

By Senator Ausley

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1 A bill to be entitled
2 An act relating to telehealth; amending s. 409.967,
3 F.S.; prohibiting Medicaid managed care plans from
4 using providers who exclusively provide services
5 through telehealth to achieve network adequacy;
6 amending s. 627.42396, F.S.; prohibiting certain
7 health insurance policies from denying coverage for
8 covered services provided through telehealth under
9 certain circumstances; prohibiting health insurers
10 from excluding covered services provided through
11 telehealth from coverage; providing reimbursement
12 requirements and cost-sharing limitations for health
13 insurers relating to telehealth services; prohibiting
14 health insurers from requiring an insured person to
15 receive services through telehealth; authorizing
16 health insurers to conduct utilization reviews under
17 certain circumstances; authorizing health insurers to
18 limit telehealth services to certain providers;
19 deleting requirements for contracts between certain
20 health insurers and telehealth providers; amending s.
21 627.6699, F.S.; requiring certain small employer
22 benefit plans to comply with certain requirements for
23 reimbursement of telehealth services; amending s.
24 641.31, F.S.; prohibiting a health maintenance
25 organization from requiring a subscriber to receive
26 certain services through telehealth; deleting
27 requirements for contracts between certain health
28 insurers and telehealth providers; creating s.
29 641.31093, F.S.; prohibiting certain health

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30 maintenance organizations from denying coverage for
31 covered services provided through telehealth under
32 certain circumstances; prohibiting health maintenance
33 organizations from excluding covered services provided
34 through telehealth from coverage; providing
35 reimbursement requirements and cost-sharing
36 limitations for health maintenance organizations
37 relating to telehealth services; prohibiting a health
38 maintenance organization from requiring a subscriber
39 to receive services through telehealth; authorizing
40 health maintenance organizations to conduct
41 utilization reviews under certain circumstances;
42 authorizing health maintenance organizations to limit
43 telehealth services to certain providers; providing an
44 effective date.

45
46 WHEREAS, it is the intent of the Legislature to mitigate
47 geographic discrimination in the delivery of health care by
48 recognizing the provision of and payment for covered medical
49 care by means of telehealth services, provided that such
50 services are provided by a physician or by another health care
51 practitioner or professional acting within the scope of practice
52 of a health care practitioner or professional and in accordance
53 with s. 456.47, Florida Statutes, NOW, THEREFORE,

54
55 Be It Enacted by the Legislature of the State of Florida:

56
57 Section 1. Paragraph (c) of subsection (2) of section
58 409.967, Florida Statutes, is amended to read:

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59 409.967 Managed care plan accountability.—

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

64 (c) Access.—

65 1. The agency shall establish specific standards for the
66 number, type, and regional distribution of providers in managed
67 care plan networks to ensure access to care for both adults and
68 children. Each plan must maintain a regionwide network of
69 providers in sufficient numbers to meet the access standards for
70 specific medical services for all recipients enrolled in the
71 plan. A plan may not use providers who exclusively provide
72 services through telehealth as defined in s. 456.47 to meet this
73 requirement. The exclusive use of mail-order pharmacies may not
74 be sufficient to meet network access standards. Consistent with
75 the standards established by the agency, provider networks may
76 include providers located outside the region. A plan may
77 contract with a new hospital facility before the date the
78 hospital becomes operational if the hospital has commenced
79 construction, will be licensed and operational by January 1,
80 2013, and a final order has issued in any civil or
81 administrative challenge. Each plan shall establish and maintain
82 an accurate and complete electronic database of contracted
83 providers, including information about licensure or
84 registration, locations and hours of operation, specialty
85 credentials and other certifications, specific performance
86 indicators, and such other information as the agency deems
87 necessary. The database must be available online to both the

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88 agency and the public and have the capability to compare the
89 availability of providers to network adequacy standards and to
90 accept and display feedback from each provider's patients. Each
91 plan shall submit quarterly reports to the agency identifying
92 the number of enrollees assigned to each primary care provider.
93 The agency shall conduct, or contract for, systematic and
94 continuous testing of the provider network databases maintained
95 by each plan to confirm accuracy, confirm that behavioral health
96 providers are accepting enrollees, and confirm that enrollees
97 have access to behavioral health services.

98 2. Each managed care plan must publish any prescribed drug
99 formulary or preferred drug list on the plan's website in a
100 manner that is accessible to and searchable by enrollees and
101 providers. The plan must update the list within 24 hours after
102 making a change. Each plan must ensure that the prior
103 authorization process for prescribed drugs is readily accessible
104 to health care providers, including posting appropriate contact
105 information on its website and providing timely responses to
106 providers. For Medicaid recipients diagnosed with hemophilia who
107 have been prescribed anti-hemophilic-factor replacement
108 products, the agency shall provide for those products and
109 hemophilia overlay services through the agency's hemophilia
110 disease management program.

111 3. Managed care plans, and their fiscal agents or
112 intermediaries, must accept prior authorization requests for any
113 service electronically.

114 4. Managed care plans serving children in the care and
115 custody of the Department of Children and Families must maintain
116 complete medical, dental, and behavioral health encounter

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117 information and participate in making such information available
118 to the department or the applicable contracted community-based
119 care lead agency for use in providing comprehensive and
120 coordinated case management. The agency and the department shall
121 establish an interagency agreement to provide guidance for the
122 format, confidentiality, recipient, scope, and method of
123 information to be made available and the deadlines for
124 submission of the data. The scope of information available to
125 the department shall be the data that managed care plans are
126 required to submit to the agency. The agency shall determine the
127 plan's compliance with standards for access to medical, dental,
128 and behavioral health services; the use of medications; and
129 follow up ~~followup~~ on all medically necessary services
130 recommended as a result of early and periodic screening,
131 diagnosis, and treatment.

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

134 627.42396 Requirements for reimbursement by health insurers
135 for telehealth services.—

136 (1) An individual, group, blanket, or franchise health
137 insurance policy delivered or issued for delivery to any insured
138 person in this state on or after January 1, 2023, may not deny
139 coverage for a covered service on the basis of the service being
140 provided through telehealth if the same service would be covered
141 if provided through an in-person encounter.

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

145 (3) A health insurer shall reimburse a telehealth provider

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

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

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

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

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

171 (8) This section does not preclude a health insurer from
172 conducting a utilization review to determine the appropriateness
173 of telehealth as a means of delivering a covered service if such
174 determination is made in the same manner as would be made for

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175 the same service provided through an in-person encounter.

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

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

190 627.6699 Employee Health Care Access Act.—

191 (5) AVAILABILITY OF COVERAGE.—

192 (h) A health benefit plan covering small employers which is
 193 delivered, issued, or renewed in this state on or after January
 194 1, 2023, must comply with s. 627.42396.

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

197 641.31 Health maintenance contracts.—

198 (45) A ~~contract between a~~ health maintenance organization
 199 ~~issuing major medical individual or group coverage~~ may not
 200 require a subscriber to consult with, seek approval from, or
 201 obtain any type of referral or authorization by way of
 202 telehealth from ~~and a telehealth provider, as defined in s.~~
 203 ~~456.47, must be voluntary between the health maintenance~~

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204 ~~organization and the provider and must establish mutually~~
205 ~~acceptable payment rates or payment methodologies for services~~
206 ~~provided through telehealth. Any contract provision that~~
207 ~~distinguishes between payment rates or payment methodologies for~~
208 ~~services provided through telehealth and the same services~~
209 ~~provided without the use of telehealth must be initialed by the~~
210 ~~telehealth provider.~~

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

213 641.31093 Requirements for reimbursement by health
214 maintenance organizations for telehealth services.-

215 (1) A health maintenance organization that offers, issues,
216 or renews a major medical or similar comprehensive contract in
217 this state on or after January 1, 2023, may not deny coverage
218 for a covered service on the basis of the covered service being
219 provided through telehealth if the same service would be covered
220 if provided through an in-person encounter.

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

225 (3) A health maintenance organization shall reimburse a
226 telehealth provider for the diagnosis, consultation, or
227 treatment of any subscriber provided through telehealth on the
228 same basis and at least the same rate that the health
229 maintenance organization would reimburse the provider if the
230 service were provided through an in-person encounter. However, a
231 health maintenance organization may not require a health care
232 provider or telehealth provider to accept a reimbursement amount

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233 greater than the amount the provider is willing to charge.

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

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

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

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

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

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

260 Section 6. This act shall take effect July 1, 2022.