

1 A bill to be entitled
2 An act relating to the Statewide Provider and
3 Subscriber Assistance Program; amending s.
4 408.7056, F.S.; providing definitions; revising
5 criteria and procedures for review of
6 grievances against a managed care entity by the
7 statewide provider and subscriber assistance
8 panel; providing for initial review by the
9 Agency for Health Care Administration;
10 providing time requirements for panel hearings
11 and recommendations, and final orders of the
12 agency or the Department of Insurance;
13 providing for notice; providing requirements
14 for expedited or emergency hearings; providing
15 an exemption from the Administrative Procedures
16 Act; providing for requests for patient
17 records; authorizing an administrative fine for
18 failure to timely provide records; providing
19 for furnishing of evidence in opposition to
20 panel recommendations; providing for adoption
21 of panel recommendations in final orders of the
22 agency or department; authorizing imposition of
23 fines and sanctions; specifying conditions for
24 rejection of panel recommendations; requiring
25 certain notice to subscribers and providers of
26 their right to file grievances; creating s.
27 408.7057, F.S.; providing for appeals;
28 providing for attorney's fees and costs;
29 amending s. 641.511, F.S.; correcting a cross
30 reference; providing an appropriation;
31 providing an effective date.

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

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3 Section 1. Section 408.7056, Florida Statutes, is
4 amended to read:

5 408.7056 Statewide Provider and Subscriber Assistance
6 Program.--

7 (1) As used in this section, the term:

8 (a) "Managed care entity" means an accountable health
9 partnership certified under s. 408.706, a health maintenance
10 organization certified under chapter 641, a prepaid health
11 clinic, a prepaid health plan authorized pursuant to s.
12 409.912, or an exclusive provider organization certified under
13 s. 627.6472.

14 (b) "Panel" means a statewide provider and subscriber
15 assistance panel selected as provided in subsection (1).

16 (2)(1) The agency for Health Care Administration shall
17 adopt and implement a program to provide assistance to
18 subscribers and providers, including those whose grievances
19 are not resolved by the managed care entity ~~accountable health~~
20 partnership, health maintenance organization, prepaid health
21 clinic, prepaid health plan authorized pursuant to s. 409.912,
22 or exclusive provider organization to the satisfaction of the
23 subscriber or provider. The program shall consist of a panel
24 which shall meet as often as necessary to timely review,
25 consider, and hear grievances and recommend to the agency or
26 the department any actions that should be taken concerning
27 individual cases heard by the panel.The panel shall hear
28 every grievance filed by subscribers and providers on behalf
29 of subscribers, unless the grievance ~~not consider grievances~~
30 which:

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1 (a) Relates to a managed care entity's ~~Relate to an~~
2 ~~accountable health partnership's, health maintenance~~
3 ~~organization's, prepaid health clinic's, prepaid health~~
4 ~~plan's, or exclusive provider organization's~~ refusal to accept
5 a provider into its network of providers;

6 (b) Is ~~Are a~~ part of a reconsideration appeal through
7 the Medicare appeals process that does not involve a quality
8 of care issue;

9 (c) Is ~~Are~~ related to a health plan not regulated by
10 the state such as an administrative services organization,
11 third-party administrator, or federal employee health benefit
12 program;

13 (d) Is ~~Are~~ related to appeals by in-plan suppliers and
14 providers, unless related to quality of care provided by the
15 plan; ~~or~~

16 (e) Is ~~Are~~ part of a Medicaid fair hearing pursued
17 pursuant to 42 C.F.R. ss. 431.220 et seq.

18 (f) Is the basis for an action pending in state or
19 federal court;

20 (g) Is related to an appeal by nonparticipating
21 providers, unless related to the quality of care provided to a
22 subscriber by the managed care entity and the provider is
23 involved in the care provided to the subscriber;

24 (h) Has been filed before the subscriber or provider
25 has completed the entire internal grievance procedure of the
26 managed care entity; provided the managed care entity has
27 complied with its timeframes for completing the internal
28 grievance procedure and the circumstances described in
29 subsection (6) do not apply;

30 (i) Has been resolved to the satisfaction of the
31 subscriber or provider who filed the grievance, unless the

1 managed care entity's initial action is egregious or may be
2 indicative of a pattern of inappropriate behavior;

3 (j) Is limited to seeking damages for pain and
4 suffering, lost wages, or other incidental expenses;

5 (k) Is limited to issues involving conduct of a health
6 care provider or facility, staff member, or employee of a
7 managed care entity which constitutes grounds for disciplinary
8 action by the appropriate professional licensing board and is
9 not indicative of a pattern of inappropriate behavior, and the
10 agency or department has reported these grievances to the
11 appropriate professional licensing board or to the health
12 facility regulation section of the agency for possible
13 investigation; or

14 (l) Is withdrawn by the subscriber or provider.
15 Failure of the subscriber or the provider to attend the
16 hearing shall be considered a withdrawal of the grievance.

17 (3) The agency shall review all grievances within 60
18 days after receipt and make a determination whether the
19 grievance shall be heard. Once the agency notifies the panel,
20 the subscriber or provider, and the managed care entity that a
21 grievance will be heard by the panel, the panel shall hear the
22 grievance either in the network area or by teleconference no
23 later than 120 days after the date the grievance was filed.
24 The panel shall issue a recommendation to the provider or
25 subscriber, to the managed care entity, and to the agency or
26 the department no later than 15 working days after hearing the
27 grievance. If at the hearing the panel requests additional
28 documentation or additional records, the time for issuing a
29 recommendation shall be tolled until the information or
30 documentation requested has been provided to the panel. The

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1 proceedings of the panel shall not be subject to the
2 provisions of chapter 120.

3 (4) If, upon receiving a proper patient authorization
4 along with a properly filed grievance, the agency requests
5 medical records from a health care provider or managed care
6 entity, the health care provider or managed care entity in
7 custody of such records shall have 10 days to provide the
8 records to the agency. Failure to provide requested medical
9 records may result in the imposition of a fine of up to \$500.
10 Each day that records are not produced shall be considered a
11 separate violation.

12 (5) Grievances that the agency determines pose an
13 immediate and serious threat to a subscriber's health shall be
14 given priority over other grievances. The panel may meet at
15 the call of the chair to hear such grievances as quickly as
16 possible but no later than 45 days after the date the
17 grievance is filed, unless the panel receives a waiver of the
18 time requirement from the subscriber. The panel shall issue a
19 recommendation to the department or the agency within 10 days
20 after hearing the expedited grievance.

21 (6) Where the agency determines that the life of a
22 subscriber is in imminent and emergent jeopardy, the chair of
23 the panel may convene an emergency hearing, within 24 hours
24 after notification to the managed care entity and to the
25 subscriber, to hear the grievance. The grievance shall be
26 heard notwithstanding that the subscriber has not completed
27 the internal grievance procedure of the managed care entity.
28 The panel shall, upon hearing the grievance, issue an
29 emergency recommendation to the managed care entity, to the
30 subscriber, and to the agency or the department for the
31 purpose of deferring the imminent and emergent jeopardy to the

1 subscriber's life. Within 24 hours after receipt of the
2 panel's emergency recommendation, the agency or department may
3 issue an emergency order to the managed care entity. The
4 emergency order shall remain in force and effect until such
5 time as:

6 (a) The grievance has been resolved by the managed
7 care entity;

8 (b) Medical intervention is no longer necessary; or

9 (c) The panel has conducted a full hearing under
10 subsection (3) and issued a recommendation to the agency or
11 the department, and the agency or department has issued a
12 final order.

13 (7) After hearing a grievance, the panel shall make a
14 recommendation to the agency or the department which may
15 include specific actions the managed care entity must take to
16 comply with state laws or rules regulating managed care
17 entities.

18 (8) A managed care entity, subscriber, or provider
19 that is affected by a panel recommendation may within 10 days
20 after receipt of the panel's recommendation, or 72 hours after
21 receipt of a recommendation in an expedited grievance, furnish
22 to the agency or department written evidence in opposition to
23 the recommendation of the panel.

24 (9) No later than 30 days after the issuance of the
25 panel's recommendation and, for an expedited grievance, no
26 later than 10 days after the issuance of the panel's
27 recommendation, the agency or the department may adopt the
28 panel's recommendation in an order which it shall issue to the
29 managed care entity. The agency's or department's order may
30 impose fines or sanctions, including those contained in ss.
31 641.25 and 641.52. The agency or the department may reject

1 all or part of the panel's recommendation if the
2 recommendation:

3 (a) Violates state or federal law, rules, or
4 regulations;

5 (b) Is inconsistent with previous agency or department
6 interpretations of state laws or rules regulating managed care
7 entities; or

8 (c) Is determined by the agency or department to be
9 unsupported by the facts.

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11 All fines collected pursuant to this subsection shall be
12 deposited into the Health Care Trust Fund.

13 (10) In determining any fine or sanction to be
14 imposed, the agency and the department may consider the
15 following factors:

16 (a) The severity of the noncompliance, including the
17 probability that death or serious harm to the health or safety
18 of the subscriber will result or has resulted, the severity of
19 the actual or potential harm, and the extent to which
20 provisions of chapter 641 were violated.

21 (b) Actions taken by the managed care entity to
22 resolve or remedy any quality of care grievance.

23 (c) Any previous incidents of noncompliance by the
24 managed care entity.

25 (d) Any other relevant factors the agency or
26 department deems appropriate in a particular grievance.

27 ~~(2) The program shall include the following:~~

28 ~~(a) A review panel which may periodically review,~~
29 ~~consider, and recommend to the agency any actions the agency~~
30 ~~or the Department of Insurance should take concerning~~
31 ~~individual cases heard by the panel, as well as the types of~~

1 ~~grievances which have not been satisfactorily resolved after~~
2 ~~subscribers or providers have followed the full grievance~~
3 ~~procedures of the accountable health partnership, health~~
4 ~~maintenance organization, prepaid health clinic, prepaid~~
5 ~~health plan, or exclusive provider organization. The~~
6 ~~proceedings of the grievance panel shall not be subject to the~~
7 ~~provisions of chapter 120.~~

8 (11) The review panel shall consist of members
9 employed by the agency and members employed by the department
10 ~~of Insurance~~, chosen by their respective agencies. The agency
11 may contract with a medical director and a primary care
12 physician who shall provide additional technical expertise to
13 the review panel. The medical director shall be selected from
14 a health maintenance organization with a current certificate
15 of authority to operate in Florida.

16 (b) ~~A plan to disseminate information concerning the~~
17 ~~program to the general public as widely as possible.~~

18 (12)(3) Every managed care entity ~~accountable health~~
19 ~~partnership, health maintenance organization, prepaid health~~
20 ~~clinic, prepaid health plan authorized pursuant to s. 409.912,~~
21 ~~or exclusive provider organization~~ shall submit a quarterly
22 report to the agency and the department ~~of Insurance~~ listing
23 the number and the nature of all subscribers' and providers'
24 grievances which have not been resolved to the satisfaction of
25 the subscriber or provider after the subscriber or provider
26 follows the entire internal full grievance procedure of the
27 managed care entity organization. The agency shall notify all
28 subscribers and providers included in the quarterly reports of
29 their right to file an unresolved grievance with the panel.

30 (4)(a) ~~The Agency for Health Care Administration may~~
31 ~~impose an administrative fine, after a formal investigation~~

1 ~~has been conducted on the accountable health partnership's,~~
2 ~~health maintenance organization's, prepaid health clinic's,~~
3 ~~prepaid health plan's, or exclusive provider organization's~~
4 ~~failure to comply with quality of health services standards~~
5 ~~set forth in statute or rule. The Agency for Health Care~~
6 ~~Administration may initiate such an investigation based on the~~
7 ~~recommendations related to the quality of health services~~
8 ~~received from the Statewide Provider and Subscriber Assistance~~
9 ~~Panel pursuant to paragraph (2)(a). The fine shall not exceed~~
10 ~~\$2,500 per violation and in no event shall such fine exceed an~~
11 ~~aggregate amount of \$10,000 for noncompliance arising out of~~
12 ~~the same action.~~

13 ~~(b) In determining the amount to be levied for~~
14 ~~noncompliance under paragraph (a), the following factors shall~~
15 ~~be considered:~~

16 ~~1. The severity of the noncompliance, including the~~
17 ~~probability that death or serious harm to the health or safety~~
18 ~~of the subscriber will result or has resulted, the severity of~~
19 ~~actual or potential harm and the extent to which provisions of~~
20 ~~this part were violated.~~

21 ~~2. Actions taken by the accountable health~~
22 ~~partnership, health maintenance organization, prepaid health~~
23 ~~clinic, prepaid health plan, or exclusive provider~~
24 ~~organization to resolve or remedy any quality of care~~
25 ~~grievance.~~

26 ~~3. Any previous incidences of noncompliance by the~~
27 ~~accountable health partnership, health maintenance~~
28 ~~organization, prepaid health clinic, prepaid health plan, or~~
29 ~~exclusive provider organization.~~

30 ~~(c) All amounts collected pursuant to this subsection~~
31 ~~shall be deposited into the Health Care Trust Fund.~~

1 ~~(13)(5)~~ Any information which would identify a
2 subscriber or the spouse, relative, or guardian of a
3 subscriber and which is contained in a report obtained by the
4 Department of Insurance pursuant to this section is
5 confidential and exempt from the provisions of s. 119.07(1)
6 and s. 24(a), Art. I of the State Constitution.

7 Section 2. Section 408.7057, Florida Statutes, is
8 created to read:

9 408.7057 Hearings appealing orders of the department
10 or agency based on recommendations of statewide provider and
11 subscriber assistance panel.--

12 (1) Orders issued by the agency or department which
13 require the managed care entity to take specific actions as
14 authorized by s. 408.7056(7) shall be subject to summary
15 hearings in accordance with s. 120.574, except as provided for
16 in subsection (2).

17 (2) If the order of the agency or department imposes
18 finances or sanctions, the findings shall be bifurcated and only
19 that portion of the order which relates to the requirement
20 that the managed care entity take specific actions as
21 specified in s. 408.7056(7) shall be subject to a summary
22 hearing pursuant to s. 120.574. All parties shall agree to
23 such summary proceedings. The remainder of the order shall be
24 subject to administrative review otherwise provided for in
25 chapter 120.

26 (3) If a hearing is held in accordance with subsection
27 (1) and the managed care entity does not prevail at the
28 hearing, the managed care entity shall pay reasonable costs
29 and attorney's fees incurred in that proceeding by the agency
30 or department.

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1 (4) All other orders of the department or agency based
2 on recommendations of the statewide provider and subscriber
3 assistance panel shall not be subject to a summary hearing or
4 payment of costs and attorney's fees as specified in
5 subsection (3), but shall be subject to administrative review
6 as otherwise provided for in chapter 120.

7 Section 3. Subsection (7) of section 641.511, Florida
8 Statutes, is amended to read:

9 641.511 Subscriber grievance reporting and resolution
10 requirements.--

11 (7) Each organization shall send to the agency a copy
12 of its annual and quarterly grievance reports submitted to the
13 Department of Insurance pursuant to s. 408.7056~~(12)~~~~(2)~~.

14 Section 4. There is hereby appropriated to the Agency
15 for Health Care Administration for fiscal year 1998-1999, 5
16 full-time equivalent positions and \$247,396 from the Health
17 Care Trust Fund for 9 months' funding for the purpose of
18 implementing this act. Of this amount, \$25,912 is
19 nonrecurring.

20 Section 5. This act shall take effect July 1 of the
21 year in which enacted.