782304

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/23/2014	.	
	.	
	.	
	.	

The Committee on Appropriations (Grimsley) recommended the following:

1 **Senate Amendment (with title amendment)**
2
3 Delete everything after the enacting clause
4 and insert:
5 Section 1. Paragraph (c) of subsection (2) of section
6 409.967, Florida Statutes, is amended to read:
7 409.967 Managed care plan accountability.—
8 (2) The agency shall establish such contract requirements
9 as are necessary for the operation of the statewide managed care
10 program. In addition to any other provisions the agency may deem

782304

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. 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 of comparing ~~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.

782304

40 2. If establishing a prescribed drug formulary or preferred
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

782304

69 benefit. The form may not exceed two pages in length, excluding
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

782304

98 step-therapy or fail-first protocol:
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 2. 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,

782304

127 issues for delivery, renews, amends, or continues an individual
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) A completed prior authorization request submitted by a
149 prescribing provider using the standardized prior authorization
150 form required under subsection (1) is deemed approved upon
151 receipt by the health insurer unless the health insurer responds
152 otherwise within 2 business days.
153 (3) This section does not apply to a grandfathered health
154 plan as defined in s. 627.402.
155 Section 3. Section 627.42393, Florida Statutes, is created

782304

156 to read:
157 627.42393 Medication protocol override.—If an individual or
158 group health insurance policy, including a policy issued by a
159 small employer as defined in s. 627.6699, restricts medications
160 for the treatment of a medical condition by a step-therapy or
161 fail-first protocol, the prescribing provider must have access
162 to a clear and convenient process to request an override of the
163 protocol from the health insurer.
164 (1) The health insurer shall authorize an override of the
165 protocol within 72 hours if the prescribing provider documents
166 that:
167 (a) Based on sound clinical evidence, the preferred
168 treatment required under the step-therapy or fail-first protocol
169 has been ineffective in the treatment of the insured's disease
170 or medical condition; or
171 (b) Based on sound clinical evidence or medical and
172 scientific evidence, the preferred treatment required under the
173 step-therapy or fail-first protocol:
174 1. Is expected or is likely to be ineffective based on
175 known relevant physical or mental characteristics of the insured
176 and known characteristics of the drug regimen; or
177 2. Will cause or is likely to cause an adverse reaction or
178 other physical harm to the insured.
179 (2) If the prescribing provider allows the insured to enter
180 the step-therapy or fail-first protocol recommended by the
181 health insurer, the duration of the step-therapy or fail-first
182 protocol may not exceed the customary period for use of the
183 medication if the prescribing provider demonstrates such
184 treatment to be clinically ineffective. If the health insurer

782304

185 can, through sound clinical evidence, demonstrate that the
186 originally prescribed medication is likely to require more than
187 the customary period for such medication to provide any relief
188 or amelioration to the insured, the step-therapy or fail-first
189 protocol may be extended for an additional period of time, but
190 no longer than the original customary period for the medication.
191 Notwithstanding this provision, a step-therapy or fail-first
192 protocol shall be terminated if the prescribing provider
193 determines that the insured is having an adverse reaction or is
194 suffering from other physical harm resulting from the use of the
195 medication.
196 (3) This section does not apply to grandfathered health
197 plans, as defined in s. 627.402.
198 Section 4. Subsection (11) of section 627.6131, Florida
199 Statutes, is amended to read:
200 627.6131 Payment of claims.—
201 (11) A health insurer may not retroactively deny a claim
202 because of insured ineligibility:
203 (a) More than 1 year after the date of payment of the
204 claim; or
205 (b) If, under a policy compliant with the federal Patient
206 Protection and Affordable Care Act, as amended by the Health
207 Care and Education Reconciliation Act of 2010, and the
208 regulations adopted pursuant to those acts, the health insurer
209 verified the eligibility of the insured at the time of treatment
210 and provided an authorization number, unless, at the time
211 eligibility was verified, the provider was notified that the
212 insured was delinquent in paying the premium.
213 Section 5. Subsection (2) of section 627.6471, Florida

782304

214 Statutes, is amended to read:
215 627.6471 Contracts for reduced rates of payment;
216 limitations; coinsurance and deductibles.—
217 (2) An ~~Any~~ insurer issuing a policy of health insurance in
218 this state~~,~~ which ~~insurance~~ includes coverage for the services
219 of a preferred provider shall~~, must~~ provide each policyholder
220 and certificateholder with a current list of preferred
221 providers, shall ~~and must~~ make the list available for public
222 inspection during regular business hours at the principal office
223 of the insurer within the state, and shall post a link to the
224 list of preferred providers on the home page of the insurer's
225 website. Changes to the list of preferred providers must be
226 reflected on the insurer's website within 24 hours.
227 Section 6. Paragraph (c) of subsection (2) of section
228 627.6515, Florida Statutes, is amended to read:
229 627.6515 Out-of-state groups.—
230 (2) Except as otherwise provided in this part, this part
231 does not apply to a group health insurance policy issued or
232 delivered outside this state under which a resident of this
233 state is provided coverage if:
234 (c) The policy provides the benefits specified in ss.
235 627.419, 627.42392, 627.42393, 627.6574, 627.6575, 627.6579,
236 627.6612, 627.66121, 627.66122, 627.6613, 627.667, 627.6675,
237 627.6691, and 627.66911, and complies with the requirements of
238 s. 627.66996.
239 Section 7. Subsection (10) of section 641.3155, Florida
240 Statutes, is amended to read:
241 641.3155 Prompt payment of claims.—
242 (10) A health maintenance organization may not

782304

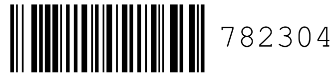
243 retroactively deny a claim because of subscriber ineligibility:
244 (a) More than 1 year after the date of payment of the
245 claim; or
246 (b) If, under a policy in compliance with the federal
247 Patient Protection and Affordable Care Act, as amended by the
248 Health Care and Education Reconciliation Act of 2010, and the
249 regulations adopted pursuant to those acts, the health
250 maintenance organization verified the eligibility of the
251 subscriber at the time of treatment and provided an
252 authorization number, unless, at the time eligibility was
253 verified, the provider was notified that the subscriber was
254 delinquent in paying the premium.
255 Section 8. Section 641.393, Florida Statutes, is created to
256 read:
257 641.393 Prior authorization.—Notwithstanding any other law,
258 in order to establish uniformity in the submission of prior
259 authorization forms, effective January 1, 2015, a health
260 maintenance organization shall use a single standardized form
261 for obtaining prior authorization for prescription drug
262 benefits. The form may not exceed two pages in length, excluding
263 any instructions or guiding documentation.
264 (1) A health maintenance organization shall make the form
265 available electronically and online to practitioners. A health
266 care provider may electronically submit the completed form to
267 the health maintenance organization.
268 (2) If a health maintenance organization contracts with a
269 pharmacy benefits manager to perform prior authorization
270 services for prescription drug benefits, the pharmacy benefits
271 manager must use and accept the standardized prior authorization

782304

272 form.
273 (3) A completed prior authorization request submitted by a
274 health care provider using the standardized prior authorization
275 form required under this section is deemed approved upon receipt
276 by the health maintenance organization unless the health
277 maintenance organization responds otherwise within 3 business
278 days.
279 (4) This section does not apply to grandfathered health
280 plans, as defined in s. 627.402.
281 Section 9. Section 641.394, Florida Statutes, is created to
282 read:
283 641.394 Medication protocol override.—If a health
284 maintenance organization contract restricts medications for the
285 treatment of a medical condition by a step-therapy or fail-first
286 protocol, the prescribing provider shall have access to a clear
287 and convenient process to request an override of the protocol
288 from the health maintenance organization.
289 (1) The health maintenance organization shall grant an
290 override within 72 hours if the prescribing provider documents
291 that:
292 (a) Based on sound clinical evidence, the preferred
293 treatment required under the step-therapy or fail-first protocol
294 has been ineffective in the treatment of the subscriber's
295 disease or medical condition; or
296 (b) Based on sound clinical evidence or medical and
297 scientific evidence, the preferred treatment required under the
298 step-therapy or fail-first protocol:
299 1. Is expected or is likely to be ineffective based on
300 known relevant physical or mental characteristics of the

782304

301 subscriber and known characteristics of the drug regimen; or
302 2. Will cause or is likely to cause an adverse reaction or
303 other physical harm to the subscriber.
304 (2) If the prescribing provider allows the subscriber to
305 enter the step-therapy or fail-first protocol recommended by the
306 health maintenance organization, the duration of the step-
307 therapy or fail-first protocol may not exceed the customary
308 period for use of the medication if the prescribing provider
309 demonstrates such treatment to be clinically ineffective. If the
310 health maintenance organization can, through sound clinical
311 evidence, demonstrate that the originally prescribed medication
312 is likely to require more than the customary period to provide
313 any relief or amelioration to the subscriber, the step-therapy
314 or fail-first protocol may be extended for an additional period,
315 but no longer than the original customary period for use of the
316 medication. Notwithstanding this provision, a step-therapy or
317 fail-first protocol shall be terminated if the prescribing
318 provider determines that the subscriber is having an adverse
319 reaction or is suffering from other physical harm resulting from
320 the use of the medication.
321 (3) This section does not apply to grandfathered health
322 plans, as defined in s. 627.402.
323 Section 10. This act shall take effect July 1, 2014.
324
325 ================ T I T L E A M E N D M E N T ================
326 And the title is amended as follows:
327 Delete everything before the enacting clause
328 and insert:
329 A bill to be entitled


782304

330 An act relating to health care; amending s. 409.967,
331 F.S.; revising contract requirements for Medicaid
332 managed care programs; providing requirements for
333 plans establishing a drug formulary or preferred drug
334 list; requiring the use of a standardized prior
335 authorization form; providing requirements for the
336 form and for the availability and submission of the
337 form; requiring a pharmacy benefits manager to use and
338 accept the form under certain circumstances;
339 establishing a process for providers to override
340 certain treatment restrictions; providing requirements
341 for approval of such overrides; providing an exception
342 to the override protocol in certain circumstances;
343 creating s. 627.42392, F.S.; requiring health insurers
344 to use a standardized prior authorization form;
345 providing requirements for the form and for the
346 availability and submission of the form; requiring a
347 pharmacy benefits manager to use and accept the form
348 under certain circumstances; providing an exemption;
349 creating s. 627.42393, F.S.; establishing a process
350 for providers to override certain treatment
351 restrictions; providing requirements for approval of
352 such overrides; providing an exception to the override
353 protocol in certain circumstances; providing an
354 exemption; amending s. 627.6131, F.S.; prohibiting an
355 insurer from retroactively denying a claim in certain
356 circumstances; amending s. 627.6471, F.S.; requiring
357 insurers to post preferred provider information on a
358 website; specifying that changes to such a website

782304

359 must be made within a certain time; amending s.
360 627.6515, F.S.; applying provisions relating to prior
361 authorization and override protocols to out-of-state
362 groups; amending s. 641.3155, F.S.; prohibiting a
363 health maintenance organization from retroactively
364 denying a claim in certain circumstances; creating s.
365 641.393, F.S.; requiring the use of a standardized
366 prior authorization form by a health maintenance
367 organization; providing requirements for the
368 availability and submission of the form; requiring a
369 pharmacy benefits manager to use and accept the form
370 under certain circumstances; providing an exemption;
371 creating s. 641.394, F.S.; establishing a process for
372 providers to override certain treatment restrictions;
373 providing requirements for approval of such overrides;
374 providing an exception to the override protocol in
375 certain circumstances; providing an exemption;
376 providing an effective date.