

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; requiring certain notice
24 to subscribers and providers of their right to
25 file grievances; providing for summary
26 hearings; providing for administrative
27 procedures; providing for attorney's fees and
28 costs; amending s. 641.511, F.S.; eliminating
29 annual grievance report filing; correcting a
30 cross-reference; providing an appropriation;
31 providing an effective date.

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

2

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 a health maintenance
9 organization or a prepaid health clinic certified under
10 chapter 641, a prepaid health plan authorized under s.
11 409.912, or an exclusive provider organization certified under
12 s. 627.6472.

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

15 (2)(1) The agency for Health Care Administration shall
16 adopt and implement a program to provide assistance to
17 subscribers and providers, including those whose grievances
18 are not resolved by the ~~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~~ to the satisfaction of the
22 subscriber or provider. The program shall consist of one or
23 more panels that meet as often as necessary to timely review,
24 consider, and hear grievances and recommend to the agency or
25 the department any actions that should be taken concerning
26 individual cases heard by the panel. The panel shall hear
27 every grievance filed by subscribers and providers on behalf
28 of subscribers, unless the grievance ~~not consider grievances~~
29 which:

30 (a) Relates to a managed care entity's ~~Relate to an~~
31 accountable health partnership's, health maintenance

1 ~~organization's, prepaid health clinic's, prepaid health~~
2 ~~plan's, or exclusive provider organization's~~ refusal to accept
3 a provider into its network of providers;

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

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

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

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

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

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

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

28 (i) Has been resolved to the satisfaction of the
29 subscriber or provider who filed the grievance, unless the
30 managed care entity's initial action is egregious or may be
31 indicative of a pattern of inappropriate behavior;

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

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

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

15 (3) The agency shall review all grievances within 60
16 days after receipt and make a determination whether the
17 grievance shall be heard. Once the agency notifies the panel,
18 the subscriber or provider, and the managed care entity that a
19 grievance will be heard by the panel, the panel shall hear the
20 grievance either in the network area or by teleconference no
21 later than 120 days after the date the grievance was filed.
22 The agency shall notify the parties, in writing, by facsimile
23 transmission, or by phone, of the time and place of the
24 hearing. The panel may take testimony under oath, request
25 certified copies of documents, and take similar actions to
26 collect information and documentation that will assist the
27 panel in making findings of fact and a recommendation. The
28 panel shall issue a written recommendation, supported by
29 findings of fact, to the provider or subscriber, to the
30 managed care entity, and to the agency or the department no
31 later than 15 working days after hearing the grievance. If at

1 the hearing the panel requests additional documentation or
2 additional records, the time for issuing a recommendation is
3 tolled until the information or documentation requested has
4 been provided to the panel. The proceedings of the panel are
5 not subject to chapter 120.

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

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

25 (6) When the agency determines that the life of a
26 subscriber is in imminent and emergent jeopardy, the chair of
27 the panel may convene an emergency hearing, within 24 hours
28 after notification to the managed care entity and to the
29 subscriber, to hear the grievance. The grievance must be
30 heard notwithstanding that the subscriber has not completed
31 the internal grievance procedure of the managed care entity.

1 The panel shall, upon hearing the grievance, issue a written
2 emergency recommendation, supported by findings of fact, to
3 the managed care entity, to the subscriber, and to the agency
4 or the department for the purpose of deferring the imminent
5 and emergent jeopardy to the subscriber's life. Within 24
6 hours after receipt of the panel's emergency recommendation,
7 the agency or department may issue an emergency order to the
8 managed care entity. An emergency order remains in force
9 until:

10 (a) The grievance has been resolved by the managed
11 care entity;

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

13 (c) The panel has conducted a full hearing under
14 subsection (3) and issued a recommendation to the agency or
15 the department, and the agency or department has issued a
16 final order.

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

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

28 (9) No later than 30 days after the issuance of the
29 panel's recommendation and, for an expedited grievance, no
30 later than 10 days after the issuance of the panel's
31 recommendation, the agency or the department may adopt the

1 panel's recommendation or findings of fact in a proposed order
2 or an emergency order, as provided in chapter 120, which it
3 shall issue to the managed care entity. The agency or
4 department may issue a proposed order or an emergency order,
5 as provided in chapter 120, imposing fines or sanctions,
6 including those contained in ss. 641.25 and 641.52. The
7 agency or the department may reject all or part of the panel's
8 recommendation. All fines collected under this subsection must
9 be deposited into the Health Care Trust Fund.

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

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

18 (b) Actions taken by the managed care entity to
19 resolve or remedy any quality-of-care grievance.

20 (c) Any previous incidents of noncompliance by the
21 managed care entity.

22 (d) Any other relevant factors the agency or
23 department considers appropriate in a particular grievance.

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

25 ~~(a) A review panel which may periodically review,~~
26 ~~consider, and recommend to the agency any actions the agency~~
27 ~~or the Department of Insurance should take concerning~~
28 ~~individual cases heard by the panel, as well as the types of~~
29 ~~grievances which have not been satisfactorily resolved after~~
30 ~~subscribers or providers have followed the full grievance~~
31 ~~procedures of the accountable health partnership, health~~

1 ~~maintenance organization, prepaid health clinic, prepaid~~
2 ~~health plan, or exclusive provider organization. The~~
3 ~~proceedings of the grievance panel shall not be subject to the~~
4 ~~provisions of chapter 120.~~

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

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

15 (12)(3) Every managed care entity ~~accountable health~~
16 ~~partnership, health maintenance organization, prepaid health~~
17 ~~clinic, prepaid health plan authorized pursuant to s. 409.912,~~
18 ~~or exclusive provider organization~~ shall submit a quarterly
19 report to the agency and the department ~~of Insurance~~ listing
20 the number and the nature of all subscribers' and providers'
21 grievances which have not been resolved to the satisfaction of
22 the subscriber or provider after the subscriber or provider
23 follows the entire internal full grievance procedure of the
24 managed care entity organization. The agency shall notify all
25 subscribers and providers included in the quarterly reports of
26 their right to file an unresolved grievance with the panel.

27 ~~(4)(a) The Agency for Health Care Administration may~~
28 ~~impose an administrative fine, after a formal investigation~~
29 ~~has been conducted on the accountable health partnership's,~~
30 ~~health maintenance organization's, prepaid health clinic's,~~
31 ~~prepaid health plan's, or exclusive provider organization's~~

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

10 ~~(b) In determining the amount to be levied for~~
11 ~~noncompliance under paragraph (a), the following factors shall~~
12 ~~be considered:~~

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

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

23 ~~3. Any previous incidences of noncompliance by the~~
24 ~~accountable health partnership, health maintenance~~
25 ~~organization, prepaid health clinic, prepaid health plan, or~~
26 ~~exclusive provider organization.~~

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

29 ~~(13)(5)~~ Any information which would identify a
30 subscriber or the spouse, relative, or guardian of a
31 subscriber and which is contained in a report obtained by the

1 Department of Insurance pursuant to this section is
2 confidential and exempt from the provisions of s. 119.07(1)
3 and s. 24(a), Art. I of the State Constitution.

4 (14) A proposed order issued by the agency or
5 department which only requires the managed care entity to take
6 a specific action under subsection (7), is subject to a
7 summary hearing in accordance with s. 120.574, unless all of
8 the parties agree otherwise. If the managed care entity does
9 not prevail at the hearing, the managed care entity must pay
10 reasonable costs and attorney's fees of the agency or the
11 department incurred in that proceeding.

12 Section 2. Subsection (7) of section 641.511, Florida
13 Statutes, is amended to read:

14 641.511 Subscriber grievance reporting and resolution
15 requirements.--

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

19 Section 3. There is appropriated to the Agency for
20 Health Care Administration for fiscal year 1998-1999 a total
21 of 6 full-time-equivalent positions and \$308,830 from the
22 Health Care Trust Fund for 9 months' funding for the purpose
23 of implementing this act.

24 Section 4. This act shall take effect December 1,
25 1998.