149458

LEGISLATIVE ACTION

| Senate | . | House |
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| Comm: RCS | . | |
| 04/20/2015 | . | |
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The Committee on Rules (Gaetz) recommended the following:

1 **Senate Amendment to Amendment (395678) (with title**
2 **amendment)**
3
4 Before line 5
5 insert:
6 Section 1. Paragraph (c) of subsection (2) of section
7 409.967, Florida Statutes, is amended to read:
8 409.967 Managed care plan accountability.—
9 (2) The agency shall establish such contract requirements
10 as are necessary for the operation of the statewide managed care
11 program. In addition to any other provisions the agency may deem

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

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41 formulary or preferred drug list on the plan’s website in a
42 manner that is accessible to and searchable by enrollees and
43 providers. The plan must update the list within 24 hours after
44 making a change. Each plan must ensure that the prior
45 authorization process for prescribed drugs is readily accessible
46 to health care providers, including posting appropriate contact
47 information on its website and providing timely responses to
48 providers. For Medicaid recipients diagnosed with hemophilia who
49 have been prescribed anti-hemophilic-factor replacement
50 products, the agency shall provide for those products and
51 hemophilia overlay services through the agency’s hemophilia
52 disease management program.
53 3. Managed care plans, and their fiscal agents or
54 intermediaries, must accept prior authorization requests for any
55 service electronically.
56 4. Managed care plans serving children in the care and
57 custody of the Department of Children and Families must maintain
58 complete medical, dental, and behavioral health encounter
59 information and participate in making such information available
60 to the department or the applicable contracted community-based
61 care lead agency for use in providing comprehensive and
62 coordinated case management. The agency and the department shall
63 establish an interagency agreement to provide guidance for the
64 format, confidentiality, recipient, scope, and method of
65 information to be made available and the deadlines for
66 submission of the data. The scope of information available to
67 the department shall be the data that managed care plans are
68 required to submit to the agency. The agency shall determine the
69 plan’s compliance with standards for access to medical, dental,

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70 and behavioral health services; the use of medications; and
71 followup on all medically necessary services recommended as a
72 result of early and periodic screening, diagnosis, and
73 treatment.
74 5. If medication for the treatment of a medical condition
75 is restricted for use by a managed care plan through a step-
76 therapy or fail-first protocol, the prescribing provider shall
77 have access to a clear and convenient process to request an
78 override of such restriction from the managed care plan. The
79 managed care plan shall grant an override of the protocol within
80 24 hours under the following circumstances:
81 a. The prescribing provider determines, based on sound
82 clinical evidence, that the preferred treatment required under
83 the step-therapy or fail-first protocol has been ineffective in
84 the treatment of the enrollee's disease or medical condition; or
85 b. The prescribing provider believes, based on sound
86 clinical evidence or medical and scientific evidence, that the
87 preferred treatment required under the step-therapy or fail-
88 first protocol:
89 (I) Is expected to, or is likely to, be ineffective given
90 the known relevant physical or mental characteristics and
91 medical history of the enrollee and the known characteristics of
92 the drug regimen; or
93 (II) Will cause, or is likely to cause, an adverse reaction
94 or other physical harm to the enrollee.
95 6. If the prescribing provider allows the enrollee to enter
96 the step-therapy or fail-first protocol recommended by the
97 managed care plan, the duration of the step-therapy or fail-
98 first protocol may not exceed a period deemed appropriate by the

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99 prescribing provider. If the prescribing provider deems the
100 treatment clinically ineffective, the enrollee is entitled to
101 receive the recommended course of therapy without requiring the
102 prescribing provider to seek approval for an override of the
103 step-therapy or fail-first protocol.
104 Section 2. Section 627.42392, Florida Statutes, is created
105 to read:
106 627.42392 Prior Authorization.—
107 (1) As used in this section, the term “health insurer”
108 means an authorized insurer offering health insurance as defined
109 in s. 624.603, a managed care plan as defined in s. 409.901(13),
110 or a health maintenance organization as defined in s.
111 641.19(12).
112 (2) Notwithstanding any other provision of law, in order to
113 establish uniformity in the submission of prior authorization
114 forms on or after January 1, 2016, a health insurer, or a
115 pharmacy benefits manager on behalf of the health insurer, which
116 does not utilize an online prior authorization form for its
117 contracted providers shall use only the prior authorization form
118 that has been approved by the Financial Services Commission to
119 obtain a prior authorization for a medical procedure, course of
120 treatment, or prescription drug benefit. Such form may not
121 exceed two pages in length, excluding any instructions or
122 guiding documentation.
123 (3) The Financial Services Commission shall adopt by rule
124 guidelines for prior authorization forms which ensure the
125 general uniformity of such forms.
126 Section 3. Subsection (11) of section 627.6131, Florida
127 Statutes, is amended to read:

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128 627.6131 Payment of claims.—
129 (11) A health insurer may not retroactively deny a claim
130 because of insured ineligibility:
131 (a) At any time, if the health insurer verified the
132 eligibility of an insured at the time of treatment and provided
133 an authorization number.
134 (b) More than 1 year after the date of payment of the
135 claim.
136 Section 4. Section 627.6466, Florida Statutes, is created
137 to read:
138 627.6466 Fail-first protocols.—If medication for the
139 treatment of a medical condition is restricted for use by an
140 insurer through a step-therapy or fail-first protocol, the
141 prescribing provider shall have access to a clear and convenient
142 process to request an override of such restriction from the
143 insurer. The insurer shall grant an override of the protocol
144 within 24 hours under the following circumstances:
145 (1) The prescribing provider determines, based on sound
146 clinical evidence, that the preferred treatment required under
147 the step-therapy or fail-first protocol has been ineffective in
148 the treatment of the insured's disease or medical condition; or
149 (2) The prescribing provider believes, based on sound
150 clinical evidence or medical and scientific evidence, that the
151 preferred treatment required under the step-therapy or fail-
152 first protocol:
153 (a) Is expected to, or is likely to, be ineffective given
154 the known relevant physical or mental characteristics and
155 medical history of the insured and the known characteristics of
156 the drug regimen; or

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157 (b) Will cause, or is likely to cause, an adverse reaction
158 or other physical harm to the insured.
159 (3) If the prescribing provider allows the insured to enter
160 the step-therapy or fail-first protocol recommended by the
161 health insurer, the duration of the step-therapy or fail-first
162 protocol may not exceed a period deemed appropriate by the
163 provider. If the prescribing provider deems the treatment
164 clinically ineffective, the insured is entitled to receive the
165 recommended course of therapy without requiring the prescribing
166 provider to seek approval for an override of the step-therapy or
167 fail-first protocol.
168 Section 5. Subsection (10) of section 641.3155, Florida
169 Statutes, is amended to read:
170 641.3155 Prompt payment of claims.—
171 (10) A health maintenance organization may not
172 retroactively deny a claim because of subscriber ineligibility:
173 (a) At any time, if the health maintenance organization
174 verified the eligibility of an insured at the time of treatment
175 and provided an authorization number.
176 (b) More than 1 year after the date of payment of the
177 claim.
178 Section 6. Section 641.393, Florida Statutes, is created to
179 read:
180 641.393 Fail-first protocols.—If medication for the
181 treatment of a medical condition is restricted for use by a
182 health maintenance organization through a step-therapy or fail-
183 first protocol, the prescribing provider shall have access to a
184 clear and convenient process to request an override of such
185 restriction from the organization. The health maintenance

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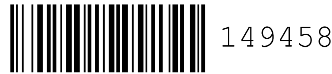
186 organization shall grant an override of the protocol within 24
187 hours under the following circumstances:
188 (1) The prescribing provider determines, based on sound
189 clinical evidence, that the preferred treatment required under
190 step-therapy or fail-first protocol has been ineffective in the
191 treatment of the subscriber's disease or medical condition; or
192 (2) The prescribing provider believes, based on sound
193 clinical evidence or medical and scientific evidence, that the
194 preferred treatment required under the step-therapy or fail-
195 first protocol:
196 (a) Is expected to, or is likely to, be ineffective given
197 the known relevant physical or mental characteristics and
198 medical history of the subscriber and the known characteristics
199 of the drug regimen; or
200 (b) Will cause, or is likely to cause, an adverse reaction
201 or other physical harm to the subscriber.
202 (3) If the prescribing provider allows the subscriber to
203 enter the step-therapy or fail-first protocol recommended by the
204 health maintenance organization, the duration of the step-
205 therapy or fail-first protocol may not exceed a period deemed
206 appropriate by the provider. If the prescribing provider deems
207 the treatment clinically ineffective, the subscriber is entitled
208 to receive the recommended course of therapy without requiring
209 the prescribing provider to seek approval for an override of the
210 step-therapy or fail-first protocol.
211
212 ================= T I T L E A M E N D M E N T ================
213 And the title is amended as follows:
214 Delete lines 882 - 884



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215 and insert:
216 An act relating to health care; amending s. 409.967,
217 F.S.; requiring a Medicaid managed care plan to allow
218 a prescribing provider to request an override of a
219 restriction on the use of medication imposed through a
220 step-therapy or fail-first protocol; requiring the
221 plan to grant such override within a specified
222 timeframe under certain circumstances; prohibiting the
223 duration of a step-therapy or fail-first protocol from
224 exceeding the time period specified by the prescribing
225 provider; providing that an override is not required
226 under certain circumstances; creating s. 627.42392,
227 F.S.; defining the term “health insurer”; providing
228 that certain health insurers shall use only a prior
229 authorization form approved by the Financial Services
230 Commission; specifying requirements to be followed by
231 the commission in reviewing such forms; requiring the
232 commission to adopt certain rules relating to such
233 forms; amending s. 627.6131, F.S.; prohibiting a
234 health insurer from retroactively denying a claim
235 under specified circumstances; creating s. 627.6466,
236 F.S.; requiring an insurer to allow a prescribing
237 provider to request an override of a restriction on
238 the use of medication imposed through a step-therapy
239 or fail-first protocol; requiring the insurer to grant
240 such override within a specified timeframe under
241 certain circumstances; prohibiting the duration of a
242 step-therapy or fail-first protocol from exceeding the
243 time period specified by the prescribing provider;

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244 providing that an override is not required under
245 certain circumstances; amending s. 641.3155, F.S.;
246 prohibiting a health maintenance organization from
247 retroactively denying a claim under specified
248 circumstances; creating s. 641.393, F.S.; requiring a
249 health maintenance organization to allow a prescribing
250 provider to request an override of a restriction on
251 the use of medication imposed through a step-therapy
252 or fail-first protocol; requiring the health
253 maintenance organization to grant such override within
254 a specified timeframe under certain circumstances;
255 prohibiting the duration of a step-therapy or fail-
256 first protocol from exceeding the time period
257 specified by the prescribing provider; providing that
258 an override is not required under certain
259 circumstances; amending s. 110.12315, F.S.; expanding
260 the