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HOUSE OF REPRESENTATIVES
AS REVISED BY THE COMMITTEE ON
HEALTH AND HUMAN SERVICES APPROPRIATIONS
BILL RESEARCH & ECONOMIC IMPACT STATEMENT

BILL #: CS/HB 1005

RELATING TO: Statewide Provider and Subscriber Assistance Program

SPONSOR(S): Committee on Health Care Standards & Regulatory Reform and Representative Saunders

STATUTE(S) AFFECTED: Sections 408.7056 and 641.511, F.S.

COMPANION BILL(S): SB 362(s), HB 1437(c), SB 364(c)

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:
(1) HEALTH CARE STANDARDS & REGULATORY REFORM YEAS 5 NAYS 1
(2) HEALTH AND HUMAN SERVICES APPROPRIATIONS YEAS 10 NAYS 0
(3)
(4)
(5)

I. SUMMARY:

The bill focuses on the Statewide Provider and Subscriber Assistance Panel's ability to hear grievances and make recommendations for actions to either the Agency for Health Care Administration (agency) or the Department of Insurance (department). This bill defines a managed care entity and the statewide provider and subscriber assistance panel (panel). The bill requires the panel to hear grievances once the agency determines that it may do so, unless it falls under a specified statutory exception. It establishes time frames for hearing grievances and issuing recommendations to the agency or department. The bill provides that proceedings of the panel are not subject to the provisions of chapter 120, F.S. The final orders of the panel are subject to the provision of chapter 120, F.S.

The bill provides for two expedited procedures depending on the health of the subscriber. First, an expedited hearing may be held when there is an immediate and serious threat to the subscriber's health. This expedited hearing must occur within 45 days. Second, an emergency hearing may be held within 24 hours in cases where the life of the subscriber is in jeopardy. In such cases, the panel will issue an emergency recommendation, and the agency or department will then issue an emergency order within 24 hours.

A managed care entity, subscriber, or provider may appeal the panel's recommendation within 10 days of a regular hearing, or 72 hours of an expedited hearing. The agency or department may adopt all or part of the panel's recommendation and impose fines or sanctions under existing Florida law. The agency or department may reject all or part of the panel's recommendations under specific circumstances.

The fiscal impact of the bill, provided by the Agency for Health Care Administration, is $247,396 for FY 1997-98. There is no direct fiscal impact on local government or the private sector in general.

II. SUBSTANTIVE ANALYSIS:

A. PRESENT SITUATION:

The Statewide Provider and Subscriber Assistance Panel (panel) was created to review enrollment/disenrollment, financial, contractual, and quality of care complaints against health maintenance organizations (HMOs) that had not been satisfactorily resolved by an HMO through its internal grievance process. The panel's jurisdiction was later expanded to include other health provider organizations. In 1993, The Agency for Health Care Administration (agency) was given the authority to impose administrative fines when a provider organization fails to comply with quality of health services standards. Under the current section 408.7056, F.S., the panel may review and consider subscriber and provider grievances and make recommendations to the agency or the Department of Insurance (department) as to any action they should take concerning such grievances. Currently, administrative fines shall not exceed $2,500 per violation or $10,000 in the aggregate. The agency may consider several factors when imposing fines. The current statute is silent as to the time frames under which the panel shall conduct hearings and recommend action or when final orders shall be issued. The existing law also fails to provide an expedited or emergency process for hearing subscriber grievances which may pose an immediate and serious threat to a subscriber's health.

Currently, the panel is composed of six members, three employed by the agency and three employed by the department. The agency may contract with a medical director and a primary care physician for technical expertise for the panel. Additionally, various provider organizations are required to report quarterly on the number and nature of subscribers' grievances which have not been resolved to the satisfaction of the subscriber after he or she follows the full grievance procedure of the organization. During 1996, the panel heard a total of 143 grievance cases which included quality of care, access to care, billing, and other miscellaneous disputes.

B. EFFECT OF PROPOSED CHANGES:

The Agency for Health Care Administration (agency) must provide notice of the Statewide Provider and Subscriber Assistance Panel's (panel) grievance procedure every three months to all subscribers and providers who have not satisfactorily resolved disputes in the provider organization's formal grievance process. Once a provider or subscriber submits a grievance to the agency, it will determine within 60 days whether or not the panel will hear the grievance. The bill amends or adds several provisions in which a grievance will not be heard. These new provisions specify that a grievance will not be heard by the panel if it relates to a managed care entity's refusal to accept a provider into its network of providers; is a part of a Medicaid appeal that does not involve a quality of care issue; is the basis for an action pending in court; is related to an appeal by non-participating providers, unless the appeal is related to emergency services and care or quality of care; has not completed the entire formal grievance procedure of the health provider; has been resolved to the satisfaction of the party who filed the grievance; attempts to seek damages for pain and suffering, lost wages, or other incidental expenses; is limited to issues involving conduct which may be grounds for disciplinary action by a professional licensing board; or is withdrawn or a party fails to attend the hearing.

If the agency determines the grievance may be heard by the panel, the panel will hear the grievance in person or by phone within 120 days. A managed care entity or provider must provide patient records for the hearing or it will be subject to a daily fine of up to $2,500. The panel will issue its recommendation to the agency or department within 15 days. The agency or department then has 30 days to issue its order.

However, under certain circumstances, the time periods for hearing and recommendation are shortened. First, in cases in which there is an immediate and serious threat to the subscriber's health, the grievance has priority and must be heard within 45 days in an "expedited" grievance procedure. The agency or department will issue a final order within 10 days of the recommendation. Additionally, an "emergency" hearing may be convened within 24 hours when the life of the subscriber is in imminent and emergent jeopardy. The panel will hear the emergency grievance even though the provider organization's formal grievance procedure has not been completed. The agency or department will issue an emergency order to the provider organization within 24 hours after an emergency hearing.

After the panel makes its recommendation, the agency or department may adopt the panel's recommendation, or impose other fines in its final order. The agency or department may also reject all or part of the panel's recommendation under a number of circumstances including any relevant factor the agency deems appropriate. The panel proceedings are exempt from the provisions of 120, F.S. However, the final order of the agency or department are subject to the provisions of chapter 120, F.S.

C. APPLICATION OF PRINCIPLES:

1. Less Government:

a. Does the bill create, increase or reduce, either directly or indirectly:

(1) any authority to make rules or adjudicate disputes?

Yes. The bill increases the ability of the Statewide Provider and Subscriber Assistance Panel to hear grievances. With a well defined grievance system, the process may become more formalized and encourage subscribers and providers to pursue remedies under this statute. As the agency or the department are not bound by the panel's recommendations, the agency or department may indirectly acquire more authority to adjudicate an increasing number of disputes.

(2) any new responsibilities, obligations or work for other governmental or private organizations or individuals?

Yes. The agency would have an increased regulatory workload as this bill would encourage an increased use of the grievance procedure. Currently, the agency and department each employ three panel members respectively. The agency also contracts with a medical director and a primary care physician who provide expertise for each hearing. The agency estimates

that it will hire a Senior Attorney, three Program Analysts, and an Administrative Secretary as a result of this bill. In short, workloads of both current and prospective employees would likely increase.

(3) any entitlement to a government service or benefit?

None.

b. If an agency or program is eliminated or reduced:

(1) what responsibilities, costs and powers are passed on to another program, agency, level of government, or private entity?

N/A.

(2) what is the cost of such responsibility at the new level/agency?

N/A.

(3) how is the new agency accountable to the people governed?

N/A.

2. Lower Taxes:

a. Does the bill increase anyone's taxes?

No.

b. Does the bill require or authorize an increase in any fees?

No.

c. Does the bill reduce total taxes, both rates and revenues?

No.

d. Does the bill reduce total fees, both rates and revenues?

No.

e. Does the bill authorize any fee or tax increase by any local government?

No.

3. Personal Responsibility:

   a. Does the bill reduce or eliminate an entitlement to government services or subsidy?

      No.

   b. Do the beneficiaries of the legislation directly pay any portion of the cost of implementation and operation?

      Yes, if HMO's are considered to be a beneficiary of the program. The additional costs of the program would be funded from the Health Care Trust Fund which receives fees paid by HMOs.

4. Individual Freedom:

   a. Does the bill increase the allowable options of individuals or private organizations/associations to conduct their own affairs?

      Yes. The bill allows an injured party to pursue this grievance procedure without the aid or expense of an attorney. Without a definite grievance procedure, an injured subscriber may be more likely to use the court system, thus subjecting him or her to increased litigation and attorney's costs.

   b. Does the bill prohibit, or create new government interference with, any presently lawful activity?

      No.

5. Family Empowerment:

   a. If the bill purports to provide services to families or children:

      (1) Who evaluates the family's needs?

          N/A.

      (2) Who makes the decisions?

          N/A.

(3) Are private alternatives permitted?

N/A.

(4) Are families required to participate in a program?

N/A.

(5) Are families penalized for not participating in a program?

N/A.

b. Does the bill directly affect the legal rights and obligations between family members?

N/A.

c. If the bill creates or changes a program providing services to families or children, in which of the following does the bill vest control of the program, either through direct participation or appointment authority:

(1) parents and guardians?

N/A.

(2) service providers?

N/A.

(3) government employees/agencies?

N/A.

D. SECTION-BY-SECTION ANALYSIS:

Section 1. Amends s. 408.7056, F.S., relating to the Statewide Provider and Subscriber Assistance Program. This bill amends the panel's authority to review grievances, establishes the grievance procedure, and provides criteria for imposing remedies.

Subsection (1). Defines "managed care entity" as an accountable health partnership certified under s. 408.706, F.S., a health maintenance organization certified under chapter 641, F.S., a prepaid health clinic, a prepaid health plan authorized pursuant to s. 409.912, F.S., or an exclusive provider organization certified under s. 627.6472, F.S. This subsection also defines "Panel" as a statewide provider and subscriber assistance panel in subsection (12).

Subsection (2). Requires the panel to meet as often as necessary to timely review, consider, and hear grievances. The panel shall recommend to the agency or department any action to be taken, unless the grievance falls under certain exceptions. Amended or added exceptions provide that the panel may not hear a grievance that is related to a managed care entity's refusal to accept a provider into its network of providers; is a part of a Medicaid appeal that does not involve a quality of care issue; is the basis for an action pending in court; is related to an appeal by non-participating providers, unless the appeal is related to emergency services and care or quality of care; has not completed the entire formal grievance procedure of the health provider; has been resolved to the satisfaction of the party who filed the grievance; attempts to seek damages for pain and suffering, lost wages, or other incidental expenses; is limited to issues involving conduct which may be grounds for disciplinary action by a professional licensing board; or is withdrawn or a party fails to attend the hearing.

Subsection (3). Establishes time frames for reviewing and hearing grievances, and issuing recommendations. Requires the agency to determine within 60 days after receipt of a grievance, whether or not the panel shall hear it. Once the agency determines that the grievance will be heard, the panel shall hear the grievance within 120 days in the network area or by teleconference. This time period may be tolled in order when additional documentation is requested by the panel. Requires panel to recommend action to the provider, subscriber, and agency within 15 working days. The proceedings of the panel are not subject to the provisions of chapter 120, F.S.

Subsection (4). Requires a provider or managed care entity to furnish the agency with medical records, after patient authorization, for the purpose of panel grievance review. A fine of $2,500 a day may be imposed for failure to furnish the records.

Subsection (5). Requires grievances in cases where a subscribers health is in immediate and serious threat to be given priority. The panel must hear the grievance as quickly as possible within 45 days, unless the subscriber waives the time requirement. The panel shall then issue its recommendation to the agency or department within 10 days.

Subsection (6). Requires the panel to convene an emergency hearing within 24 hours when the life of a subscriber is in imminent and emergent jeopardy regardless of whether the formal grievance procedure of the provider organization is completed. The panel will then issue an emergency recommendation to the provider, subscriber, and the agency or department. The agency or department may then issue an emergency order to the managed care entity within 24 hours. The order shall remain is in effect until the grievance has been resolved by the provider organization, medical intervention is no longer necessary, or the panel has conducted a full hearing and the agency or department has issued a final order under subsection (3).

Subsection (7). Requires the panel, after concluding the hearing, to recommend to the agency or department actions the provider organization must take in order to comply with state laws or rules.

Subsection (8). Allows a managed care entity, subscriber, or provider that is affected by a panel recommendation to appeal that recommendation to the agency or department within 10 days after receipt of such recommendation involving a regular hearing, or within 72 hours after receipt of such recommendation involving an expedited hearing,

Subsection (9). Allows the agency or department to adopt the panel's recommendation within 30 days, or within 10 days of an expedited grievance, in a final order issued to the managed care entity. The final order may impose fines or sanctions including those within chapter 641, F.S. The agency or department may reject all or part of the panel's recommendation if it violates state or federal law, rules, or regulations; is inconsistent with previous agency or department interpretations of laws or rules regulating managed care entities; or is determined to be unsupported by the facts. All fines will be deposited in the Health Care Trust Fund.

Subsection (10). Provides the agency or department several factors to consider when determining fines or sanctions. These may include the severity of noncompliance; any actions taken by the respective provider organization to resolve any quality of care grievance; any previous incidences of noncompliance; or any other factors deemed appropriate by the agency or department.

Subsection (11). Technical changes.

Subsection (12). Requires the agency to notify all subscribers and providers, included in its quarterly report provided to the agency or department by managed care entities listing grievances that have not been resolved to the satisfaction of the subscriber or providers, of the right to file unresolved grievances with the panel.

Subsection (13). Amends the subsection number.

<u>Section 2.</u> Creates s. 408.7057, F.S. to require appeals of agency or department orders to be made to DOAH. Any portion of the order requiring the managed care entity to take specific actions is appealed through a summary hearing under chapter 120, F.S.. If the managed care entity fails to prevail in such an appeal, it must pay attorney's fees and court costs to the agency or department. The portion of the order relating to sanctions imposed by the agency or department is appealed though the normal Chapter 120 process.

<u>Section 3.</u> Amends s. 641.511, F.S., to require HMOs to submit a copy of their annual and quarterly grievance reports to the Department of Insurance pursuant to s. 408.7056(13), F.S.

<u>Section 4.</u> Provides an effective date of July 1, 1997.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring Effects:

   The Agency for Health Care Administration estimates total non-recurring costs of $25,912 from the Health Care Trust Fund for FY 1997-98.

2. Recurring Effects:

   The Agency for Health Care Administration indicates a need for 5 FTE and $221,484 from the Health Care Trust Fund for nine months funding to implement the bill.

3. Long Run Effects Other Than Normal Growth:

   None.

4. Total Revenues and Expenditures:

   Increased fines may result in increased revenues to the Health Care Trust Fund.

   Total expenditure requirements for FY 1997-98 are $247,396 from the Health Care Trust Fund.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1. Non-recurring Effects:

   None.

2. Recurring Effects:

   None.

3. Long Run Effects Other Than Normal Growth:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

   Indeterminate.