members present must elect a temporary chair by a majority vote.

(b) Members shall serve without compensation but may be reimbursed for per diem and travel expenses pursuant to s. 112.061.

(c) The chair may establish subcommittees as needed to

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fulfill the committee's duties.

(d) The committee shall convene at least twice a year, and as often as necessary to conduct its business as required under this section. Meetings may be held through teleconference or other electronic means.

(2) COMMITTEE DUTIES.—

(a) The committee shall evaluate all aspects of the state Medicaid program related to program financing, quality of care and health outcomes, administrative functions, and operational functions to ensure that the program is providing transparency in the provision of health care plans and providers, ensuring Medicaid recipients have access to quality health care services and providing stability to the state's budget through a health care delivery system designed to contain costs.

(b) The committee shall identify and recommend policies that limit Medicaid spending growth while improving health care outcomes for Medicaid recipients. In developing its recommendations, the committee shall do all of the following:

1. Evaluate legislation for its long-term impact on the state Medicaid program.

2. Review data submitted to the Agency for Health Care Administration by the Medicaid managed care plans pursuant to statutory and contract requirements, including, but not limited to, timeliness of provider credentialing, timely payment of claims, rate of claim denials, prior authorizations for services, and consumer complaints.

3. Review the Medicaid managed care plans' encounter data, financial data, and audits and the data used to calculate the plans' achieved savings rebates and medical loss ratios.

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4. Review data related to health outcomes of Medicaid recipients, including, but not limited to, Healthcare Effectiveness Data and Information Set measures developed by the National Committee for Quality Assurance, for each Medicaid managed care plan, each Medicaid managed care plan's performance improvement projects, and outcome data related to all quality goals included in the Medicaid managed care organization contracts to improve quality for recipients.

5. Identify any areas for improvement in statute and rule relating to the state Medicaid program.

6. Develop a plan of action for the future of the state Medicaid program.

(c) The committee may submit periodic reports, including recommendations, to the Legislature on issues related to the state Medicaid program and any affiliated programs.

(3) COOPERATION.—

(a) The Auditor General and the Agency for Health Care Administration shall enter into and maintain a data sharing agreement by July 1, 2026, to ensure the committee has full access to all data needed to fulfill its responsibilities.

(b) The Auditor General shall assist the committee in its work by providing credentialed professional staff or consulting services, including, but not limited to, an actuary not associated with the state Medicaid program or any Medicaid managed care organization who currently has a contract with the state.

(c) The committee, in the course of its official duties, must be given access to any relevant record, paper, or document in possession of a state agency, any political subdivision of

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the state, or any entity engaged in business or under contract with a state agency, and may compel the attendance and testimony of any state official or employee before the committee or secure any evidence as provided in s. 11.143. The committee may also have any other powers conferred on it by joint rules of the Senate and the House of Representatives, and any joint rules of the Senate and the House of Representatives applicable to joint legislative committees apply to the proceedings of the committee under this section.

(4) AGENCY REPORTS.—

(a) Before implementing any change to the Medicaid managed care capitation rates, the Agency for Health Care Administration shall notify the committee of the change and appear before the committee to provide a report detailing the managed care capitation rates and administrative costs built into the capitation rates. The report must include the agency's historical and projected Medicaid program expenditure and utilization trend rates by Medicaid program and service category for the rate year, an explanation of how the trend rates were calculated, and the policy decisions that were included in setting the capitation rates.

(b) If the Agency for Health Care Administration or any division within the agency is required by law to report to the Legislature or to any legislative committee or subcommittee on matters relating to the state Medicaid program, the agency must also submit a copy of the report to the committee.

Section 3. Present subsections (2) through (5), (6) through (10), and (11) through (18) of section 409.962, Florida Statutes, are redesignated as subsections (3) through (6), (8)

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through (12), and (14) through (21), respectively, and new subsections (2), (7), and (13) are 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, including parent and subsidiary entities; or

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

(7) "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

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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, the 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(3) 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.

(13) "Market rate" means the price that a willing buyer will pay and a willing seller will accept in an arm's-length transaction which is beneficial to both parties.

Section 4. Subsections (1) and (2), paragraph (h) of subsection (3), and subsection (4) 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

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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. 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

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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

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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

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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 follow-up ~~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

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reporting requirements for the Medicaid Encounter Data System. Prepaid plans must submit encounter data, including data on encounters for which payment was denied and encounters for which a health care provider was reimbursed by the plan on a capitated basis, 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 overspending on administrative costs, payments by plans in excess of market rates, systemic underutilization or denials of claims and inappropriate service utilization such as higher-than-expected emergency department encounters, and potential managed care plan fraud, waste, and abuse. 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. The analysis shall be used in managed care plan capitation rate-setting processes provided under this part.

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

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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.

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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

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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

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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

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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).

(p) *Third-party administrators.*—The agency's contract with a managed care plan must require that any third-party administrative entity contracted by the plan adheres to all pertinent requirements of the Medicaid program placed on the plan under the plan's contract with the agency.

(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.

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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 affiliates as defined in s. 409.962 in excess of market rates.

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

(4) MEDICAL LOSS RATIOS ~~RATIO~~.—

(a) If required by federal regulations or as a condition of a waiver, the agency must ~~may~~ calculate ~~a~~ medical loss ratios ~~ratio~~ for all managed care plans contracted with the agency under this part. The calculations must ~~calculation shall~~ use uniform financial data collected from all plans ~~and shall be computed for each plan on a statewide basis~~. If a plan participates in the managed medical assistance program, the long-term care managed care program, or the pilot program for individuals with developmental disabilities, the agency must calculate medical loss ratios for the plan's participation in each program separately and, if the plan participates in more than one of these programs, for the plan's overall participation in statewide Medicaid managed care. Medical loss ratios must be

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calculated and ~~The method for calculating the medical loss ratio shall meet the following criteria:~~

~~(a) Except as provided in paragraphs (b) and (c),~~ expenditures must ~~shall~~ be classified in a manner consistent with 42 C.F.R. part 438 ~~45 C.F.R. part 158~~.

(b) The agency shall report medical loss ratios quarterly and annually for each managed care plan contracted with the agency under this part to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than 6 months after the end of each such period ~~Funds provided by plans to graduate medical education institutions to underwrite the costs of residency positions shall be classified as medical expenditures, provided the funding is sufficient to sustain the positions for the number of years necessary to complete the residency requirements and the residency positions funded by the plans are active providers of care to Medicaid and uninsured patients.~~

~~(c) Before final determination of the medical loss ratio for any period, a plan may contribute to a designated state trust fund for the purpose of supporting Medicaid and indigent care and have the contribution counted as a medical expenditure for the period. Funds contributed for this purpose shall be deposited into the Grants and Donations Trust Fund~~.

(5) AFFILIATED ENTITIES AND RELATED PARTIES.—

(a) The agency shall ensure oversight of affiliated entities and related parties paid by managed care plans under this part, including, but not limited to, examining financial records and self-referral data of any managed care plan providing services within the statewide managed care program

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which uses affiliated entities and related parties.

(b) The agency shall consider data examined under paragraph (a) and the findings of the annual assessment required under s. 409.9675(4) when developing managed care plan capitation rates under this part.

Section 5. Effective January 1, 2027, paragraph (f) of subsection (3) of section 409.967, Florida Statutes, is amended, and paragraph (g) of that subsection is republished, to read:

409.967 Managed care plan accountability.—

(3) ACHIEVED SAVINGS REBATE.—

(f) Achieved savings rebates validated by the certified public accountant are due within 30 days after the report is submitted. Except as provided in paragraph (h), the achieved savings rebate is established by determining pretax income as a percentage of revenues and applying the following income sharing ratios:

1. One hundred percent of income up to and including 3 ~~5~~ percent of revenue shall be retained by the plan.

2. Thirty ~~Fifty~~ percent of income above 3 ~~5~~ percent and up to 10 percent shall be retained by the plan, and the other 70 ~~50~~ percent shall be refunded to the state and adjusted for the Federal Medical Assistance Percentages. The state share shall be transferred to the General Revenue Fund, unallocated, and the federal share shall be transferred to the Medical Care Trust Fund, unallocated.

3. One hundred percent of income above 10 percent of revenue shall be refunded to the state and adjusted for the Federal Medical Assistance Percentages. The state share shall be transferred to the General Revenue Fund, unallocated, and the

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federal share shall be transferred to the Medical Care Trust Fund, unallocated.

(g) A plan that exceeds agency-defined quality measures in the reporting period may retain an additional 1 percent of revenue. For the purpose of this paragraph, the quality measures must include plan performance for preventing or managing complex, chronic conditions that are associated with an elevated likelihood of requiring high-cost medical treatments.

Section 6. Section 409.9675, Florida Statutes, is created to read:

409.9675 Affiliated entities and controlling interests; reports required.—

(1) Each managed care plan contracted by the agency under this part shall report all of the following by March 31, 2027, for the prior calendar year, and annually thereafter, to the agency and the Office of Insurance Regulation in a manner prescribed by the agency:

(a) Any person controlled by or affiliated with the managed care plan, including, but not limited to, any provider, provider group, group practice 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 which has, either directly or indirectly through one or more intermediaries, an investment or ownership interest representing 10 percent or more, shares common ownership with, or has an

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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.

(2) For any affiliation reported by a managed care plan under subsection (1), the report must include all of the following:

(a) The percentage of ownership or control of any person or affiliate with whom the managed care plan has had business transactions totaling in the aggregate more than $25,000 during the prior 12-month period in the annual achieved savings rebate financial reporting required under s. 409.967(3) and identification of the specific contract or contracts involved in such business transactions.

(b) Any significant business transactions between the managed care plan and any affiliated person during the 12-month period in the annual achieved savings rebate 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 the 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

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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 7. Present paragraphs (b), (c), and (d), and (e) through (x) of subsection (1) of section 626.8825, Florida Statutes, are redesignated as paragraphs (c), (d), and (e), and (g) through (z), respectively, new paragraphs (b) and (f) are added to that subsection, and present paragraph (u) of subsection (1), paragraphs (e) and (g) of subsection (2), and paragraphs (c) and (h) of subsection (3) of that section are amended, to read:

626.8825 Pharmacy benefit manager transparency and accountability.—

(1) DEFINITIONS.—As used in this section, the term:

(b) "Affiliated manufacturer" means a prescription drug manufacturer permitted under chapter 499 or a private label distributor as defined in 21 C.F.R. s. 207.1 which directly or indirectly through one or more intermediaries:

1. Has an investment or ownership interest in a pharmacy benefit manager holding a certificate of authority issued under this part;

2. Shares common ownership with a pharmacy benefit manager holding a certificate of authority issued under this part; or

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3. Has an investor or a holder of an ownership interest which is a pharmacy benefit manager holding a certificate of authority issued under this part.

(f) "Covered prescription drug" means any drug or biologic included in a pharmacy benefit manager's formulary which is paid for as a pharmacy benefit under the plan at any of the plan's network pharmacies.

(w) ~~(u)~~ "Pharmacy benefits plan or program" means a plan or program that pays for, reimburses, covers the cost of, or provides access to discounts on pharmacist services provided by one or more pharmacies to covered persons who reside in, are employed by, or receive pharmacist services from this state.

1. The term includes, but is not limited to, health maintenance organizations, health insurers, self-insured employer health plans, discount card programs, and government-funded health plans, including the Statewide Medicaid Managed Care program established pursuant to part IV of chapter 409 and the state group insurance program pursuant to part I of chapter 110.

2. The term excludes such a plan or program under s. 430.84 or chapter 440.

(2) CONTRACTS BETWEEN A PHARMACY BENEFIT MANAGER AND A PHARMACY BENEFITS PLAN OR PROGRAM.—In addition to any other requirements in the Florida Insurance Code, all contractual arrangements executed, amended, adjusted, or renewed on or after July 1, 2023, which are applicable to pharmacy benefits covered on or after January 1, 2024, between a pharmacy benefit manager and a pharmacy benefits plan or program must include, in substantial form, terms that ensure compliance with all of the

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following requirements and that, except to the extent not allowed by law, shall supersede any contractual terms to the contrary:

(e) Include network adequacy requirements that meet or exceed Medicare Part D program standards for convenient access to the network pharmacies set forth in 42 C.F.R. s. 423.120(a)(1) and that:

1. Do not limit a network to solely include affiliated pharmacies;

2. Require a pharmacy benefit manager to offer a provider contract to licensed pharmacies physically located on the physical site of providers that are:

a. Within the pharmacy benefits plan's or program's geographic service area and that have been specifically designated as essential providers by the Agency for Health Care Administration pursuant to s. 409.975(1)(a);

b. Designated as cancer centers of excellence under s. 381.925, regardless of the pharmacy benefits plan's or program's geographic service area;

c. Organ transplant hospitals, regardless of the pharmacy benefits plan's or program's geographic service area;

d. Hospitals licensed as specialty children's hospitals as defined in s. 395.002; or

e. Regional perinatal intensive care centers as defined in s. 383.16(2), regardless of the pharmacy benefits plan's or program's geographic service area.

Such provider contracts must be solely for the administration and ~~or~~ dispensing of covered prescription drugs~~, including~~

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~~biological products, which are administered through infusions, intravenously injected, or inhaled during a surgical procedure or are covered parenteral drugs,~~ as part of ~~onsite~~ outpatient care;

3. Do not require a covered person to receive a prescription drug by United States mail, common carrier, local courier, third-party company or delivery service, or pharmacy direct delivery unless the prescription drug cannot be acquired at any retail pharmacy in the pharmacy benefit manager's network for the covered person's pharmacy benefits plan or program. This subparagraph does not prohibit a pharmacy benefit manager from operating mail order or delivery programs on an opt-in basis at the sole discretion of a covered person, provided that the covered person is not penalized through the imposition of any additional retail cost-sharing obligations or a lower allowed-quantity limit for choosing not to select the mail order or delivery programs;

4. For the in-person administration of covered prescription drugs, prohibit requiring a covered person to receive pharmacist services from an affiliated pharmacy or an affiliated health care provider; and

5. Prohibit offering or implementing pharmacy networks that require or provide a promotional item or an incentive, defined as anything other than a reduced cost-sharing amount or enhanced quantity limit allowed under the benefit design for a covered drug, to a covered person to use an affiliated pharmacy or an affiliated health care provider for the in-person administration of covered prescription drugs; or advertising, marketing, or promoting an affiliated pharmacy to covered persons. Subject to

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the foregoing, a pharmacy benefit manager may include an affiliated pharmacy in communications to covered persons regarding network pharmacies and prices, provided that the pharmacy benefit manager includes information, such as links to all nonaffiliated network pharmacies, in such communications and that the information provided is accurate and of equal prominence. This subparagraph may not be construed to prohibit a pharmacy benefit manager from entering into an agreement with an affiliated pharmacy to provide pharmacist services to covered persons.

(g) Prohibit a pharmacy benefit manager from instituting a network that requires a pharmacy to meet accreditation standards inconsistent with or more stringent than applicable federal and state requirements for licensure and operation as a pharmacy in this state. However, a pharmacy benefit manager may specify additional specialty networks that require enhanced standards related to the safety and competency necessary to meet the United States Food and Drug Administration's limited distribution requirements for dispensing any drug that, on a drug-by-drug basis, requires extraordinary special handling~~, provider coordination, or clinical care or monitoring~~ when such extraordinary requirements cannot be met by a retail pharmacy. For purposes of this paragraph, drugs requiring extraordinary special handling are limited to drugs that are subject to a risk evaluation and mitigation strategy approved by the United States Food and Drug Administration and that:

1. Require special certification of a health care provider to prescribe, receive, dispense, or administer; or

2. Require special handling due to the molecular complexity

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or cytotoxic properties of the biologic or biosimilar product or drug.

For participation in a specialty network, a pharmacy benefit manager may not require a pharmacy to meet requirements for participation beyond those necessary to demonstrate the pharmacy's ability to dispense the drug in accordance with the United States Food and Drug Administration's approved manufacturer labeling.

(3) CONTRACTS BETWEEN A PHARMACY BENEFIT MANAGER AND A PARTICIPATING PHARMACY.—In addition to other requirements in the Florida Insurance Code, a participation contract executed, amended, adjusted, or renewed on or after July 1, 2023, that applies to pharmacist services on or after January 1, 2024, between a pharmacy benefit manager and one or more pharmacies or pharmacists, must include, in substantial form, terms that ensure compliance with all of the following requirements, and that, except to the extent not allowed by law, shall supersede any contractual terms in the participation contract to the contrary:

(c) A prohibition of financial clawbacks, reconciliation offsets, or offsets to adjudicated claims. A pharmacy benefit manager may not charge, withhold, offset, or recoup any direct or indirect remuneration fees, dispensing fees, brand name or generic effective rate adjustments through reconciliation, or any other monetary charge, withholding, or recoupments as related to discounts, multiple network reconciliation offsets, adjudication transaction fees, and any other instance when an amount ~~a fee~~ may be recouped from a pharmacy if such action

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would result in a reduction in the amount paid to the pharmacy or pharmacist. This prohibition does not apply to:

1. Any incentive payments provided by the pharmacy benefit manager to a network pharmacy for meeting or exceeding predefined quality measures, such as Healthcare Effectiveness Data and Information Set measures; recoupment due to an erroneous claim, fraud, waste, or abuse; a claim adjudicated in error; a maximum allowable cost appeal pricing adjustment; or an adjustment made as part of a pharmacy audit pursuant to s. 624.491.

2. Any recoupment that is returned to the state for programs in chapter 409 or the state group insurance program in s. 110.123.

(h) The pharmacy benefit manager shall provide a reasonable administrative appeal procedure to allow a pharmacy or pharmacist to challenge the maximum allowable cost pricing information and the reimbursement made under the maximum allowable cost as defined in s. 627.64741 for a specific drug as being below the acquisition cost available to the challenging pharmacy or pharmacist.

1. The administrative appeal procedure must include a telephone number and e-mail address, or a website, for the purpose of submitting the administrative appeal. The appeal may be submitted by the pharmacy or an agent of the pharmacy directly to the pharmacy benefit manager or through a pharmacy service administration organization. The administrative appeal process must allow a pharmacy or pharmacist the option to submit an electronic spreadsheet or similar electronic document containing a consolidated administrative appeal representing

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multiple adjudicated claims that share the same drug and day supply and have a date of service occurring within the same calendar month. The pharmacy or pharmacist must be given at least 30 business days after a maximum allowable cost update or after an adjudication for an electronic claim or reimbursement for a nonelectronic claim to file the administrative appeal.

2. The pharmacy benefit manager must respond to the administrative appeal within 30 business days after receipt of the appeal.

3. If the appeal is upheld, the pharmacy benefit manager must:

a. Update the maximum allowable cost pricing information to at least the acquisition cost available to the pharmacy;

b. Permit the pharmacy or pharmacist to reverse and rebill the claim in question;

c. Provide to the pharmacy or pharmacist the national drug code on which the increase or change is based; and

d. Make the increase or change effective for each similarly situated pharmacy or pharmacist who is subject to the applicable maximum allowable cost pricing information.

4. If the appeal is denied, the pharmacy benefit manager must provide to the pharmacy or pharmacist the national drug code and the name of the national or regional pharmaceutical wholesalers operating in this state which have the drug currently in stock at a price below the maximum allowable cost pricing information.

5. Beginning August 15, 2026 ~~Every 90 days~~, a pharmacy benefit manager shall report to the office the total number of appeals received and denied in the preceding quarter ~~90-day~~

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~~period~~, with an explanation or reason for each denial, for each specific drug for which an appeal was submitted pursuant to this paragraph. The deadlines for each filing are March 1 for the preceding year's fourth quarter; May 15 for each year's first quarter; August 15 for each year's second quarter; and November 15 for each year's third quarter.

Section 8. Subsection (7) of section 626.8827, Florida Statutes, is amended, and subsections (8), (9), and (10) are added to that section, to read:

626.8827 Pharmacy benefit manager prohibited practices.—In addition to other prohibitions in this part, a pharmacy benefit manager may not do any of the following:

(7) Fail to comply with the requirements in s. 624.491 or s. 626.8825, or breach contractual terms required under s. 626.8825.

(8) Prohibit or restrict a pharmacy from declining to dispense a drug if the reimbursement rate for the drug is less than the actual acquisition cost to the pharmacy.

(9) Reimburse a pharmacy less than it reimburses an affiliate pharmacy.

(10) Maintain an ownership interest, investment interest, or common ownership with an affiliated manufacturer, or share any investor or holder of an ownership interest with an affiliated manufacturer.

Section 9. 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

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

Section 10. Except as otherwise provided in this act and except for this section, which shall take effect upon this act becoming a law, this act shall take effect July 1, 2026.

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to health care coverage; amending s. 1.01, F.S.; defining the term "Joint Legislative Committee on Medicaid Oversight"; creating s. 11.405, F.S.; establishing the Joint Legislative Committee on Medicaid Oversight for specified purposes; providing for membership, subcommittees, and meetings of the committee; specifying duties of the committee; authorizing the committee to submit periodic reports to the Legislature; requiring the Auditor General and the Agency for Health Care Administration to enter into and maintain a data sharing agreement for a certain purpose by a specified date; requiring the Auditor General to assist the committee by providing certain staff or consulting services; requiring that state agencies, political subdivisions of the state, and entities contracted with state agencies give the committee access to certain records, papers, and

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documents; authorizing the committee to compel testimony and evidence according to specified provisions; providing for additional powers of the committee; providing that certain joint rules of the Legislature apply to the proceedings of the committee; requiring the agency to notify the committee of certain changes and provide a report containing specified information to the committee; requiring the agency to submit a copy of certain reports to the committee; amending s. 409.962, F.S.; defining terms; amending s. 409.967, F.S.; revising encounter data reporting requirements for prepaid Medicaid plans; requiring the agency's analysis of such encounter data to include identification of specified occurrences; requiring the agency to use such analysis in setting managed care plan capitation rates; 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, rather than authorizing, the agency to calculate the medical loss ratio for all managed care plans under certain circumstances; revising requirements for the calculation of medical loss ratios; requiring the agency to report medical loss ratios quarterly and annually for each managed care plan to the Governor and the Legislature within a specified timeframe; requiring the agency to ensure

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oversight of affiliated entities and related parties paid by managed care plans; 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 developing managed care plan capitation rates; revising the income sharing ratios used to calculate the achieved savings rebate beginning on a specified date; creating s. 409.9675, F.S.; requiring managed care plans to report to the agency and the Office of Insurance Regulation the existence of and specified 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. 626.8825, F.S.; defining the terms "affiliated manufacturer" and "covered prescription drug"; revising the definition of the term "pharmacy benefits plan or program"; revising requirements for contracts between a pharmacy benefit manager and a pharmacy benefits plan or program and a participating pharmacy; revising the frequency of and deadlines for certain reports pharmacy benefit managers are required to submit to

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the office beginning on a specified date; amending s. 626.8827, F.S.; revising and specifying additional practices pharmacy benefit managers are prohibited from engaging in; amending s. 627.42392, F.S.; conforming a cross-reference; providing effective dates.