By Senator Brown-Waite

10-174-98

A bill to be entitled

An act relating to the Statewide Provider and Subscriber Assistance Program; amending s. 408.7056, F.S.; providing definitions; revising criteria and procedures for review of grievances against a managed care entity by the statewide provider and subscriber assistance panel; providing for initial review by the Agency for Health Care Administration; providing time requirements for panel hearings and recommendations, and final orders of the agency or the Department of Insurance; providing for notice; providing requirements for expedited or emergency hearings; providing an exemption from the Administrative Procedures Act; providing for requests for patient records; authorizing an administrative fine for failure to timely provide records; providing for furnishing of evidence in opposition to panel recommendations; providing for adoption of panel recommendations in final orders of the agency or department; authorizing imposition of fines and sanctions; specifying conditions for rejection of panel recommendations; requiring certain notice to subscribers and providers of their right to file grievances; creating s. 408.7057, F.S.; providing for appeals; providing for attorney's fees and costs; amending s. 641.511, F.S.; correcting a cross-reference; providing an appropriation; providing an effective date.

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

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

408.7056 Statewide Provider and Subscriber Assistance Program.--

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

(a) "Managed care entity" means an accountable health partnership certified under s. 408.706, a health maintenance organization certified under chapter 641, a prepaid health clinic, a prepaid health plan authorized under s. 409.912, or an exclusive provider organization certified under s. 627.6472.

(b) "Panel" means a statewide provider and subscriber assistance panel selected as provided in subsection (11).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

proceedings of the panel are not subject to the provisions of chapter 120.

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

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

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

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

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

(b) Medical intervention is no longer necessary; or

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

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

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

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

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

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

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

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

All fines collected under this subsection shall be deposited into the Health Care Trust Fund.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) If the order of the agency or department imposes fines or sanctions, the findings must be bifurcated and only that portion of the order which relates to the requirement that the managed care entity take specific actions as specified in s. 408.7056(7) is subject to a summary hearing under s. 120.574. All parties must agree to the summary proceedings. The remainder of the order is subject to administrative review otherwise provided for in chapter 120.

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

(4) All other orders of the department or agency based on recommendations of the statewide provider and subscriber

assistance panel are not subject to a summary hearing or payment of costs and attorney's fees as specified in subsection (3), but are subject to administrative review as otherwise provided for in chapter 120.

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

641.511 Subscriber grievance reporting and resolution requirements.--

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

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

Section 5. This act shall take effect July 1, 1998.

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LEGISLATIVE SUMMARY

Revises criteria and procedures for review of grievances against managed care entities under the Statewide Provider and Subscriber Assistance Program. Provides for review of grievances by the Agency for Health Care Administration prior to referral to the statewide subscriber and provider assistance panel. Expands the list of circumstances under which a grievance will not be heard. Specifies time requirements for panel hearings and recommendations, and for final orders by the agency or the Department of Insurance, including requirements for expedited or emergency procedures. Provides certain notification requirements. Exempts grievance proceedings and final orders from the provisions of ch. 120, F.S., the Administrative Procedures Act. Authorizes the agency to obtain patient medical records for grievance review, and to impose a fine of up to $500 per day of violation against an entity that fails to timely provide the records. Provides for furnishing of evidence in opposition to panel recommendations. Provides for adoption of panel recommendations in final orders of the agency or department. Authorizes impositions of fines and sanctions. Provides conditions for rejection of panel recommendations. Requires the agency and department to notify certain subscribers and providers of their right to file a grievance. Provides for appeals and for attorney's fees and costs. Provides an appropriation to implement the act for 9 months.