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LEGISLATIVE ACTION

Senate

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House

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Floor: WD

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05/02/2014 06:38 PM

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Senator Grimsley moved the following:

**Senate Amendment (with title amendment)**

Between lines 2694 and 2695

insert:

Section 48. 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:



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12 (c) Access.—

13 1. The agency shall establish specific standards for the  
14 number, type, and regional distribution of providers in managed  
15 care plan networks to ensure access to care for both adults and  
16 children. Each plan must maintain a regionwide network of  
17 providers in sufficient numbers to meet the access standards for  
18 specific medical services for all recipients enrolled in the  
19 plan. The exclusive use of mail-order pharmacies may not be  
20 sufficient to meet network access standards. Consistent with the  
21 standards established by the agency, provider networks may  
22 include providers located outside the region. A plan may  
23 contract with a new hospital facility before the date the  
24 hospital becomes operational if the hospital has commenced  
25 construction, will be licensed and operational by January 1,  
26 2013, and a final order has issued in any civil or  
27 administrative challenge. Each plan shall establish and maintain  
28 an accurate and complete electronic database of contracted  
29 providers, including information about licensure or  
30 registration, locations and hours of operation, specialty  
31 credentials and other certifications, specific performance  
32 indicators, and such other information as the agency deems  
33 necessary. The database must be available online to ~~both~~ the  
34 agency and the public and have the capability of comparing ~~to~~  
35 ~~compare~~ the availability of providers to network adequacy  
36 standards and to accept and display feedback from each  
37 provider's patients. Each plan shall submit quarterly reports to  
38 the agency identifying the number of enrollees assigned to each  
39 primary care provider.

40 2. If establishing a prescribed drug formulary or preferred



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41 drug list, a managed care plan shall:

42 a. Provide a broad range of therapeutic options for the  
43 treatment of disease states which are consistent with the  
44 general needs of an outpatient population. If feasible, the  
45 formulary or preferred drug list must include at least two  
46 products in a therapeutic class.

47 b. ~~Each managed care plan must~~ Publish the ~~any~~ prescribed  
48 drug formulary or preferred drug list on the plan's website in a  
49 manner that is accessible to and searchable by enrollees and  
50 providers. The plan shall ~~must~~ update the list within 24 hours  
51 after making a change. ~~Each plan must ensure that the prior~~  
52 ~~authorization process for prescribed drugs is readily accessible~~  
53 ~~to health care providers, including posting appropriate contact~~  
54 ~~information on its website and providing timely responses to~~  
55 ~~providers.~~

56 3. For ~~enrollees~~ Medicaid recipients diagnosed with  
57 hemophilia who have been prescribed anti-hemophilic-factor  
58 replacement products, the agency shall provide for those  
59 products and hemophilia overlay services through the agency's  
60 hemophilia disease management program.

61 ~~3. Managed care plans, and their fiscal agents or~~  
62 ~~intermediaries, must accept prior authorization requests for any~~  
63 ~~service electronically.~~

64 4. Notwithstanding any other law, in order to establish  
65 uniformity in the submission of prior authorization forms,  
66 effective January 1, 2015, a managed care plan shall use a  
67 single standardized form for obtaining prior authorization for a  
68 medical procedure, course of treatment, or prescription drug  
69 benefit. The form may not exceed two pages in length, excluding



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70 any instructions or guiding documentation.

71 a. The managed care plan shall make the form available  
72 electronically and online to practitioners. The prescribing  
73 provider may electronically submit the completed prior  
74 authorization form to the managed care plan.

75 b. If the managed care plan contracts with a pharmacy  
76 benefits manager to perform prior authorization services for a  
77 medical procedure, course of treatment, or prescription drug  
78 benefit, the pharmacy benefits manager must use and accept the  
79 standardized prior authorization form.

80 c. A completed prior authorization request submitted by a  
81 health care provider using the standardized prior authorization  
82 form is deemed approved upon receipt by the managed care plan  
83 unless the managed care plan responds otherwise within 3  
84 business days.

85 5. If medications for the treatment of a medical condition  
86 are restricted for use by a managed care plan by a step-therapy  
87 or fail-first protocol, the prescribing provider must have  
88 access to a clear and convenient process to request an override  
89 of the protocol from the managed care plan.

90 a. The managed care plan shall grant an override within 72  
91 hours if the prescribing provider documents that:

92 (I) Based on sound clinical evidence, the preferred  
93 treatment required under the step-therapy or fail-first protocol  
94 has been ineffective in the treatment of the enrollee's disease  
95 or medical condition; or

96 (II) Based on sound clinical evidence or medical and  
97 scientific evidence, the preferred treatment required under the  
98 step-therapy or fail-first protocol:



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99           (A) Is expected or is likely to be ineffective based on  
100 known relevant physical or mental characteristics of the  
101 enrollee and known characteristics of the drug regimen; or

102           (B) Will cause or will likely cause an adverse reaction or  
103 other physical harm to the enrollee.

104           b. If the prescribing provider allows the enrollee to enter  
105 the step-therapy or fail-first protocol recommended by the  
106 managed care plan, the duration of the step-therapy or fail-  
107 first protocol may not exceed the customary period for use of  
108 the medication if the prescribing provider demonstrates such  
109 treatment to be clinically ineffective. If the managed care plan  
110 can, through sound clinical evidence, demonstrate that the  
111 originally prescribed medication is likely to require more than  
112 the customary period to provide any relief or amelioration to  
113 the enrollee, the step-therapy or fail-first protocol may be  
114 extended for an additional period, but no longer than the  
115 original customary period for use of the medication.

116 Notwithstanding this provision, a step-therapy or fail-first  
117 protocol shall be terminated if the prescribing provider  
118 determines that the enrollee is having an adverse reaction or is  
119 suffering from other physical harm resulting from the use of the  
120 medication.

121           Section 49. Section 627.42392, Florida Statutes, is created  
122 to read:

123           627.42392 Prior authorization.—

124           (1) Notwithstanding any other law, in order to establish  
125 uniformity in the submission of prior authorization forms,  
126 effective January 1, 2015, a health insurer that delivers,  
127 issues for delivery, renews, amends, or continues an individual



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128 or group health insurance policy in this state, including a  
129 policy issued to a small employer as defined in s. 627.6699,  
130 shall use a single standardized form for obtaining prior  
131 authorization for a medical procedure, course of treatment, or  
132 prescription drug benefit. The form may not exceed two pages in  
133 length, excluding any instructions or guiding documentation.

134 (a) The health insurer shall make the form available  
135 electronically and online to practitioners. The prescribing  
136 provider may submit the completed prior authorization form  
137 electronically to the health insurer.

138 (b) If the health insurer contracts with a pharmacy  
139 benefits manager to perform prior authorization services for a  
140 medical procedure, course of treatment, or prescription drug  
141 benefit, the pharmacy benefits manager must use and accept the  
142 standardized prior authorization form.

143 (c) A completed prior authorization request submitted by a  
144 health care provider using the standardized prior authorization  
145 form is deemed approved upon receipt by the health insurer  
146 unless the health insurer responds otherwise within 3 business  
147 days.

148 (2) This section does not apply to a grandfathered health  
149 plan as defined in s. 627.402.

150 Section 50. Section 627.42393, Florida Statutes, is created  
151 to read:

152 627.42393 Medication protocol override.—If an individual or  
153 group health insurance policy, including a policy issued by a  
154 small employer as defined in s. 627.6699, restricts medications  
155 for the treatment of a medical condition by a step-therapy or  
156 fail-first protocol, the prescribing provider must have access



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157 to a clear and convenient process to request an override of the  
158 protocol from the health insurer.

159 (1) The health insurer shall authorize an override of the  
160 protocol within 72 hours if the prescribing provider documents  
161 that:

162 (a) Based on sound clinical evidence, the preferred  
163 treatment required under the step-therapy or fail-first protocol  
164 has been ineffective in the treatment of the insured's disease  
165 or medical condition; or

166 (b) Based on sound clinical evidence or medical and  
167 scientific evidence, the preferred treatment required under the  
168 step-therapy or fail-first protocol:

169 1. Is expected or is likely to be ineffective based on  
170 known relevant physical or mental characteristics of the insured  
171 and known characteristics of the drug regimen; or

172 2. Will cause or is likely to cause an adverse reaction or  
173 other physical harm to the insured.

174 (2) If the prescribing provider allows the insured to enter  
175 the step-therapy or fail-first protocol recommended by the  
176 health insurer, the duration of the step-therapy or fail-first  
177 protocol may not exceed the customary period for use of the  
178 medication if the prescribing provider demonstrates such  
179 treatment to be clinically ineffective. If the health insurer  
180 can, through sound clinical evidence, demonstrate that the  
181 originally prescribed medication is likely to require more than  
182 the customary period for such medication to provide any relief  
183 or amelioration to the insured, the step-therapy or fail-first  
184 protocol may be extended for an additional period of time, but  
185 no longer than the original customary period for the medication.



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186 Notwithstanding this provision, a step-therapy or fail-first  
187 protocol shall be terminated if the prescribing provider  
188 determines that the insured is having an adverse reaction or is  
189 suffering from other physical harm resulting from the use of the  
190 medication.

191 (3) This section does not apply to grandfathered health  
192 plans, as defined in s. 627.402.

193 Section 51. Subsection (11) of section 627.6131, Florida  
194 Statutes, is amended to read:

195 627.6131 Payment of claims.—

196 (11) A health insurer may not retroactively deny a claim  
197 because of insured ineligibility:

198 (a) More than 1 year after the date of payment of the  
199 claim; or

200 (b) If, under a policy compliant with the federal Patient  
201 Protection and Affordable Care Act, as amended by the Health  
202 Care and Education Reconciliation Act of 2010, and the  
203 regulations adopted pursuant to those acts, the health insurer  
204 verified the eligibility of the insured at the time of treatment  
205 and provided an authorization number, unless, at the time  
206 eligibility was verified, the provider was notified that the  
207 insured was delinquent in paying the premium.

208 Section 52. Subsection (2) of section 627.6471, Florida  
209 Statutes, is amended to read:

210 627.6471 Contracts for reduced rates of payment;  
211 limitations; coinsurance and deductibles.—

212 (2) An ~~Any~~ insurer issuing a policy of health insurance in  
213 this state, ~~which insurance~~ includes coverage for the services  
214 of a preferred provider shall, ~~must~~ provide each policyholder





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215 and certificateholder with a current list of preferred  
216 providers, shall ~~and must~~ make the list available for public  
217 inspection during regular business hours at the principal office  
218 of the insurer within the state, and shall post a link to the  
219 list of preferred providers on the home page of the insurer's  
220 website. Changes to the list of preferred providers must be  
221 reflected on the insurer's website within 24 hours.

222 Section 53. Paragraph (c) of subsection (2) of section  
223 627.6515, Florida Statutes, is amended to read:

224 627.6515 Out-of-state groups.—

225 (2) Except as otherwise provided in this part, this part  
226 does not apply to a group health insurance policy issued or  
227 delivered outside this state under which a resident of this  
228 state is provided coverage if:

229 (c) The policy provides the benefits specified in ss.  
230 627.419, 627.42392, 627.42393, 627.6574, 627.6575, 627.6579,  
231 627.6612, 627.66121, 627.66122, 627.6613, 627.667, 627.6675,  
232 627.6691, and 627.66911, and complies with the requirements of  
233 s. 627.66996.

234 Section 54. Subsection (10) of section 641.3155, Florida  
235 Statutes, is amended to read:

236 641.3155 Prompt payment of claims.—

237 (10) A health maintenance organization may not  
238 retroactively deny a claim because of subscriber ineligibility:

239 (a) More than 1 year after the date of payment of the  
240 claim; or

241 (b) If, under a policy in compliance with the federal  
242 Patient Protection and Affordable Care Act, as amended by the  
243 Health Care and Education Reconciliation Act of 2010, and the



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244 regulations adopted pursuant to those acts, the health  
245 maintenance organization verified the eligibility of the  
246 subscriber at the time of treatment and provided an  
247 authorization number, unless, at the time eligibility was  
248 verified, the provider was notified that the subscriber was  
249 delinquent in paying the premium.

250 Section 55. Section 641.393, Florida Statutes, is created  
251 to read:

252 641.393 Prior authorization.—Notwithstanding any other law,  
253 in order to establish uniformity in the submission of prior  
254 authorization forms, effective January 1, 2015, a health  
255 maintenance organization shall use a single standardized form  
256 for obtaining prior authorization for prescription drug  
257 benefits. The form may not exceed two pages in length, excluding  
258 any instructions or guiding documentation.

259 (1) A health maintenance organization shall make the form  
260 available electronically and online to practitioners. A health  
261 care provider may electronically submit the completed form to  
262 the health maintenance organization.

263 (2) If a health maintenance organization contracts with a  
264 pharmacy benefits manager to perform prior authorization  
265 services for prescription drug benefits, the pharmacy benefits  
266 manager must use and accept the standardized prior authorization  
267 form.

268 (3) A completed prior authorization request submitted by a  
269 health care provider using the standardized prior authorization  
270 form required under this section is deemed approved upon receipt  
271 by the health maintenance organization unless the health  
272 maintenance organization responds otherwise within 3 business



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273 days.

274 (4) This section does not apply to grandfathered health  
275 plans, as defined in s. 627.402.

276 Section 56. Section 641.394, Florida Statutes, is created  
277 to read:

278 641.394 Medication protocol override.—If a health  
279 maintenance organization contract restricts medications for the  
280 treatment of a medical condition by a step-therapy or fail-first  
281 protocol, the prescribing provider shall have access to a clear  
282 and convenient process to request an override of the protocol  
283 from the health maintenance organization.

284 (1) The health maintenance organization shall grant an  
285 override within 72 hours if the prescribing provider documents  
286 that:

287 (a) Based on sound clinical evidence, the preferred  
288 treatment required under the step-therapy or fail-first protocol  
289 has been ineffective in the treatment of the subscriber's  
290 disease or medical condition; or

291 (b) Based on sound clinical evidence or medical and  
292 scientific evidence, the preferred treatment required under the  
293 step-therapy or fail-first protocol:

294 1. Is expected or is likely to be ineffective based on  
295 known relevant physical or mental characteristics of the  
296 subscriber and known characteristics of the drug regimen; or

297 2. Will cause or is likely to cause an adverse reaction or  
298 other physical harm to the subscriber.

299 (2) If the prescribing provider allows the subscriber to  
300 enter the step-therapy or fail-first protocol recommended by the  
301 health maintenance organization, the duration of the step-



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302 therapy or fail-first protocol may not exceed the customary  
303 period for use of the medication if the prescribing provider  
304 demonstrates such treatment to be clinically ineffective. If the  
305 health maintenance organization can, through sound clinical  
306 evidence, demonstrate that the originally prescribed medication  
307 is likely to require more than the customary period to provide  
308 any relief or amelioration to the subscriber, the step-therapy  
309 or fail-first protocol may be extended for an additional period,  
310 but no longer than the original customary period for use of the  
311 medication. Notwithstanding this provision, a step-therapy or  
312 fail-first protocol shall be terminated if the prescribing  
313 provider determines that the subscriber is having an adverse  
314 reaction or is suffering from other physical harm resulting from  
315 the use of the medication.

316 (3) This section does not apply to grandfathered health  
317 plans, as defined in s. 627.402.

318  
319 ===== T I T L E A M E N D M E N T =====

320 And the title is amended as follows:

321 Delete line 292

322 and insert:

323 home health agencies; amending s. 409.967, F.S.;

324 revising contract requirements for Medicaid managed

325 care programs; providing requirements for plans

326 establishing a drug formulary or preferred drug list;

327 requiring the use of a standardized prior

328 authorization form; providing requirements for the

329 form and for the availability and submission of the

330 form; requiring a pharmacy benefits manager to use and



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331 accept the form under certain circumstances;  
332 establishing a process for providers to override  
333 certain treatment restrictions; providing requirements  
334 for approval of such overrides; providing an exception  
335 to the override protocol in certain circumstances;  
336 creating s. 627.42392, F.S.; requiring health insurers  
337 to use a standardized prior authorization form;  
338 providing requirements for the form and for the  
339 availability and submission of the form; requiring a  
340 pharmacy benefits manager to use and accept the form  
341 under certain circumstances; providing an exemption;  
342 creating s. 627.42393, F.S.; establishing a process  
343 for providers to override certain treatment  
344 restrictions; providing requirements for approval of  
345 such overrides; providing an exception to the override  
346 protocol in certain circumstances; providing an  
347 exemption; amending s. 627.6131, F.S.; prohibiting an  
348 insurer from retroactively denying a claim in certain  
349 circumstances; amending s. 627.6471, F.S.; requiring  
350 insurers to post preferred provider information on a  
351 website; specifying that changes to such a website  
352 must be made within a certain time; amending s.  
353 627.6515, F.S.; applying provisions relating to prior  
354 authorization and override protocols to out-of-state  
355 groups; amending s. 641.3155, F.S.; prohibiting a  
356 health maintenance organization from retroactively  
357 denying a claim in certain circumstances; creating s.  
358 641.393, F.S.; requiring the use of a standardized  
359 prior authorization form by a health maintenance



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360 organization; providing requirements for the  
361 availability and submission of the form; requiring a  
362 pharmacy benefits manager to use and accept the form  
363 under certain circumstances; providing an exemption;  
364 creating s. 641.394, F.S.; establishing a process for  
365 providers to override certain treatment restrictions;  
366 providing requirements for approval of such overrides;  
367 providing an exception to the override protocol in  
368 certain circumstances; providing an exemption;  
369 providing effective dates.  
370