

1
2 An act relating to managed health care
3 entities; amending s. 636.003, F.S.; providing
4 an exemption from the definition of "prepaid
5 limited health service organization"; amending
6 s. 641.315, F.S.; prohibiting provider
7 contracts from restricting a provider's ability
8 to communicate certain information to
9 subscribers; creating s. 641.316, F.S.;
10 providing for regulation of fiscal intermediary
11 services organizations; providing requirements
12 and restrictions; requiring a bond; requiring
13 registration with the Department of Insurance;
14 providing exemptions; providing for rules;
15 creating the Florida Commission on Integrated
16 Health Care Delivery Systems; providing
17 membership and duties; requiring
18 recommendations to the Legislature; providing
19 for future repeal; amending s. 641.47, F.S.;
20 providing definitions; amending s. 641.495,
21 F.S.; requiring designation of a licensed
22 physician as medical director; amending s.
23 641.51, F.S.; requiring development of policies
24 relating to out-of-network referrals; requiring
25 written procedures for standing referrals for
26 individuals who require ongoing specialty care
27 for chronic and disabling conditions; requiring
28 certain continued access to terminated treating
29 providers for subscribers with a
30 life-threatening or a disabling and
31 degenerative condition, and for certain

1 pregnant subscribers; providing limitations;
2 requiring report to the Agency for Health Care
3 Administration of access, quality of care, and
4 customer satisfaction data; requiring
5 publication of data; requiring adoption of
6 certain recommendations and goals for
7 preventive pediatric health care; amending s.
8 641.511, F.S.; specifying procedures,
9 requirements, and timeframes for addressing
10 subscriber grievances; requiring certain notice
11 to subscribers; providing for review of adverse
12 determinations; providing for certain referral
13 to the Statewide Provider and Subscriber
14 Assistance Program; providing for expedited
15 review of urgent grievances; authorizing
16 administrative sanctions for noncompliance with
17 grievance procedure requirements; amending s.
18 641.54, F.S.; requiring disclosure to
19 subscribers, upon request, of certain policies,
20 procedures, and processes relating to
21 authorization and referral for services,
22 determination of medical necessity, quality of
23 care, prescription drug benefits,
24 confidentiality of medical records, approval or
25 denial of experimental or investigational
26 treatments, addressing the needs of
27 non-English-speaking subscribers, and examining
28 qualifications of and the credentialing of
29 providers; requiring report to the agency of
30 changes in authorization and referral criteria
31

1 or the process used to determine medical
2 necessity; providing effective dates.

3
4 Be It Enacted by the Legislature of the State of Florida:

5
6 Section 1. Paragraph (c) is added to subsection (9) of
7 section 636.003, Florida Statutes, to read:

8 636.003 Definitions.--As used in this act, the term:

9 (9) "Prepaid limited health service organization"
10 means any person, corporation, partnership, or any other
11 entity which, in return for a prepayment, undertakes to
12 provide or arrange for, or provide access to, the provision of
13 a limited health service to enrollees through an exclusive
14 panel of providers. Prepaid limited health service
15 organization does not include:

16 (a) An entity otherwise authorized pursuant to the
17 laws of this state to indemnify for any limited health
18 service; ~~or~~

19 (b) A provider or entity when providing limited health
20 services pursuant to a contract with a prepaid limited health
21 service organization, a health maintenance organization, a
22 health insurer, or a self-insurance plan; or-

23 (c) Any person who, in exchange for fees, dues,
24 charges or other consideration, provides access to a limited
25 health service provider without assuming any responsibility
26 for payment for the limited health service or any portion
27 thereof.

28 Section 2. Subsection (8) is added to section 641.315,
29 Florida Statutes, 1996 Supplement, to read:

30 641.315 Provider contracts.--

31

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

8 Section 3. Section 641.316, Florida Statutes, is
9 created to read:

10 641.316 Fiscal intermediary services.--

11 (1) It is the intent of the Legislature, through the
12 adoption of this section, to ensure the financial soundness of
13 fiscal intermediary services organizations established to
14 develop, manage, and administer the business affairs of health
15 care professional providers such as medical doctors, doctors
16 of osteopathy, doctors of chiropractic, doctors of podiatric
17 medicine, doctors of dentistry, or other health professionals
18 regulated by the Department of Health.

19 (2)(a) The term "fiduciary" or "fiscal intermediary
20 services" means reimbursements received or collected on behalf
21 of health care professionals for services rendered, patient
22 and provider accounting, financial reporting and auditing,
23 receipts and collections management, compensation and
24 reimbursement disbursement services, or other related
25 fiduciary services pursuant to health care professional
26 contracts with health maintenance organizations.

27 (b) The term "fiscal intermediary services
28 organization" means a person or entity which performs
29 fiduciary or fiscal intermediary services to health care
30 professionals who contract with health maintenance
31 organizations other than a fiscal intermediary services

1 organization owned, operated, or controlled by a hospital
2 licensed under chapter 395, an insurer licensed under chapter
3 624, a third-party administrator licensed under chapter 626, a
4 prepaid limited health organization licensed under chapter
5 636, a health maintenance organization licensed under chapter
6 641, or physician group practices as defined in s.
7 455.236(3)(f).

8 (3) A fiscal intermediary services organization which
9 is operated for the purpose of acquiring and administering
10 provider contracts with managed care plans for professional
11 health care services, including, but not limited to, medical,
12 surgical, chiropractic, dental, and podiatric care, and which
13 performs fiduciary or fiscal intermediary services shall be
14 required to secure and maintain a fidelity bond in the minimum
15 amount of \$10 million. This requirement shall apply to all
16 persons or entities engaged in the business of providing
17 fiduciary or fiscal intermediary services to any contracted
18 provider or provider panel. The fidelity bond shall provide
19 coverage against misappropriation of funds by the fiscal
20 intermediary or its officers, agents, or employees; must be
21 posted with the department for the benefit of managed care
22 plans, subscribers, and providers; and must be on a form
23 approved by the department. The fidelity bond must be
24 maintained and remain unimpaired as long as the fiscal
25 intermediary services organization continues in business in
26 this state and until the termination of its registration.

27 (4) A fiscal intermediary services organization may
28 not collect from the subscriber any payment other than the
29 copayment or deductible specified in the subscriber agreement.

30 (5) Any fiscal intermediary services organization,
31 other than a fiscal intermediary services organization owned,

1 operated, or controlled by a hospital licensed under chapter
2 395, an insurer licensed under chapter 624, a third-party
3 administrator licensed under chapter 626, a prepaid limited
4 health organization licensed under chapter 636, a health
5 maintenance organization licensed under chapter 641, or
6 physician group practices as defined in s. 455.236(3)(f), must
7 register with the department and meet the requirements of this
8 section. In order to register as a fiscal intermediary
9 services organization, the organization must comply with ss.
10 641.21(1)(c) and (d) and 641.22(6). Should the department
11 determine that the fiscal intermediary services organization
12 does not meet the requirements of this section, the
13 registration shall be denied. In the event that the registrant
14 fails to maintain compliance with the provisions of this
15 section, the department may revoke or suspend the
16 registration. In lieu of revocation or suspension of the
17 registration, the department may levy an administrative
18 penalty in accordance with s. 641.25.

19 (6) The department shall promulgate rules necessary to
20 implement the provisions of this section.

21 Section 4. (1) (1) The Florida Commission on
22 Integrated Health Care Delivery Systems is created to conduct
23 an analysis of the various arrangements by which providers, as
24 defined in s. 641.19, Florida Statutes, may contract with
25 insurers, health maintenance organizations, and other health
26 care purchasers or potential purchasers for the provision of
27 health care goods and services. The commission shall also
28 analyze how such arrangements or potential arrangements fit
29 into Florida's current regulatory structure. The commission
30 shall be composed of 13 members, four selected by the
31 President of the Senate; four by the Speaker of the House of

1 Representatives; three by the Insurance Commissioner, of which
2 two shall represent consumers; the Director of Health Care
3 Administration, or a designee; and the Secretary of Health, or
4 a designee. Members of the commission, other than the
5 Insurance Commissioner's members, shall be selected from
6 entities regulated by the Department of Insurance and the
7 Agency for Health Care Administration and professionals
8 regulated by the Department of Health or from associations of
9 such professionals and entities. Persons appointing commission
10 members, other than the Insurance Commissioner, shall make at
11 least one appointment from each category specified.

12 (2) The commission shall report its findings to the
13 President of the Senate and the Speaker of the House of
14 Representatives by January 1, 1998. The commission shall
15 include in its report proposed draft legislation that it deems
16 necessary to implement the findings and recommendations
17 contained in its report. The commission may recommend
18 regulatory requirements, including whether and to what extent
19 various arrangements should be regulated and what quality of
20 care standards should be met.

21 (3) The Department of Insurance shall provide any
22 necessary staff support for the commission. Private-sector
23 members of the commission, except consumer members, are not
24 eligible for per diem or travel expenses.

25 (4) The commission is abolished and this section
26 expires on the last day of the 1998 Regular Session of the
27 Legislature.

28 (2) This section shall take effect upon becoming a
29 law.

30 Section 5. Section 641.47, Florida Statutes, 1996
31 Supplement, is amended to read:

1 641.47 Definitions.--As used in this part, the term:
2 (1) "Adverse determination" means a coverage
3 determination by an organization that an admission,
4 availability of care, continued stay, or other health care
5 service has been reviewed and, based upon the information
6 provided, does not meet the organization's requirements for
7 medical necessity, appropriateness, health care setting, level
8 of care or effectiveness, and coverage for the requested
9 service is therefore denied, reduced, or terminated.
10 ~~(2)~~⁽¹⁾ "Agency" means the Agency for Health Care
11 Administration.
12 (3) "Clinical peer" means a health care professional
13 in the same or similar specialty as typically manages the
14 medical condition, procedure, or treatment under review.
15 (4) "Clinical review criteria" means the written
16 screening procedures, decision abstracts, clinical protocols,
17 and practice guidelines used by the organization to determine,
18 for coverage purposes, the necessity and appropriateness of
19 health care services.
20 (5) "Complaint" means any expression of
21 dissatisfaction by a subscriber, including dissatisfaction
22 with the administration, claims practices, or provision of
23 services, which relates to the quality of care provided by a
24 provider pursuant to the organization's contract and which is
25 submitted to the organization or to a state agency. A
26 complaint is part of the informal steps of a grievance
27 procedure and is not part of the formal steps of a grievance
28 procedure unless it is a grievance as defined in subsection
29 (10).

1 (6) "Concurrent review" means utilization review
2 conducted during a patient's hospital stay or course of
3 treatment.

4 (7)~~(2)~~ "Emergency medical condition" means:

5 (a) A medical condition manifesting itself by acute
6 symptoms of sufficient severity, which may include severe pain
7 or other acute symptoms, such that the absence of immediate
8 medical attention could reasonably be expected to result in
9 any of the following:

10 1. Serious jeopardy to the health of a patient,
11 including a pregnant woman or a fetus.

12 2. Serious impairment to bodily functions.

13 3. Serious dysfunction of any bodily organ or part.

14 (b) With respect to a pregnant woman:

15 1. That there is inadequate time to effect safe
16 transfer to another hospital prior to delivery;

17 2. That a transfer may pose a threat to the health and
18 safety of the patient or fetus; or

19 3. That there is evidence of the onset and persistence
20 of uterine contractions or rupture of the membranes.

21 (8)~~(3)~~ "Emergency services and care" means medical
22 screening, examination, and evaluation by a physician or, to
23 the extent permitted by applicable law, by other appropriate
24 personnel under the supervision of a physician, to determine
25 if an emergency medical condition exists, and if it does, the
26 care, treatment, or surgery for a covered service by a
27 physician necessary to relieve or eliminate the emergency
28 medical condition within the service capability of a hospital.

29 (9)~~(4)~~ "Geographic area" means the county or counties,
30 or any portion of a county or counties, within which the
31 health maintenance organization provides or arranges for

1 comprehensive health care services to be available to its
2 subscribers.

3 (10) "Grievance" means a written complaint submitted
4 by or on behalf of a subscriber to an organization or a state
5 agency regarding the:

6 (a) Availability, coverage for the delivery, or
7 quality of health care services, including a complaint
8 regarding an adverse determination made pursuant to
9 utilization review;

10 (b) Claims payment, handling, or reimbursement for
11 health care services; or

12 (c) Matters pertaining to the contractual relationship
13 between a subscriber and an organization.

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15 A grievance does not include a written complaint submitted by
16 or on behalf of a subscriber eligible for a grievance and
17 appeals procedure provided by an organization pursuant to
18 contract with the Federal Government under Title XVIII of the
19 Social Security Act.

20 (11)(5) "Health care services" means comprehensive
21 health care services, as defined in s. 641.19, when applicable
22 to a health maintenance organization, and means basic
23 services, as defined in s. 641.402, when applicable to a
24 prepaid health clinic.

25 (12)(6) "Minimum services" includes any of the
26 following: emergency care, inpatient hospital services,
27 physician care, ambulatory diagnostic treatment, and
28 preventive health care services.

29 (13)(7) "Organization" means any health maintenance
30 organization as defined in s. 641.19 and any prepaid health
31 clinic as defined in s. 641.402.

1 ~~(14)(8)~~ "Provider" means any physician, hospital, or
2 other institution, organization, or person that furnishes
3 health care services and is licensed or otherwise authorized
4 to practice in the state. To submit or pursue a grievance on
5 behalf of a subscriber, a provider must previously have been
6 directly involved in the treatment or diagnosis of the
7 subscriber.

8 (15) "Retrospective review" means a review, for
9 coverage purposes, of medical necessity conducted after
10 services have been provided to a patient.

11 ~~(16)(9)~~ "Subscriber" means an individual who has
12 contracted, or on whose behalf a contract has been entered
13 into, with a health maintenance organization for health care
14 services.

15 (17) "Urgent grievance" means an adverse determination
16 when the standard timeframe of the grievance procedure would
17 seriously jeopardize the life or health of a subscriber or
18 would jeopardize the subscriber's ability to regain maximum
19 function.

20 Section 6. Subsection (11) is added to section
21 641.495, Florida Statutes, 1996 Supplement, to read:

22 641.495 Requirements for issuance and maintenance of
23 certificate.--

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

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

29 641.51 Quality assurance program; second medical
30 opinion requirement.--

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1 (5) Each organization shall develop and maintain a
2 policy to determine when exceptional referrals to
3 out-of-network specially qualified providers should be
4 provided to address the unique medical needs of a subscriber.
5 All financial arrangements for the provision of these services
6 shall be agreed to prior to the services being rendered.

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

11 (7) Each organization shall allow subscribers to
12 continue care for 60 days with a terminated treating provider
13 when medically necessary, provided the subscriber has a
14 life-threatening condition or a disabling and degenerative
15 condition. Each organization shall allow a subscriber who is
16 in the third trimester of pregnancy to continue care with a
17 terminated treating provider until completion of postpartum
18 care. The organization and the provider shall continue to be
19 bound by the terms of the contract for such continued care.
20 This subsection shall not apply to treating providers who have
21 been terminated by the organization for cause.

22 (8) Each organization shall release to the agency data
23 which are indicators of access and quality of care. The
24 agency shall develop rules specifying data-reporting
25 requirements for these indicators. The indicators shall
26 include the following characteristics:

27 (a) They must relate to access and quality of care
28 measures.

29 (b) They must be consistent with data collected
30 pursuant to accreditation activities and standards.

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1 (c) They must be consistent with frequency
2 requirements under the accreditation process.

3 The agency shall develop by rule a uniform format for
4 publication of the data for the public which shall contain
5 explanations of the data collected and the relevance of such
6 data. The agency shall publish such data no less frequently
7 than every 2 years.

8 (9) Each organization shall conduct a standardized
9 customer satisfaction survey, as developed by the agency by
10 rule, of its membership at intervals specified by the agency.
11 The survey shall be consistent with surveys required by
12 accrediting organizations and may contain up to 10 additional
13 questions based on concerns specific to Florida. Survey data
14 shall be submitted to the agency, which shall make comparative
15 findings available to the public.

16 (10) Each organization shall adopt recommendations for
17 preventive pediatric health care consistent with early
18 periodic screening, diagnosis, and treatment requirements
19 developed for the Medicaid program. Each organization shall
20 establish goals to achieve 80-percent compliance by July 1,
21 1998, and 90-percent compliance by July 1, 1999, for their
22 enrolled pediatric population.

23 Section 8. Section 641.511, Florida Statutes, is
24 amended to read:

25 641.511 Subscriber grievance reporting and resolution
26 requirements.--

27 (1) Every organization must have a grievance procedure
28 available to its subscribers for the purpose of addressing
29 complaints and grievances. Every organization must notify its
30 subscribers that a subscriber must submit a grievance within 1
31 year after the date of occurrence of the action that initiated

1 the grievance, and may submit the grievance for review to the
2 Statewide Provider and Subscriber Assistance Program panel as
3 provided in s. 408.7056 after receiving a final disposition of
4 the grievance through the organization's grievance process.
5 ~~An The health maintenance~~ organization shall maintain records
6 of all grievances and shall report annually to the agency
7 ~~department a description of~~ the total number of grievances
8 handled, a categorization of the cases underlying the
9 grievances, and the final disposition ~~resolution~~ of the
10 grievances.

11 (2) When an organization receives an initial complaint
12 from a subscriber, the organization must respond to the
13 complaint within a reasonable time after its submission. At
14 the time of receipt of the initial complaint, the organization
15 shall inform the subscriber that the subscriber has a right to
16 file a written grievance at any time and that assistance in
17 preparing the written grievance shall be provided by the
18 organization.

19 (3) Each organization's grievance procedure, as
20 required under subsection (1), must include, at a minimum:

21 (a) An explanation of how to pursue redress of a
22 grievance.

23 (b) The names of the appropriate employees or a list
24 of grievance departments that are responsible for implementing
25 the organization's grievance procedure. The list must include
26 the address and the toll-free telephone number of each
27 grievance department, the address of the agency and its
28 toll-free telephone hotline number, and the address of the
29 Statewide Provider and Subscriber Assistance Program and its
30 toll-free telephone number.

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1 (c) The description of the process through which a
2 subscriber may, at any time, contact the toll-free telephone
3 hotline of the agency to inform it of the unresolved
4 grievance.

5 (d) A procedure for establishing methods for
6 classifying grievances as urgent and for establishing time
7 limits for an expedited review within which such grievances
8 must be resolved.

9 (e) A notice that a subscriber may voluntarily pursue
10 binding arbitration in accordance with the terms of the
11 contract if offered by the organization, after completing the
12 organization's grievance procedure and as an alternative to
13 the Statewide Provider and Subscriber Assistance Program.
14 Such notice shall include an explanation that the subscriber
15 may incur some costs if the subscriber pursues binding
16 arbitration, depending upon the terms of the subscriber's
17 contract.

18 (f) A process whereby the grievance manager
19 acknowledges the grievance and investigates the grievance in
20 order to notify the subscriber of a final decision in writing.

21 (g) A procedure for providing individuals who are
22 unable to submit a written grievance with access to the
23 grievance process, which shall include assistance by the
24 organization in preparing the grievance and communicating back
25 to the subscriber.

26 (4)(a) With respect to a grievance concerning an
27 adverse determination, an organization shall make available to
28 the subscriber a review of the grievance by an internal review
29 panel; such review must be requested within 30 days after the
30 organization's transmittal of the final determination notice
31 of an adverse determination. A majority of the panel shall be

1 persons who previously were not involved in the initial
2 adverse determination. A person who previously was involved
3 in the adverse determination may appear before the panel to
4 present information or answer questions. The panel shall have
5 the authority to bind the organization to the panel's
6 decision.

7 (b) An organization shall ensure that a majority of
8 the persons reviewing a grievance involving an adverse
9 determination are providers who have appropriate expertise.

10 An organization shall issue a copy of the written decision of
11 the review panel to the subscriber and to the provider, if
12 any, who submits a grievance on behalf of a subscriber. In
13 cases where there has been a denial of coverage of service,
14 the reviewing provider shall not be a provider previously
15 involved with the adverse determination.

16 (c) An organization shall establish written procedures
17 for a review of an adverse determination. Review procedures
18 shall be available to the subscriber and to a provider acting
19 on behalf of a subscriber.

20 (d) In any case when the review process does not
21 resolve a difference of opinion between the organization and
22 the subscriber or the provider acting on behalf of the
23 subscriber, the subscriber or the provider acting on behalf of
24 the subscriber may submit a written grievance to the Statewide
25 Provider and Subscriber Assistance Program.

26 (5) Except as provided in subsection (6), the
27 organization shall resolve a grievance within 60 days after
28 receipt of the grievance, or within a maximum of 90 days if
29 the grievance involves the collection of information outside
30 the service area. These time limitations are tolled if the
31 organization has notified the subscriber, in writing, that

1 additional information is required for proper review of the
2 grievance and that such time limitations are tolled until such
3 information is provided. After the organization receives the
4 requested information, the time allowed for completion of the
5 grievance process resumes.

6 (6)(a) An organization shall establish written
7 procedures for the expedited review of an urgent grievance. A
8 request for an expedited review may be submitted orally or in
9 writing and shall be subject to the review procedures of this
10 section, if it meets the criteria of this section. Unless it
11 is submitted in writing, for purposes of the grievance
12 reporting requirements in subsection (1), the request shall be
13 considered an appeal of a utilization review decision and not
14 a grievance. Expedited review procedures shall be available to
15 a subscriber and to the provider acting on behalf of a
16 subscriber. For purposes of this subsection, "subscriber"
17 includes the legal representative of a subscriber.

18 (b) Expedited reviews shall be evaluated by an
19 appropriate clinical peer or peers. The clinical peer or peers
20 shall not have been involved in the initial adverse
21 determination.

22 (c) In an expedited review, all necessary information,
23 including the organization's decision, shall be transmitted
24 between the organization and the subscriber, or the provider
25 acting on behalf of the subscriber, by telephone, facsimile,
26 or the most expeditious method available.

27 (d) In an expedited review, an organization shall make
28 a decision and notify the subscriber, or the provider acting
29 on behalf of the subscriber, as expeditiously as the
30 subscriber's medical condition requires, but in no event more
31 than 72 hours after receipt of the request for review. If the

1 expedited review is a concurrent review determination, the
2 service shall be continued without liability to the subscriber
3 until the subscriber has been notified of the determination.

4 (e) An organization shall provide written confirmation
5 of its decision concerning an expedited review within 2
6 working days after providing notification of that decision, if
7 the initial notification was not in writing.

8 (f) An organization shall provide reasonable access,
9 not to exceed 24 hours after receiving a request for an
10 expedited review, to a clinical peer who can perform the
11 expedited review.

12 (g) In any case when the expedited review process does
13 not resolve a difference of opinion between the organization
14 and the subscriber or the provider acting on behalf of the
15 subscriber, the subscriber or the provider acting on behalf of
16 the subscriber may submit a written grievance to the Statewide
17 Provider and Subscriber Assistance Program.

18 (h) An organization shall not provide an expedited
19 retrospective review of an adverse determination.

20 (7)(2) Each ~~health maintenance~~ organization shall send
21 to the ~~agency department~~ a copy of its annual and quarterly
22 grievance reports submitted to the Department of Insurance
23 pursuant to s. 408.7056(2).

24 (8)(3) The ~~agency department~~ shall investigate all
25 reports of unresolved quality of care grievances received
26 from:

27 (a) Annual and quarterly grievance reports submitted
28 by the ~~health maintenance~~ organization to the Department of
29 Insurance.

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1 (b) Review requests ~~Appeals~~ of subscribers whose
2 grievances remain unresolved after the subscriber has followed
3 the full grievance procedure of the organization.

4 ~~(9)(a)(4)~~ The agency department shall advise
5 subscribers with grievances to follow their organization's ~~the~~
6 ~~health maintenance organization~~ formal grievance process for
7 resolution prior to review by the Statewide Provider and
8 Subscriber Assistance Program department. The subscriber may,
9 however, submit a copy of the grievance to the agency at any
10 time during the process.

11 (b) Requiring completion of the organization's
12 grievance process before the Statewide Provider and Subscriber
13 Assistance Program panel's review does ~~However, this shall not~~
14 preclude the agency department from investigating any
15 complaint or grievance before the organization makes its final
16 determination ~~prior to completion of the health maintenance~~
17 ~~organization's formal grievance process.~~

18 ~~(10)(5)~~ Each organization must notify the subscriber
19 in a final decision letter that the subscriber may request
20 review of the organization's decision concerning the grievance
21 by the Statewide Provider and Subscriber Assistance Program,
22 as provided in s. 408.7056, if the grievance is not resolved
23 to the satisfaction of the subscriber. The final decision
24 letter must inform the subscriber that the request for review
25 must be made within 365 days after receipt of the final
26 decision letter, must explain how to initiate such a review,
27 and must include the addresses and toll-free telephone numbers
28 of the agency and the Statewide Provider and Subscriber
29 Assistance Program. ~~A quality of care grievance which remains~~
30 ~~unresolved after a subscriber has followed the full grievance~~
31 ~~procedure of the organization, after review by the department,~~

1 ~~may be presented to the Statewide Subscriber Assistance~~
2 ~~Program Panel as set forth in s. 408.7056.~~

3 (11) The agency may impose administrative sanction, in
4 accordance with s. 641.52, against an organization for
5 noncompliance with this section.

6 Section 9. Subsections (3), (4), and (5) are added to
7 section 641.54, Florida Statutes, to read:

8 641.54 ~~Hospital and physician~~ Information
9 disclosure.--

10 (3) The organization shall make available to
11 subscribers, upon request, a detailed description of the
12 authorization and referral process for health care services.
13 Any changes in the organization's authorization and referral
14 process shall be reported to the agency immediately.

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

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

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

26 (b) Policies and procedures relating to the
27 organization's prescription drug benefits, including the
28 disclosure, upon request of a subscriber or potential
29 subscriber, of whether the organization uses a formulary. A
30 subscriber or potential subscriber may also request

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1 information as to whether a specific drug is covered by the
2 organization.

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

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

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

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

13 Section 10. Except as otherwise provided herein, this
14 act shall take effect July 1, 1997.

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