By Representative Logan

A bill to be entitled

An act relating to health maintenance organizations; amending s. 641.315, F.S.; prohibiting provider contracts from restricting a provider's ability to communicate certain information to subscribers; amending s. 641.495, F.S.; requiring designation of a state-licensed physician or osteopath as medical director; amending s. 641.51, F.S.; requiring out-of-network referrals to specialists, under certain circumstances; requiring written procedures for standing referrals for individuals who require ongoing specialty care for chronic and disabling conditions; requiring certain continued access to terminated treating providers for subscribers with a life-threatening or a disabling and degenerative condition, and for certain pregnant subscribers; providing limitations; requiring report to the Agency for Health Care Administration of access, quality of care, and customer satisfaction data; requiring adoption of certain recommendations for preventive pediatric health care; amending s. 641.511, F.S.; requiring an expedited grievance procedure for reviewing the denial of urgently needed health care services; providing a time limit; amending s. 641.54, F.S.; requiring disclosure to subscribers, upon request, of certain policies, procedures, and processes relating to authorization and

referral for services, determination of medical necessity, quality of care, prescription drug benefits, confidentiality of medical records, approval or denial of experimental or investigational treatments, addressing the needs of non-English-speaking subscribers, and examining qualifications of and the credentialing of providers; requiring report to the agency of changes in authorization and referral criteria or the process used to determine medical necessity; providing an effective date.

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

Section 1. Subsection (8) is added to section 641.315, Florida Statutes, 1996 Supplement, to read:

641.315 Provider contracts.--

(8) A contract between a health maintenance organization and a provider of health care services shall not contain any provision restricting the provider's ability to communicate information to the provider's patient regarding medical care or treatment options for the patient when the provider deems knowledge of such information by the patient to be in the best interest of the health of the patient.

Section 2. Subsection (11) is added to section 641.495, Florida Statutes, 1996 Supplement, to read:

641.495 Requirements for issuance and maintenance of certificate.--

(11) The organization shall designate a medical director who is a physician licensed under chapter 458 or chapter 459.

Section 3. Subsections (5), (6), (7), (8), (9), and (10) are added to section 641.51, Florida Statutes, to read:

641.51 Quality assurance program; second medical opinion requirement.--

(5) Each organization shall provide the subscriber with an out-of-network referral when the organization has not contracted with or employed an appropriately trained and experienced specialist to provide medically necessary health care services appropriate to a subscriber's special medical needs.

(6) Each organization shall develop and maintain written policies and procedures for the provision of standing referrals to subscribers with chronic and disabling conditions which require ongoing specialty care.

(7) Each organization shall allow subscribers to continue care for 60 days with a terminated treating provider when medically necessary, provided the subscriber has a life-threatening condition or a disabling and degenerative condition. Each organization shall allow a subscriber who is in the third trimester of pregnancy to continue care with a terminated treating provider until completion of postpartum care. This subsection shall not apply to treating providers who have been terminated by the organization for cause.

(8) Each organization shall release to the agency data which are indicators of access and quality of care. The agency shall develop rules specifying data-reporting requirements for these indicators. The agency shall develop a uniform format for publication of the data to the public. The

agency shall publish such data no less frequently than every 2 years.

(9) Each organization shall conduct a standardized customer satisfaction survey, as developed by the agency in consultation with the industry, of its membership, at intervals specified by the agency. Survey data shall be submitted to the agency which shall make comparative findings available to the public.

(10) Each organization shall adopt recommendations for preventive pediatric health care, as developed by the American Academy of Pediatrics, and set goals to achieve 90-percent compliance for the enrolled pediatric population.

Section 4. Subsection (6) is added to section 641.511, Florida Statutes, to read:

641.511 Subscriber grievance reporting and resolution requirements.--

(6) Each organization shall maintain an expedited grievance procedure for reviewing denials of urgently needed health care services. A procedure for establishing methods for classifying grievances as urgent or emergency grievances shall be developed which shall include time limits within which such grievances must be resolved. However, in no instance shall an emergency grievance procedure take longer than 7 days for resolution.

Section 5. Subsections (3), (4), and (5) are added to section 641.54, Florida Statutes, to read:

641.54 ~~Hospital and physician~~ Information disclosure.--

(3) The organization shall make available to subscribers, upon request, a detailed description of the process used to determine authorization and referral criteria

for health care services. Any change in the organization's authorization and referral criteria shall be reported to the agency immediately.

(4) The organization shall make available to subscribers, upon request, a detailed description of the process used to determine whether health care services are "medically necessary." Any change in the organization's definition of "medically necessary" or the process used to determine medical necessity shall be reported to the agency immediately.

(5) Each organization shall provide to subscribers, upon request, the following:

(a) A description of the organization's quality assurance program.

(b) Policies and procedures relating to the organization's prescription drug benefits, including the disclosure, upon request of a subscriber or potential subscriber, of any included and excluded drugs and the use of any formulary.

(c) Policies and procedures relating to the confidentiality and disclosure of the subscriber's medical records.

(d) The decisionmaking process used for approving or denying experimental or investigational medical treatments.

(e) Policies and procedures for addressing the needs of non-English-speaking subscribers.

(f) A detailed description of the process used to examine qualifications of and the credentialing of all providers under contract with or employed by the organization.

Section 6. This act shall take effect July 1, 1997.

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HOUSE SUMMARY

Prohibits health maintenance organization (HMO) provider contracts from restricting a provider's ability to communicate certain information to subscribers. Requires HMO medical directors to be Florida-licensed physicians or osteopaths. Requires out-of-network referrals to specialists not available within the HMO's network. Requires written procedures for standing referrals to specialists for individuals with chronic and disabling conditions. Requires certain continued access to terminated treating providers for subscribers with a life-threatening or a disabling and degenerative condition, and certain pregnant subscribers. Requires HMOs to report access, quality of care, and customer satisfaction data to the Agency for Health Care Administration. Requires adoption of recommendations of th American Academy of Pediatrics for preventive pediatric health care. Requires an expedited grievance procedure for resolution within 7 days or less of grievances involving the denial of urgently needed services. Requires HMOs to disclose to subscribers, upon request, certain policies, procedures, and processes relating to authorization and referral for services, determination of medical necessity, quality of care, prescription drug benefits, confidentiality of medical records, approval or denial of experimental or investigational medical treatments, addressing the needs of non-English-speaking subscribers, and examining qualifications of and the credentialing of providers.