By Senator Clary

7-1546-99

A bill to be entitled

An act relating to managed health care; amending s. 408.7056, F.S.; excluding certain additional grievances from consideration by a statewide provider and subscriber assistance panel; revising the membership of the panel; providing for the Agency for Health Care Administration or the Department of Insurance to adopt the panel's recommendation in a final order rather than in a proposed order; providing that a final order is subject to judicial review; amending s. 641.51, F.S.; requiring that health maintenance organizations provide additional information to the Agency for Health Care Administration indicating quality of care; removing a requirement that organizations conduct customer satisfaction surveys; revising requirements for preventive pediatric health care provided by health maintenance organizations; amending s. 641.58, F.S.; providing for moneys in the Health Care Trust Fund to be used for additional purposes; creating the Health Care Information Council within the Agency for Health Care Administration; providing for the appointment of members to the council; providing terms of office; providing that the council members are entitled for reimbursement for per diem and travel expenses; authorizing the council to employ an executive director and staff members; requiring that the council advise the Governor

and Legislature on matters of health care accountability and consumer information; requiring that the council administer a member-satisfaction survey of health maintenance organizations; requiring that the survey results be made public; providing an effective date.

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

Section 1. Subsections (2), (9), (11), and (14) of section 408.7056, Florida Statutes, 1998 Supplement, are amended to read:

408.7056 Statewide Provider and Subscriber Assistance Program.--

(2) The agency 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 to the satisfaction of the subscriber or provider. The program shall consist of one or more panels that meet 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:

(a) Relates to a managed care entity's refusal to accept a provider into its network of providers;

(b) Is part of <u>an internal grievance in a managed care entity or</u> a reconsideration appeal through the Medicare

appeals process which does not involve a quality of care issue;

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

(e) Is part of a Medicaid fair hearing pursued under 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, including accrued interest on unpaid balances, court costs, and transportation costs associated with a grievance procedure;

(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.

(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 or findings of fact in a final ~~proposed~~ order or an emergency order, as provided in chapter 120, which it shall issue to the managed care entity. The agency or department may issue a proposed order or an emergency order, as provided in chapter 120, imposing 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. All fines collected under this subsection must be deposited into the Health Care Trust Fund.

(11) The panel shall consist of members employed by the agency and members employed by the department, chosen by their respective agencies; a consumer; a physician, as a standing member; and physicians who have expertise relevant to the case to be heard, on a rotating basis. The agency may contract with a medical director and a primary care physician

who shall provide additional technical expertise to the panel. The medical director shall be selected from a health maintenance organization with a current certificate of authority to operate in Florida.

(14) A final ~~proposed~~ order issued by the agency or department which only requires the managed care entity to take a specific action under subsection (7) is subject to judicial review under s. 120.68 ~~a summary hearing in accordance with s. 120.574~~, unless all of the parties agree otherwise. If the managed care entity does not prevail at a judicial review ~~the hearing~~, the managed care entity must pay reasonable costs and attorney's fees of the agency or the department incurred in that proceeding.

Section 2. Subsections (8), (9), and (10) of section 641.51, Florida Statutes, are amended to read:

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

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

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

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

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

(d) They must include measures of the management of chronic diseases.

(e) They must include preventative health care for adults and children.

(f) They must include measures of prenatal care.

(g) They must include measures of health checkups for children.

The agency shall develop by rule a uniform format for publication of the data for the public which shall contain explanations of the data collected and the relevance of such data. 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 by rule, of its membership at intervals specified by the agency. The survey shall be consistent with surveys required by accrediting organizations and may contain up to 10 additional questions based on concerns specific to Florida. Survey data shall be submitted to the agency, which shall make comparative findings available to the public.~~

(9)~~(10)~~ Each organization shall adopt recommendations for preventive pediatric health care which are consistent with the ~~early periodic screening, diagnosis, and treatment~~ requirements for health checkups for children developed for the Medicaid program. Each organization shall establish goals to achieve 80-percent compliance by July 1, 1998, and 90-percent compliance by July 1, 1999, for their enrolled pediatric population.

Section 3. Subsection (4) of section 641.58, Florida Statutes, is amended to read:

641.58 Regulatory assessment; levy and amount; use of funds; tax returns; penalty for failure to pay.--

(4) The moneys ~~so~~ received and deposited into the Health Care Trust Fund shall be used to defray the expenses of the agency in the discharge of its administrative and regulatory powers and duties under this part, including administering the Health Care Information Council; conducting an annual survey of the satisfaction of members of health maintenance organizations; contracting with physician consultants for the Statewide Provider and Subscriber Assistance Panel; ~~the~~ maintaining ~~of~~ offices and necessary supplies, essential equipment, and other materials, salaries and expenses of required personnel; ~~,~~ and discharging ~~all other legitimate expenses relating to the discharge of~~ the administrative and regulatory powers and duties imposed under this ~~such~~ part.

Section 4. Health Care Information Council.--

(1) There is created a Health Care Information Council. The council shall be located within the Agency for Health Care Administration for administrative purposes, but shall independently exercise the powers and duties specified in this section.

(a) The council shall be composed of 11 members, including the Director of the Agency for Health Care Administration, or his or her designee; the Insurance Commissioner, or his or her designee; three members appointed by the Governor; three members appointed by the President of the Senate; and three members appointed by the Speaker of the House of Representatives. The appointments shall be made in such a manner as to achieve a balance between managed care organizations, health care providers, and consumers.

(b) Members shall be appointed for staggered terms of not more than 2 years. An appointment to fill a vacancy shall

be for the remainder of the term. The Governor may remove any member who, without cause, fails to attend two consecutive meetings.

(c) The council shall annually select a chairperson and vice chairperson from among its members. The council shall meet at least quarterly, but shall also meet at the call of its chairperson or at the request of a majority of its members. A majority of the members of the council constitutes a quorum.

(d) Membership on the council does not disqualify a member from holding any other public office or from being employed by a public entity, except that a member of the Legislature may not serve on the council.

(e) Members of the council shall serve without compensation, but are entitled to reimbursement for per diem and travel expenses as provided in section 112.061, Florida Statutes.

(2) The council shall employ an executive director and necessary staff members, as provided by legislative appropriation. The council may retain consultants as necessary to accomplish its purposes. The executive director and any consultant retained by the council may not be a current or former contract vendor of the Department of Insurance or the Agency for Health Care Administration.

(3) The Health Care Information Council shall act in an advisory capacity to the Governor, the Legislature, the Department of Insurance, and the Agency for Health Care Administration on matters of health care accountability and consumer information. The duties of the council include, but are not limited to:

(a) Contracting with an independent contractor to administer an annual member-satisfaction survey for all health maintenance organizations, including the Medicare and Medicaid programs.

(b) Selecting the instrument and the sampling design to meet the requirements for member-satisfaction surveys for accreditation organizations of health maintenance organizations.

(c) Producing a report card for health maintenance organizations.

(d) Making comparative survey results available to health maintenance organizations and the public.

(4) In addition to the results of the member-satisfaction survey, the report card for health maintenance organizations must include benefit availability, physician qualifications, payment arrangements, copayment requirements, and the quality indicators provided under section 641.51(8)(d), (e), (f), and (g), Florida Statutes.

Section 5. This act shall take effect upon becoming a law.

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SENATE SUMMARY

Revises certain provisions of the grievance procedures for subscribers of health maintenance organizations. Provides for the provider and subscriber assistance panel to include a consumer, a physician, and physicians who have specific expertise. Requires that the Agency for Health Care Administration or the Department of Insurance adopt the panel's recommendation as a final order rather than a proposed order. Provides that the final order is subject to judicial review. Provides additional requirements for health maintenance organizations in providing pediatric health care. Creates the Health Care Information Council to administer member-satisfaction surveys of health maintenance organizations and advise the Governor and Legislature on matters of health care accountability and consumer information. (See bill for details.)