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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/01/2014	.	
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The Committee on Communications, Energy, and Public Utilities (Garcia) recommended the following:

Senate Amendment (with title amendment)

Between lines 360 and 361
insert:

Section 7. Subsection (3) is added to section 627.645, Florida Statutes, to read:

627.645 Denial of health insurance claims restricted.—

(3) A claim for payment under a health insurance policy for medical care or treatment may not be denied on the basis of a medical necessity determination conducted via telemedicine as

defined in s. 456.4502 unless the determination is made by a physician licensed under chapter 458 or chapter 459.

Section 8. Paragraph (m) is added to subsection (1) of section 641.185, Florida Statutes, to read:

641.185 Health maintenance organization subscriber protections.—

(1) With respect to the provisions of this part and part III, the principles expressed in the following statements shall serve as standards to be followed by the commission, the office, the department, and the Agency for Health Care Administration in exercising their powers and duties, in exercising administrative discretion, in administrative interpretations of the law, in enforcing its provisions, and in adopting rules:

(m) A health maintenance organization may not deny a claim for payment for medical care or treatment on the basis of a medical necessity determination conducted via telemedicine as defined in s. 456.4502 unless the determination is made by a physician licensed under chapter 458 or chapter 459.

Section 9. Paragraph (c) of subsection (2) of section 409.967, Florida Statutes, is amended to read:

409.967 Managed care plan accountability.—

(2) The agency shall establish such contract requirements as are necessary for the operation of the statewide managed care program. In addition to any other provisions the agency may deem necessary, the contract must require:

(c) *Access.*—

1. The agency shall establish specific standards for the number, type, and regional distribution of providers in managed care plan networks to ensure access to care for both adults and

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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. A plan may not use telemedicine providers as defined in s. 456.4502 to meet this requirement unless the provider is licensed under chapter 458 or chapter 459. The exclusive use of mail-order pharmacies may not be sufficient to meet network access standards. Consistent with the standards established by the agency, provider networks may include providers located outside the region. A plan may contract with a new hospital facility before the date the hospital becomes operational if the hospital has commenced construction, will be licensed and operational by January 1, 2013, and a final order has issued in any civil or administrative challenge. Each plan shall establish and maintain an accurate and complete electronic database of contracted providers, including information about licensure or registration, locations and hours of operation, specialty credentials and other certifications, specific performance indicators, and such other information as the agency deems necessary. The database must be available online to both the agency and the public and have the capability to compare the availability of providers to network adequacy standards and to accept and display feedback from each provider's patients. Each plan shall submit quarterly reports to the agency identifying the number of enrollees assigned to each primary care provider.

2. Each managed care plan must publish any prescribed drug formulary or preferred drug list on the plan's website in a manner that is accessible to and searchable by enrollees and providers. The plan must update the list within 24 hours after

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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.

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

And the title is amended as follows:

Delete line 34

and insert:

providing for future repeal; amending ss. 627.645 and 641.185, F.S.; prohibiting the denial of a claim for payment for medical services based on a medical necessity determination conducted via telemedicine unless the determination is made by a physician; prohibiting a managed care plan under Medicaid from using telemedicine providers that are not physicians; providing an effective date.