**By** Senator Ausley

3-01061-21 20211250__

A bill to be entitled

An act relating to telehealth; amending s. 409.967, F.S.; prohibiting Medicaid managed care plans from using providers who exclusively provide services through telehealth to achieve network adequacy; amending s. 627.42396, F.S.; prohibiting certain health insurance policies from denying coverage for covered services provided through telehealth under certain circumstances; prohibiting health insurers from excluding covered services provided through telehealth from coverage; providing reimbursement requirements and cost-sharing limitations for health insurers relating to telehealth services; prohibiting health insurers from requiring an insured to receive services through telehealth services; authorizing health insurers to conduct utilization reviews under certain circumstances; authorizing health insurers to limit telehealth services to certain providers; deleting requirements for contracts between certain health insurers and telehealth providers; amending s. 627.6699, F.S.; requiring certain small employer benefit plans to comply with certain requirements for reimbursement of telehealth services; amending s. 641.31, F.S.; prohibiting a health maintenance organization from requiring a subscriber to receive certain services through telehealth; deleting requirements for contracts between certain health insurers and telehealth providers; creating s. 641.31093, F.S.; prohibiting certain health

maintenance organizations from denying coverage for covered services provided through telehealth under certain circumstances; prohibiting health maintenance organizations from excluding covered services provided through telehealth from coverage; providing reimbursement requirements and cost-sharing limitations for health maintenance organizations relating to telehealth services; prohibiting a health maintenance organization from requiring a subscriber to receive services through telehealth; authorizing health maintenance organizations to conduct utilization reviews under certain circumstances; authorizing health maintenance organizations to limit telehealth services to certain providers; providing an effective date.

WHEREAS, it is the intent of the Legislature to mitigate geographic discrimination in the delivery of health care by recognizing the provision of and payment for covered medical care by means of telehealth services, provided that such services are provided by a physician or by another health care practitioner or professional acting within the scope of practice of such health care practitioner or professional and in accordance with section 456.47, Florida Statutes, NOW, THEREFORE,

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

Section 1. Paragraph (c) of subsection (2) of section

409.967, Florida Statutes, is amended to read:

409.967 Managed care plan accountability.—

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

(c) *Access.*—

1. The agency shall establish specific standards for the number, type, and regional distribution of providers in managed care plan networks to ensure access to care for both adults and children. Each plan must maintain a regionwide network of providers in sufficient numbers to meet the access standards for specific medical services for all recipients enrolled in the plan. A plan may not use providers who exclusively provide services through telehealth, as defined in s. 456.47, to meet this requirement. 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. 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.

Section 2. Section 627.42396, Florida Statutes, is amended to read:

627.42396 Requirements for reimbursement by health insurers for telehealth services.—

(1) An individual, group, blanket, or franchise health insurance policy delivered or issued for delivery to any insured person in this state on or after January 1, 2022, may not deny coverage for a covered service on the basis of the service being provided through telehealth if the same service would be covered if provided through an in-person encounter.

(2) A health insurer may not exclude an otherwise covered service from coverage solely because the service is provided through telehealth rather than through an in-person encounter.

(3) A health insurer shall reimburse a telehealth provider for the diagnosis, consultation, or treatment of any insured person provided through telehealth on the same basis and at least at the same rate that the health insurer would reimburse the provider if the covered service were delivered through an in-person encounter. However, a health insurer may not require a health care provider or telehealth provider to accept a reimbursement amount greater than the amount the provider is willing to charge.

(4) A health insurer shall reimburse a telehealth provider for reasonable originating site fees or costs for the provision of telehealth services.

(5) A covered service provided through telehealth may not be subject to a greater deductible, copayment, or coinsurance amount than would apply if the same service were provided through an in-person encounter.

(6) A health insurer may not impose upon any insured person receiving benefits under this section any copayment, coinsurance, or deductible amount or any policy-year, calendar-year, lifetime, or other durational benefit limitation or maximum for benefits or services provided through telehealth which is not equally imposed upon all terms and services covered under the policy.

(7) A health insurer may not require an insured person to obtain a covered service through telehealth instead of an in-person encounter.

(8) This section does not preclude a health insurer from conducting a utilization review to determine the appropriateness of telehealth as a means of delivering a covered service if such

determination is made in the same manner as would be made for the same service provided through an in-person encounter.

(9) A health insurer may limit the covered services that are provided through telehealth to providers who are in a network approved by the insurer ~~A contract between a health insurer issuing major medical comprehensive coverage through an individual or group policy and a telehealth provider, as defined in s. 456.47, must be voluntary between the insurer and the provider and must establish mutually acceptable payment rates or payment methodologies for services provided through telehealth. Any contract provision that distinguishes between payment rates or payment methodologies for services provided through telehealth and the same services provided without the use of telehealth must be initialed by the telehealth provider~~.

Section 3. Paragraph (h) is added to subsection (5) of section 627.6699, Florida Statutes, to read:

627.6699 Employee Health Care Access Act.—

(5) AVAILABILITY OF COVERAGE.—

(h) A health benefit plan covering small employers which is delivered, issued, or renewed in this state on or after January 1, 2022, must comply with s. 627.42396.

Section 4. Subsection (45) of section 641.31, Florida Statutes, is amended to read:

641.31 Health maintenance contracts.—

(45) A ~~contract between a~~ health maintenance organization issuing major medical individual or group coverage may not require a subscriber to consult with, seek approval from, or obtain any type of referral or authorization by way of telehealth from ~~and~~ a telehealth provider, as defined in s.

456.47~~, must be voluntary between the health maintenance organization and the provider and must establish mutually acceptable payment rates or payment methodologies for services provided through telehealth. Any contract provision that distinguishes between payment rates or payment methodologies for services provided through telehealth and the same services provided without the use of telehealth must be initialed by the telehealth provider~~.

Section 5. Section 641.31093, Florida Statutes, is created to read:

641.31093 Requirements for reimbursement by health maintenance organizations for telehealth services.—

(1) A health maintenance organization that offers, issues, or renews a major medical or similar comprehensive contract in this state on or after January 1, 2022, may not deny coverage for a covered service on the basis of the covered service being provided through telehealth if the same service would be covered if provided through an in-person encounter.

(2) A health maintenance organization may not exclude an otherwise covered service from coverage solely because the service is provided through telehealth rather than through an in-person encounter.

(3) A health maintenance organization shall reimburse a telehealth provider for the diagnosis, consultation, or treatment of any subscriber provided through telehealth on the same basis and at least the same rate that the health maintenance organization would reimburse the provider if the service were provided through an in-person encounter. However, a health maintenance organization may not require a health care

provider or telehealth provider to accept a reimbursement amount greater than the amount the provider is willing to charge.

(4) A health maintenance organization shall reimburse a telehealth provider for reasonable originating site fees or costs for the provision of telehealth services.

(5) A covered service provided through telehealth may not be subject to a greater deductible, copayment, or coinsurance amount than would apply if the same service were provided through an in-person encounter.

(6) A health maintenance organization may not impose upon any subscriber receiving benefits under this section any copayment, coinsurance, or deductible amount or any contract-year, calendar-year, lifetime, or other durational benefit limitation or maximum for benefits or services provided through telehealth which is not equally imposed upon all services covered under the contract.

(7) A health maintenance organization may not require an insured person to obtain a covered service through telehealth instead of an in-person encounter.

(8) This section does not preclude a health maintenance organization from conducting a utilization review to determine the appropriateness of telehealth as a means of delivering a covered service if such determination is made in the same manner as would be made for the same service provided through an in-person encounter.

(9) A health maintenance organization may limit covered services that are provided through telehealth to providers who are in a network approved by the health maintenance organization.

Section 6. This act shall take effect July 1, 2021.