By Senator Laurent

17-420-00

A bill to be entitled

An act relating to health maintenance organizations; amending s. 641.3155, F.S.; defining the term "clean claim"; providing prerequisites to an HMO's contesting such a claim; providing procedures; providing penalties for failure to pay part or all of a clean claim; amending s. 408.7056, F.S.; providing for the Agency for Health Care Administration to review all provider grievances alleging that an HMO has violated s. 641.3155, F.S.; providing for the appointment of a review panel and specifying its membership; providing applicability; providing an effective date.

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

Section 1. Section 641.3155, Florida Statutes, is amended to read:

641.3155 Provider contracts; payment of claims.--

(1) As used in this section, the term "clean claim" means a completed claim, as determined under department rules adopted under chapter 120, which claim is for medical care or health care services under a health care plan and is submitted by a physician on an HCFA 1500 claim form or by other providers on a UB-92 claim form.

(2)~~(1)~~(a) A health maintenance organization shall pay any clean claim or any portion of a clean claim made by a contract provider for services or goods provided under a contract with the health maintenance organization which the

organization does not contest or deny within 35 days ~~after receipt of the claim by~~ the health maintenance organization receives the claim, which has been sent by mail or electronic transfer from ~~is mailed or electronically transferred by~~ the provider.

(b) A health maintenance organization that denies or contests a provider's clean claim or any portion of a clean claim shall notify the contract provider, in writing, within 35 days after ~~receipt of the claim by~~ the health maintenance organization receives the claim that the claim is contested or denied. The notice that the claim is denied or contested must identify the contested portion of the claim and the specific reason for contesting or denying the claim, and must ~~may~~ include a request for additional information. If the provider submits ~~health maintenance organization requests~~ additional information, the provider shall, within 35 days after receipt of such notice ~~request~~, mail or electronically transfer the information to the health maintenance organization. The provider may charge the organization the reasonable costs of copying and providing the additional information, including the cost of reasonable staff time, as provided in ss. 395.3025 and 455.667. The health maintenance organization shall pay or deny the claim or portion of the claim within 45 days after receipt of the information.

(3) In order for a health maintenance organization to contest a portion of a clean claim, the health maintenance organization must pay to the provider the uncontested portion of the claim. The failure to pay the uncontested portion of a claim constitutes a complete waiver of the health maintenance organization's right to deny any part of the claim. If the health maintenance organization unreasonably denies the entire

claim for the purpose of delaying payment of the uncontested portion of the claim, the organization must pay to the provider three times the amount of the claim which was unreasonably contested.

(4)~~(2)~~ Payment of a claim is considered made on the date the payment was received or electronically transferred or otherwise delivered. An overdue payment of a claim bears simple interest at the rate of 10 percent per year.

(5) Failure to pay the amount of the undisputed clean claim to a provider within 35 days after receipt of the claim entitles the provider to the procedures set forth in s. 408.7056(4).

(6)~~(3)~~ A health maintenance organization shall pay or deny any clean claim no later than 120 days after receiving the claim. The failure of a health maintenance organization to pay any disputed clean claim or portion of a clean claim within such period entitles the provider to the procedures specified in s. 408.7056(4).

(7)~~(4)~~ Any retroactive reductions of payments or demands for refund of previous overpayments which are due to retroactive review-of-coverage decisions or payment levels must be reconciled to specific claims unless the parties agree to other reconciliation methods and terms. Any retroactive demands by providers for payment due to underpayments or nonpayments for covered services must be reconciled to specific claims unless the parties agree to other reconciliation methods and terms. The look-back period may be specified by the terms of the contract.

Section 2. 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 a health maintenance organization or a prepaid health clinic certified under chapter 641, 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 subsections (12) and (13)~~subsection (11)~~.

(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 an internal grievance in a Medicare managed care entity or 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 or to the payment of claims submitted to the organization by the providers;

(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 or to the payment of claims submitted to the organization by the provider;

(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(7) ~~(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.

(3) Except for grievances that are filed by providers and that relate to the payment of claims by a health maintenance organization, 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 agency shall notify the parties, in writing, by facsimile transmission, or by phone, of the time and place of the hearing. The panel may take testimony under oath, request certified copies of documents, and take similar actions to collect information and documentation that will assist the panel in making findings of fact and a recommendation. The panel shall issue a written recommendation, supported by findings of fact, 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 chapter 120.

(4) Within 15 days after receiving a grievance filed by a provider against an organization, which grievance alleges that the organization violated s. 641.3155, the agency must review the grievance and make a determination as to whether the grievance shall be heard. After the agency notifies the panel created under subsection (13), the provider, and the managed care entity that the panel will hear the grievance, the panel must hear the grievance, either in the network area or by teleconference, no later than 45 days after the date on which the grievance was filed, unless that deadline is waived by both the provider and the managed care entity. The agency shall notify the parties, either in writing, by facsimile transmission, or by telephone, of the time and place of the hearing. The panel may take testimony under oath, request certified copies of documents, and take similar actions to collect information and documentation that will assist the panel in making findings of fact and a recommendation. No later than 15 working days after hearing the grievance, the panel shall issue a written recommendation, supported by findings of fact, to the provider, to the managed care entity, and to the agency or the department. If, at the hearing, the panel requests additional documentation or additional records, the time for issuing a recommendation is tolled until the requested information or documentation has been provided to the panel. The proceedings of the panel are not subject to chapter 120.

(5)~~(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.

(6)~~(5)~~ Grievances considered under subsection (3) which ~~that~~ the agency determines pose an immediate and serious threat to a subscriber's health must 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 written recommendation, supported by findings of fact, to the department or the agency within 10 days after hearing the expedited grievance.

(7)~~(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 a written emergency recommendation, supported by findings of fact, 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. An emergency order remains in force until:

(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.

(8)~~(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.

(9)~~(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 or findings of fact of the panel.

(10)~~(9)~~ No later than 30 days after the issuance of the panel's recommendation and, for an expedited grievance or a grievance conducted under subsection (4), 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 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, and, for hearings conducted under subsection (4), requiring payment of the unpaid portion of any claim not paid by the organization, which shall bear a simple interest rate of 10 percent from the date the provider filed the grievance under this section. The agency or the department may reject all or part of the panel's recommendation as provided in s. 120.57. All fines collected under this subsection must be deposited into the Health Care Trust Fund.

(11)~~(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 considers appropriate in a particular grievance.

(12)~~(11)~~ Except for the panel created under subsection (13), the panel shall consist of members employed by the agency and members employed by the department, chosen by their respective agencies; a consumer appointed by the Governor; a physician appointed by the Governor, 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.

(13) The panel created to hear grievances filed by providers under subsection (4) shall be composed of five members, consisting of a medical director of an organization that holds a current certificate of authority to operate in this state, a physician licensed under chapter 458 or chapter 459, a member who represents a hospital, a member employed by the agency, and a member employed by the department. The Governor shall appoint the three members of the panel who are not employed by the agency or the department. The remaining two members of the panel shall be chosen by mutual agreement of the agency and the department. Each member of the panel must be proficient in coding methodology.

(14)~~(12)~~ Every managed care entity shall submit a quarterly report to the agency and the department 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 grievance procedure of the managed care entity. The agency shall notify all subscribers and providers included in the quarterly reports of their right to file an unresolved grievance with the panel.

(15)~~(13)~~ 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.

(16)~~(14)~~ A proposed order issued by the agency or department which only requires the managed care entity to take a specific action under subsection(8)~~(7)~~is subject to 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 the hearing, the managed care entity must pay reasonable costs and attorney's fees of the agency or the department incurred in that proceeding.

(17)~~(15)~~(a) Any information which would identify a subscriber or the spouse, relative, or guardian of a subscriber which is contained in a document, report, or record prepared or reviewed by the panel or obtained by the agency 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.

(b) Meetings of the panel shall be open to the public unless the provider or subscriber whose grievance will be heard requests a closed meeting or the agency or the Department of Insurance determines that information of a sensitive personal nature which discloses the subscriber's medical treatment or history; or information which constitutes a trade secret as defined by s. 812.081; or information relating to internal risk management programs as defined in s. 641.55(5)(c), (6), and (8) may be revealed at the panel meeting, in which case that portion of the meeting during which such sensitive personal information, trade secret information, or internal risk management program information is discussed shall be exempt from the provisions of s. 286.011 and s. 24(b), Art. I of the State Constitution. All closed meetings shall be recorded by a certified court reporter.

This subsection is subject to the Open Government Sunset Review Act of 1995 in accordance with s. 119.15, and shall stand repealed on October 2, 2003, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 3. This act shall take effect July 1, 2000, and shall apply to all claims submitted by a provider to a health maintenance organization after June 30, 2000.

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SENATE SUMMARY

Provides procedures that a health maintenance organization must follow in contesting certain claims made by providers. Provides penalties for failure to pay part or all of a "clean claim," as that term is defined in the bill. Provides for the Agency for Health Care Administration to review all provider grievances alleging that a health maintenance organization has violated s. 641.3155, F.S. Provides for the appointment of a review panel and specifies panel membership. Provides applicability. Provides an effective date.