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HOUSE OF REPRESENTATIVES

COUNCIL FOR HEALTHY COMMUNITIES
ANALYSIS

BILL #: HB 2007 (PCB HCC 02-06)

RELATING TO: Health Care Coverage Procedures

SPONSOR(S): Council for Healthy Communities and Rep. Fasano

TIED BILL(S): None.

ORIGINATING COMMITTEE(S)/COUNCIL(S)/COMMITTEE(S) OF REFERENCE:

(1) COUNCIL FOR HEALTHY COMMUNITIES YEAS 12 NAYS 5
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I. SUMMARY:

THIS DOCUMENT IS NOT INTENDED TO BE USED FOR THE PURPOSE OF CONSTRUING STATUTES, OR TO BE CONSTRUED AS AFFECTING, DEFINING, LIMITING, CONTROLLING, SPECIFYING, CLARIFYING, OR MODIFYING ANY LEGISLATION OR STATUTE.

HB 2007 bill relates to regulation of health care providers, health insurers and health maintenance organizations. It addresses issues relating to the Certificate of Need program and reimbursement procedures of health care providers.

The Certificate of Need (CON) review process is a regulatory program that requires health care providers to obtain state approval from the Agency of Health Care Administration (AHCA) before offering new or expanded services. This proposed bill eliminates the need for a CON review process for hospitals utilizing existing licensed bed capacity. Hospitals could build a new facility transferring existing beds to a new location, and/or provide health services, long-term hospital care and tertiary care services, excluding solid organ transplantation, with an exemption from AHCA. It also provides an exemption: for open-heart surgery programs; for the establishment of a satellite hospital through the relocation of 100 general acute care beds from an existing hospital located in the same district; and for certain acute care hospitals seeking to add beds. According to AHCA, there is a negative fiscal impact of $352,000 associated with the CON open heart surgery component of this bill. It is anticipated that the fiscal impact will be greater with the other exemptions provided within this bill.

The bill also revises various provisions relating to certain health insurers and health maintenance organizations, and health providers, specific to dispute resolution, claim submission, processing, and payment, process of claims for overpayment, and treatment authorization. It revises the types of entities eligible to utilize the statewide provider and managed care organization claim dispute resolution program and adds new requirements. The PCB also substantially revises prompt payment requirements, timeframes, requirements related to appeals, provider billing, retroactive denials, expands the requirements to include certain health insurers, and authorizes fines. It establishes new authorization procedures for health insurers and HMOs. It specifies that an HMO contracting with certain entities transferring the obligation to pay providers remain responsible for any violations by specified statutes of those entities. The PCB also authorizes an HMO primary care physician to solely make referral decisions regarding ophthalmology services.

Except as otherwise provided, the bill takes effect on October 1, 2002, and applies to claims for service rendered after that date.

SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

1.	Less Government	Yes []	No [x]	N/A []
2.	Lower Taxes	Yes []	No []	N/A [x]
3.	Individual Freedom	Yes []	No []	N/A [x]
4.	Personal Responsibility	Yes []	No []	N/A [x]
5.	Family Empowerment	Yes []	No []	N/A [x]

For any principle that received a "no" above, please explain:

Less Government: The bill provides that violation of various timeframes for payment of claims is a violation of the insurance code and that each violation is a separate offense, thus increasing enforcement authority for the Department of Insurance. The Department of Insurance has added responsibilities relating to auditing an HMO's or health insurer's compliance with prompt payment of claims requirements and must determine and utilize a permissive error ratio of 5 percent.

B. PRESENT SITUATION:

CERTIFICATE OF NEED

Legislative History of CON Review Process:

Over the past year, the Florida Legislature took into consideration the total repeal or reform of the Certificate of Need process, which created fervent debate among health care providers. Debate among the members of the 2001 Legislature primarily focused on two main concerns:

- If total deregulation of the CON review process occurred, that would allow for an open market, thereby creating a scenario for new providers to come into the area and cherry pick for services. Those new providers are apt to create boutique hospitals, performing only the more lucrative services, thereby leaving emergency and charity care for the existing hospitals to absorb; and

- By placing in licensing statute the rules for health service programs, it did not allow for any flexibility in regulating health services programs to advance with the corresponding advancement of medical technology. For example, by specifying equipment types in statutes, that may be state-of-the-art today, two years from now, industry standards may be replaced with less invasive technology, making statutory requirements obsolete compared to industry standards.

The 2001 Legislative session ended without any notable changes to the CON review process. However, the 2001 Legislature did create Chapter 2001-167, Laws of Florida (CS/SB 684) directing the Agency for Health Care Administration to create a 15-member Organ Transplant Task Force. The summarized purpose of the task force was to study organ transplant programs and to make recommendations to the Governor and Legislature regarding: 1) the need to issue certificates of need (CON) for transplant programs; and 2) funding for organ transplants. A report was submitted by the task force to the Governor and the Legislature, January 15, 2002.

The Task Force reported that the CON process for organ transplant programs is ineffective, as it has existed. The task force recommended that:

- The CON regulation for adult kidney, pancreas, liver, heart, and lung programs be abolished unless all the suggested changes are implemented; and
- The CON process be maintained for pediatric patients and the changes recommended for the adult programs be implemented for pediatric kidney, pancreas, liver, heart and lung programs.

Section 15 of Chapter 2000-318, Laws of Florida (CS/CS/HB 591), created a 30-member certificate-of-need workgroup staffed by the Agency for Health Care Administration. The Legislature specified that the workgroup study issues pertaining to the certificate-of-need program, including the impact of trends in health care delivery and financing. In addition, the workgroup was charged with studying issues relating to implementation of the certificate-of-need program and was required to report to the Legislature with an interim report by December 31, 2001, with a final report by December 31, 2002. The workgroup is set to be abolished effective July 1, 2003. The recommendations for hospitals include:

- Hospitals operating at 80% acute care occupancy over the most recent 12 month period, or hospital having 90% occupancy for any 3 consecutive months, will be exempt from CON review for the greater of 10% of their licensed capacity or 30 beds.
- Tertiary services will continue to be subject to CON.
- All tertiary services subject to CON review should be defined in statute. In addition to tertiary services that are currently included in statute, NICU Level II beds and adult open heart programs should be included.
- Providers of tertiary services will cooperate with the State in the development of outcome and quality measures.
- Criteria for new tertiary services will be more detailed.
- A medical advisory group should be established to determine which existing services and what new emerging services should be classified as tertiary.
- AHCA is to be directed to redefine the measures of hospital occupancy.
- Providers of NICU Level III services will be allowed to shift their capacity between their Level III unit and their Level II unit, subject to providing appropriate staffing.
- Projects now subject to expedited review (other than replacement hospitals and conversion of mental health beds to general acute beds) will now be exempt.
- The Certificate of Need Task Force should be allowed to continue its work through 2002 to address in more detail tertiary services, transplantation and new technology.
- All providers of invasive services, to at least include diagnostic catheterization and outpatient surgery, regardless of setting, will report utilization data to the State of Florida.

As stated in the recommendations of the CON Interim report, “The CON Workgroup recognizes the need to make recommendations about streamlining the CON process. Recommendations related to a streamlined process will be a priority when the group reconvenes in 2002.”

Rulemaking Provisions for AHCA:

In October 2000, the Agency proposed amendments to the adult open-heart surgery need methodology in rule 59C-1.033, F.A.C., which would allow approval of more programs than the existing methodology. The amendments also recognized technological/medical changes in open heart surgery procedures that have occurred since the present version of the rule was adopted in

1991. Related proposed amendments would have eliminated adult open-heart surgery from the list of tertiary services.

During the ensuing 14 months, the proposed amendments were thoroughly debated, notably at a rule development workshop, a public hearing, and a trial at the Division of Administrative Hearings (DOAH). In summary, those supporting the amendments stressed the need for additional programs to improve geographic access to adult open heart surgery services, given the emergency needs of some of the patients receiving open heart surgery. Those opposing the amendments were concerned that new programs would draw patients and staff away from existing programs, and cited evidence that outcomes from the surgery are poorer at hospitals with a low volume of open heart surgery.

The amendments to the rule, as validated at DOAH on November 15, 2001, retain adult open heart surgery as a tertiary health service, update the definition of open heart surgery, recognize that there are circumstances in some counties that indicate need for a such a program, and reduce the numeric standard that defines an acceptable hospital-specific minimum annual volume of adult open heart surgeries.

Exemptions to the CON Review Process:

Requirements for the Certificate of Need (CON) review process are set forth in Chapter 408, Florida Statutes. The CON review process is a regulatory program that requires health care providers to obtain state approval from the Agency of Health Care Administration before offering new or expanded services.

Currently, there are 19 statutorily defined exemptions to the CON review process. An exemption is not automatic under the current statutory language in s. 408.036(3) and (4), F.S. The applicant must request an exemption, and must support the request with documentation required by agency rule. Similar to the proposed committee bill, several of the current statutory exemptions contain provisions specifying limitations or other conditions that must be met by the applicant; and three of the exemptions specifically require the applicant to "certify" that it will meet specified conditions.

Terminology specific to CON exemptions created in this bill include:

Acute Care Hospital Bed. A patient accommodation or space in a hospital licensed by the Agency pursuant to Chapter 395, F.S. Acute care hospital beds exclude neonatal intensive care beds, comprehensive medical rehabilitation beds, hospital inpatient psychiatric beds, hospital inpatient substance abuse beds, beds in distinct-part skilled nursing units, and beds in long term care hospitals. All other inpatient beds enumerated on a hospital's license issued under Chapter 395, F.S., are acute care hospital beds subject to the provisions of AHCA rule.

As defined in sections 409.2663(2) and 409.911(1), F.S., ***charity care*** is that portion of hospital charges for which there is no compensation for care provided to a patient whose family income for the 12 months preceding the determination is less than or equal to 150 percent of the current Federal Poverty Guidelines (FPG), as published in the Federal Register; or for which there is no compensation for care provided to a patient whose family income for the 12 months preceding the determination is greater than 150 percent of the current FPG but not more than four times the current FPG for a family of four and the amount of hospital charges due from the patient exceeds 25 percent of the 12-month family income. Charity care does not include bad debt, which is the portion of health care provider charges for which there is no compensation for care provided to a patient who fails to qualify for charity care; and does not include administrative or courtesy

discounts, contractual allowances to third-party payors, or failure of the hospital to collect full charges due to partial payment by government programs.

By rule and statute, ***Tertiary health service,*** means a health service which, due to its high level of intensity, complexity, specialized or limited applicability, and cost, should be limited to, and concentrated in, a limited number of hospitals to ensure the quality, availability, and cost effectiveness of such service. Examples of such service include, but are not limited to, organ transplantation, specialty burn units, neonatal intensive care units, comprehensive rehabilitation, and medical or surgical services which are experimental or developmental in nature to the extent that the provision of such services is not yet contemplated within the commonly accepted course of diagnosis or treatment for the condition addressed by a given service. The types of tertiary services to be regulated under the Certificate of Need Program not listed in statute, but instead, AHCA [within their statutory authority] develops the list of services, which include: heart transplantation; kidney transplantation; liver transplantation; bone marrow transplantation; lung transplantation; pancreas and islet cells transplantation; heart/lung transplantation; adult open heart surgery; neonatal and pediatric cardiac and vascular surgery; and pediatric oncology and hematology. Furthermore, by rule, AHCA is authorized to determine whether services should be added or deleted to this list of tertiary care services, the listing is reviewed annually by the Agency.

Neonatal Care Services. The aspect of perinatal medicine pertaining to the care of neonates. Hospital units providing neonatal care are classified according to the intensity and specialization of the care that can be provided. The Agency distinguishes three levels of neonatal care services: Level I, Level II and Level III.

Burn Unit. A burn unit is a discrete unit within a hospital that occupies designated physical space separate from other areas of the hospital. A burn unit shall have a minimum of five dedicated burn beds and shall be equipped and staffed to provide specialized care solely for severely burned persons.

Bone Marrow Transplantation. Human blood precursor cells, stem cells, administered to a patient to restore normal hematological and immunological functions following ablative therapy with curative intent. Human blood precursor cells may be obtained from the patient in an autologous transplant or from a medically acceptable related or unrelated donor, and may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood. If chemotherapy is an integral part of the treatment involving bone marrow transplantation, the term "bone marrow transplantation" includes both the transplantation and the chemotherapy. (Section 627.4236(1), Florida Statutes).

Open Heart Surgery Program. A program established in a room or suite of rooms in a hospital, equipped for open heart surgery operations and staffed with qualified surgical teams and support staff. Rule 59C-1.033, Florida Administrative Code, defines Open Heart Surgery Operation as surgery assisted by a heart-lung by-pass machine that is used to treat conditions such as congenital heart defects, heart and coronary artery diseases, including replacement of heart valves, cardiac vascularization, and cardiac trauma.

CON Requirements for Open Heart Surgery Programs:

Under current rules of ACHA, specifications for open heart surgery programs require that in order to establish an adult or pediatric open heart surgery program, a health facility must show specified minimum requirements for staffing and equipment; and it specifies a methodology for determining the numeric need for a new program. A certificate of need for the establishment of an open heart surgery program shall not normally be approved unless the applicant meets the applicable review

criteria in section 408.035, F.S., and the standards and need determination criteria set forth by rule. Rule 59C-1.33. F.A.C., Open Heart Surgery Program, effective January 24, 2002 states:
"An additional open heart surgery program shall not normally be approved in the district if any of the following conditions exist:

- There is an approved adult open heart surgery program in the district;
- One or more of the operational adult open heart surgery programs in the district that were operational for at least 12 months as of 3 months prior to the beginning date of the quarter of the publication of the fixed need pool performed less than 300 adult open heart surgery operations during the 12 months ending 3 months prior to the beginning date of the quarter of the publication of the fixed need pool; or,
- One or more of the adult open heart surgery programs in the district that were operational for less than 12 months during the 12 months ending 3 months prior to the beginning date of the quarter of the publication of the fixed need pool performed less than an average of 25 adult open heart surgery operations per month.

According to AHCA, there has been considerable provider interest in establishing adult open heart surgery services. During the last 3 years, the Agency has reviewed 48 applications for the service, an average of 16 applications per year.

Each day, people suffering from heart disease are transported by emergency vehicle to an emergency room. Many need emergency access to a life-saving procedure called angioplasty. This procedure will open their blocked heart vessel saving their life and their heart muscle from further damage. Others must undergo the more serious open heart surgery. Either way, if a patient is taken to a hospital that is not approved to perform these procedures, he or she must be transferred to an open heart surgery facility. Critically important time will pass before the patient receives an angioplasty. Cardiologists have coined the phrase "time is muscle" when referring to heart attack victims. The sooner blood flow can be restored to the heart muscle the higher the probability the victim will not suffer permanent heart damage or death.[1]

Currently, there are 271 hospitals licensed in Florida; 263 are Medicare certified, 234 are accredited, and 59 offer an open heart surgery program. The inventory of Florida hospitals that offer programs is categorized by health planning district and is outlined as follows:

District	County(ies)	Approved/ Operational Programs	Approved/Non-Operational Programs	Total Approved Programs	Total Population In District
1	Escambia, Santa Rosa, Okaloosa, & Walton	3	0	3	644,215
2	Bay, Holmes, Washington, Jackson, Franklin, Gulf, Gadsden, Liberty, Calhoun, Leon, Wakulla, Jefferson, Madison, & Taylor	3	0	3	659,368
3	Hamilton, Suwannee, Lafayette, Dixie, Columbia, Gilcrist, Levy, Union, Bradford, Putnam, Alachua, Marion, Citrus, Hernando, Sumter, & Lake	6	1	7	1,373,198

[1] Tallahassee Democrat, January 23, 2002.

4	Baker, Nassau, Duval, Clay, St. Johns, Flagler, & Volusia	7		7	1,682,483
5	Pasco & Pinellas	5	0	5	1,295,793
6	Hillsborough, Manatee, Hardee, Highlands & Polk	6	1	7	1,945,487
7	Brevard, Orange, Seminole, & Osceola	6	0	6	2,020,901
8	Charlotte, Desoto, Lee, Sarasota, Glades, Hendry, & Collier	5	1	6	1,310,715
9	Indian River, Okeechobee, Martin, Palm Beach, St. Lucie	4	2	6	1,666,744
10	Broward	6	1	7	1,678,940
11	Dade & Monroe	8	0	8	2,397,292
Total	**State Wide**	**53**	**6**	**59**	**16,635,136**

The table above indicates that District 3 has a population of 1,373,198, with 7 approved programs, while District 7, with a population of 2,020,901 has 6 approved programs (with a hospital recently denied a CON in this service planning area), which has more than 700,000 additional residents in the planning district. It is unclear what criteria AHCA used to deny the recent CON request in District 7.

Currently, there are 19 statutorily defined exemptions to the CON review process. An exemption is not automatic under the current statutory language in s. 408.036(3) and (4), F.S. The applicant must request an exemption, and must support the request with documentation required by agency rule. Several of the current statutory exemptions contain provisions specifying limitations or other conditions that must be met by the applicant; and three of the exemptions specifically require the applicant to "certify" that it will meet specified conditions. The exemption created by HB 581 would require the applicant to certify that: "... it will provide a minimum of 2 percent of such services to charity or Medicaid patients."

Administrative Hearing Procedures for the CON Review Process:

The Administrative Hearing Procedures for the CON review process are defined by Rule 59C-1.012, F.A.C., and are conducted pursuant to the timeframes and conditions specified in s. 408.039(5), F.S.

A request for an administrative hearing is filed with the Agency within 21 days after publication of the Notice of Intent in the Florida Administrative Weekly by the Agency. The failure of a noticed intended denied applicant to timely file a proper request for administrative hearing challenging the denial of its application shall result in the denial becoming final agency action with respect to such applicant, and the application being severed from the remainder of the batch.

If a valid request for administrative hearing is timely filed challenging the noticed intended award of any certificate of need application in the batch, that challenged granted applicant shall have ten days from the date the notice of litigation is published in the Florida Administrative Weekly to file a petition challenging any or all other co-batched applications.

If no valid request for administrative hearing is timely filed challenging the noticed intended award of a certificate of need to an applicant, there is no pending challenge to the applicable published fixed need pool projection, and there has been no petition filed pursuant to sub- paragraph (2)(a), the noticed intended granted application shall be severed from the rest of the batch and become final agency action with respect to such application. If there are pending challenges to the applicable published fixed need pool projection, no noticed intended granted application can be severed from the batch and become final agency action, unless the application is withdrawn.

If all requests for administrative hearings challenging a noticed intended award of a CON, and all challenges to the relevant published fixed need pool projection, if any, are subsequently voluntarily dismissed, the unchallenged noticed intended granted application shall be severed from the remainder of the batch and the noticed intended award shall become final agency action with respect to such applicant. If there remain any pending challenges to the applicable published fixed need pool projection, no noticed intended granted application can be severed from the batch and become final agency action, unless the application is withdrawn.

For purposes of comparative hearing on any remaining applications in the batch, the beds or services awarded to unchallenged noticed intended granted applications in the batch which have become final agency action shall automatically be subtracted from the unchallenged numeric fixed need pool projection applicable to the batch, even if the projection is zero, and it shall be conclusively presumed that the award of beds or services in the batch which have become final agency action will become operative in the service area in accordance with the representations contained in the certificate of need application leading to approval.

The difficulties encountered in this process are best described by Martin Memorial Hospital, in a situation where a CON was granted by AHCA for an adult open heart surgery program in 1985. Although the Agency approved the CON application, this issue has been tied up in litigation since the original approval and 17 years later; the hospital still does not have an operating open heart surgery program.

Hospital Licensure:

Chapter 395, F.S., provides for the licensing requirements of hospitals and other licensed health facilities. A hospital is defined as offering services more intensive than those required for room, board, personal services and general nursing care. Hospital services include beds offered for use beyond 24 hours by individuals requiring medical, surgical, or psychiatric testing and diagnosis; and treatment for illness, injury, deformity, infirmity, abnormality, disease, or pregnancy. Other recognized hospital services include: clinical laboratory services, diagnostic X-ray services, and treatment facilities for surgery or obstetrical care, or other definitive medical treatment of similar extent.

Unaccredited facilities and initial licenses require a certification and/or licensing survey. Currently, under state and federal regulations, accredited hospitals are "deemed" to meet the requirements and do not receive an annual license and certification survey. Life-Safety and Risk Management surveys are conducted annually. In addition, each hospital must be surveyed for certification as directed by the Centers of Medicare and Medicaid Services (a federal agency) to receive Medicare reimbursement.

In order to be licensed by ACHA, facilities must meet federal and state licensing requirements, submit a completed application, required documentation and have a satisfactory survey completed. Renewal applications must be submitted every two years, 90 days in advance of expiration of a license. The initial and renewal fee is $1,500 or $30 per bed, whichever is greater. The

survey/inspection fee is $400 or $12 per bed, whichever is greater. The life safety inspection fee is $40 or $1.50 per bed, whichever is greater.

Currently, there are 271 hospitals licensed in Florida; 263 are Medicare certified, and 234 are accredited. As required by Rule 59A-3.202, Florida Administrative Code, hospitals are licensed by the following classification:

- Class I are general hospitals which include: general acute care hospitals with an average length of stay of 25 days or less for all beds; long term care hospitals, which meet the provisions of Rule 59A-3.201(31), Florida Administrative Code; and rural hospitals designated under Chapter 395, Part III, Florida Statutes.

- Class II are specialty hospitals offering the same range of medical services offered by general hospitals, but restricted to a defined age or gender group of a population which includes; specialty hospitals for children; and specialty hospitals for women.

- Class III are specialty hospitals offering a restricted range of services appropriate to the diagnosis, care, and treatment of patients with specific categories of medical or psychiatric illnesses or disorders. Class III facilities include: specialty medical hospitals; specialty rehabilitation hospitals; specialty psychiatric hospitals, which may include beds licensed to offer intensive residential treatment programs; specialty substance abuse hospitals, which may include beds licensed to offer intensive residential treatment programs.

- Class IV is specialty hospitals restricted to offering intensive residential treatment programs for children and adolescents, pursuant to section 395.002(16), Florida Statutes.

According to Rule 59A-3.203, F.A.C., a person or governmental unit proposing to establish, conduct, or maintain a hospital in this state, must first obtain a license. All persons requesting licensure for the operation of a hospital under the provisions of Chapter 395, Florida Statutes, must make application to the Agency and must receive a regular or provisional license prior to the acceptance of patients for care or treatment. The following documents must accompany the initial application: the hospital's zoning certificate; articles of incorporation; registration of a fictitious name; the name and address of the ultimate owner of the hospital; a valid certificate of need or letter of exemption as required by s. 408.031 through 408.045, F.S. As well as, approval for licensure from the Agency's Office of Plans and Construction; and evidence of medical malpractice insurance through the Patient Compensation Fund or other means of demonstrating financial responsibility as provided for under Chapter 766, Florida Statutes.

An application for biennial licensure renewal must be accompanied by evidence of medical malpractice insurance through the Patient Compensation Fund or other means of demonstrating financial responsibility as provided for under Chapter 766, Florida Statutes. In lieu of an agency licensure inspection, a copy of the hospital's most recent accreditation report may be submitted, if the hospital is accredited by an accrediting organization and has evidence of accreditation. Each license shall specifically state the name of the licensed operator of the hospital, and the class of hospital. A license, unless suspended or revoked, automatically expires two years from date of issuance, and is renewable biennially upon application for renewal and payment of the fee prescribed, provided that the applicant and hospital meet the requirements established under the Chapter 395, Part I, F.S., and Rules 59A-3.077–3.093 and 59A-3.200–3.232, F.A.C. Application for renewal of license shall be made not less than 90 days before expiration of a license.

AHCA also issues a provisional license for any hospital in substantial compliance with the statute and Rules 59A-3.077–3.093 and 59A-3.200–3.232 or 59A-3.100–3.111, F.A.C. Provisional

licenses are issued only after AHCA is satisfied that preparations are being made by the hospital to qualify for regular license, and that the health and safety of patients will not be endangered during the interim. Any new hospital will be issued a provisional license before opening date, provided plans, specifications for the building have been approved by the licensing agency, and the hospital has been surveyed and found to meet construction standards and health and safety surveys. A provisional license may be granted for a period of no more than one (1) year and expires automatically at the end of its term. A provisional license may not be renewed.

A regular license may be issued after the proposed hospital becomes operational and after the completion of a resurvey to determine compliance with rules. Florida Department of Law Enforcement, FBI fingerprinting, and Abuse Registry screening must be completed on the administrator/chief executive officer prior to the facility being licensed.

PROMPT PAY

Prompt Payment of Claims

Other States

With health care providers complaining that laws requiring prompt payment of claims have not resulted in insurers and health maintenance organizations (HMOs) actually paying claims promptly, nine states, Florida among them, in their 2000-2001 legislative sessions revised their laws to tighten deadlines, stiffen fines, or attempt to close other loopholes that providers say allow plans to evade state-mandated time limits. According to a June 4, 2001, *American Medical Association News Report,* even more states are likely to consider further revisions to their prompt pay statutes and regulations in their next regular legislative sessions.

Currently, forty-eight states have put HMOs and/or health insurers on notice to pay clean claims in a timely fashion or face possible penalties and fines. The term "clean claim" generally means a claim that has no defect or impropriety or particular circumstance requiring special treatment. Most states require insurers to pay clean claims within 45 days, however state requirements range from 15 days (Georgia) to 60 days (Michigan). Under Georgia law, insurers are required to pay 18 percent interest on claims not paid within 15 days. Although Georgia's law is considered to be the strictest, Hawaii requires that claims filed electronically be paid within 15 days. The trend in the most recent state “prompt-pay” legislation is to adopt the Medicare standard of 95 percent clean claims paid within 30 days and all claims approved or denied within 30 days.

During their 2001 sessions, five states passed “prompt-pay” laws with specified interest requirements. Typically, these standards are similar, if not identical, to the Medicare 30-day prompt pay requirement.

State	Prompt-Pay Deadline	Interest Rate
Arizona	30 days	Rate equal to state legal rate
Kansas	30 days	1% per month
Kentucky	30 days	12% for up to 60 days and 21% after 90 days
Minnesota	30 days	1.5% per month
New Mexico	45 days	1.5 times state legal rate

Typical of the newly adopted “prompt-pay” laws is the Minnesota law, which requires all health plan companies and third-party administrators to pay or deny clean claims within 30 calendar days of receiving the claims, or face an interest penalty of 1.5 percent per month. The act defines “clean claim” to mean "a claim that has no defect or impropriety, including any lack of any required

substantiating documentation, or a particular circumstance requiring special treatment that prevents the timely payment from being made on a claim under this section." This is very similar to the definition for Medicare claims. The Minnesota act applies not only to health plan companies but also to third-party administrators. This act applies to all health care providers except pharmacists. The health plan company or third-party administrator must itemize any interest payment separately from other payments being made for services provided. The health plan company or third-party administrator may, at its discretion, require the health care provider to bill the health plan company or third-party administrator for the interest required under this section before an interest payment is made.

Health Insurers

Section 627.613, F.S., relating to time of payment of health insurer claims, requires health insurers to pay claims under a health insurance policy within 45 days after receipt of the claim by the health insurer. If a claim or a portion of a claim is contested by the health insurer within the 45 days, then the insured or the insured's assignees must be notified, in writing, that the claim is contested or denied. Upon receipt of the additional information, a health insurer must pay or deny the contested claim or portion of the contested claim within 60 days. All claims must be paid or denied no later than 120 days after receiving the claim. Overdue payment of a claim accrues a simple interest rate penalty at the rate of 10 percent per year. Health insurance policies typically covered by this section include: Medicare supplemental policies, disease specific policies such as cancer policies, and long-term disability policies.

Health Maintenance Organizations

In 1999, the Legislature authorized the director of the Agency for Health Care Administration in ch. 99-393, L.O.F., to establish an advisory group on the submission and payment of health claims. The advisory group was composed of eight members, with three members from HMOs licensed in Florida, one representative from a not-for-profit hospital, one representative from a for-profit hospital, one representative who was a licensed physician, one representative from the Office of the Insurance Commissioner, and one representative from the Agency for Health Care Administration. The advisory group was required to study and make recommendations concerning timely and accurate submission and payment of health claims; electronic billing and claims processing; the form and content of claims; and measures to reduce fraud and abuse. The advisory board made its recommendations to the Legislature and Governor on February 1, 2001. The advisory board made the following recommendations for changes of the prompt payment of claims requirements:

- Clarification of the statute on the inclusion of interest with late payments.
- Development of a state-supervised mediation mechanism for both providers and managed care organizations for hearing and resolving claims disputes promises to help resolve serious disputes, including disputes over reimbursement for emergency care, and without the parties resorting to civil litigation or the termination of their contracts and service relationships.
- Clarification of the balance billing prohibition to make it easier to enforce this consumer protection statute.
- Adoption of the National Uniform Billing Committee definition of institutional clean claim and the endorsement.
- Adoption of the HIPAA Administrative Simplification process to expedite the standardization of claims forms and the automated processing of claims.
- Adoption of electronic claims processing by providers and insurers, as soon as possible.
- Require managed care organizations to pay for pre-authorized services except under very limited circumstances.

- Require a receipt for claims submitted electronically.

In the 2000 legislative session, s. 641.3155, F.S., relating to payment for claims requirements of health maintenance organizations (HMO), was substantially revised as part of ch. 2000-252, L.O.F. That law included the following:

- Deleted provisions relating to provider billings, revised provisions relating to provider contracts, provided for disclosure and notice, and required procedures for requesting and granting authorization for utilization of services.
- Provided for HMO liability for payment for services rendered to subscribers, and prohibited certain provider billing of subscribers.
- Defined the term "clean claim" in the institutional and non-institutional setting, and specified the basis for determining when a claim is to be considered clean or not clean.
- Required the Department of Insurance to adopt rules to establish a claim form and requirement for the form and granted discretionary rulemaking authority for coding standard.
- Provided for payment, denial, and contesting of clean claims or portions of clean claims, and provided for interest accrual, payment of interest, and an uncontestable obligation to pay a claim.
- Required HMOs to make a claim for overpayment; prohibited an HMO from reducing payment for other services and provided exceptions.
- Required providers to pay a claim for overpayment within a specified timeframe and procedures, timeframes for overpayments were specified, and created an uncontestable obligation to ay a claim for overpayment.
- Specified when an electronically transmitted or mailed provider claim is considered received; mandated acknowledgement of receipt for electronically submitted provider claims; prescribed a timeframe for an HMO to retroactively deny a claim for services provided to an eligible subscriber; and provided for treatment authorization and payment of claims for emergency services subject to specified provisions of law.
- Provided that downcoding with intent to deny reimbursement by an HMO is an unfair method of competition and an unfair or deceptive act or practice.
- Authorized the Department of Insurance to issue a cease and desist order for a payment-of-claims violation, and revised provisions relating to treatment-authorization capabilities.
- Established a statewide claim dispute resolution program for providers and managed care organizations for all claims for services rendered after October 1, 2000, submitted by a provider or managed care organization 60 days after a certain date, and provided the Agency for Health Care Administration specific rulemaking authority for the program. [s. 408.7057, F.S.]
- Authorized administrative sanctions against a hospital's license for improper subscriber billing and violations of requirements relating to claims payments.
- Provided that certain actions by a provider are punishable, and expanded a provision of law relating to fraud against hospitals to include health care providers.

Statewide Provider and Managed Care Organization Claim Dispute Resolution Program

In the 2000 legislative session, CS/CS/CS/SB 1508, created s. 408.7057, F.S., relating to the Statewide Provider and Managed Care Organization Claim Dispute Resolution Program. The bill required the Agency for Health Care Administration (agency) to contract with an independent third-party organization to resolve claims payment disputes between managed care organizations and providers, with the organization's final determination adopted by agency order.

The program provides for an independent mediator to hear disputes regarding amounts paid for services. The program requires that physicians have at least $500 in disputed claims to enter the process, hospitals must have $25,000 for inpatient treatment and $10,000 for outpatient services they believe they are owed. In addition, HMOs are also able to initiate the process after meeting the same $500 monetary threshold as physicians. In each case, the loser would pay the cost for the mediation. Submitted claims must be for dates of service after October 1, 2000.

On February 27, 2001, the Agency signed a two-year contract with Maximus to resolve claims disputes. Maximus was selected from eight firms through a competitive bid process. The Reston, VA-based firm has contracted since 1986 with the federal government to resolve Medicare beneficiary disputes with their managed care plans. The program became operational on May 1, 2001. On August 18, 2001, the Agency received 6 claims (1 was a duplication). According to a recent e-mail from Maximus, the company responsible for the independent mediation, only one health plan has responded to the mediation process. According to provider representatives, providers are hesitant to participate in the program due to its lack of public records exemption for its confidential and proprietary information and the potential costs associated with the review process to the non-prevailing party. The Agency issues final orders based on the recommendation by the resolution organization and tracks compliance by the non-prevailing party. All review costs are borne by the parties involved in the dispute and fines can be levied for unpaid review costs.

Authorization for Treatment

Health Insurers

There are no statutory requirements relating to health insurers' authorization for treatment. Some health insurers may require by contract notification or authorization prior to delivery of specified services.

Health Maintenance Organizations

Traditionally, HMOs emphasize preventative medicine and have utilized primary care physicians as "gatekeepers" to obtain referrals to specialists. In addition, such referrals, certain medical or treatment procedures, and hospital admissions typically require authorization prior to service. Section 641.3156, F.S., relating to HMO treatment authorization and payment of claims requires the following:

- An HMO must pay any hospital service or referral service claim for treatment of an eligible subscriber which was authorized by a provider with contract authority to authorize or direct the subscriber's use of the HMO's health care services and which was authorized in accordance to the HMO's procedures, unless the provider provided misinformation to the HMO with the willful intent to misinform the HMO.
- An HMO may not deny a claim for treatment if the provider followed the HMO's authorization procedures and received authorization for an eligible subscriber for a covered service, unless the provider provided misinformation to the HMO with the willful intent to misinform the HMO.
- Emergency services are not subject to the requirements of this section, but are subject to s. 641.513, F.S.

Additional Current Florida Statutory Provisions

Health Insurers

Section 627.651, F.S., relating to health insurance group contracts and plans of self-insurance requirements, specifically excludes plans established or maintained by an individual employer in accordance with the Employee Retirement Income Security Act of 1974 (ERISA), or to multiple-employer welfare arrangements, defined by s. 624.437(1), F.S., with specified exceptions. Authorized insurers are prohibited from issuing a group health insurance policy or certificate which does not comply with this part.

Section 627.662, F.S., relates to health insurance and other applicable provisions. These provisions apply to group health insurance, blanket health insurance, and franchise health insurance. The applicable provisions are as follows:

- Provisions relating to the use of dividends, refunds, rate reductions, commissions, and services fees (s. 627.569, F.S.);
- Identification numbers and statement of deductible provisions (s. 627.602(1)(f) and (2), F.S.);
- Excess insurance (s. 627.635, F.S.);
- Direct payment for hospital or medical services (s. 627.638, F.S.);
- Filing and classification of rates (s. 627.640, F.S.);
- Denial of claims (s. 627.645(1), F.S.);
- Time of payment of claims (s. 627.613, F.S.);
- Preferred provider organizations (s. 627.6471, F.S.);
- Exclusive provider organizations (s. 627.6472, F.S.);
- Combined preferred provider and exclusive provider policies (s. 627.6473, F.S.); and
- Provider contracts (s. 627.6474, F.S.).

Section 627.638(2), F.S., relating to direct payment for hospital and medical services, requires that whenever a health insurance claim form specifically authorizes payment of benefits directly to a recognized hospital or physician, the insurer must make the payment to the designated provider unless such payment is prohibited in the insurance contract.

Health Maintenance Organizations

Section 641.234, F.S., relating to administrative, provider, and management contracts, authorizes the department to require an HMO to submit specified types of contracts for review. Upon review of the contract by the Department of Insurance, the department may order the HMO to cancel the contract if it determines the fees are so unreasonably high that the contract is detrimental to the subscribers, stockholders, investors, or creditors of the HMO or the contract is with an entity not licensed under state statutes (if required) or is not in good standing with the appropriate regulatory agency. Requires that all contracts, as specified, entered into or renewed by an HMO on or after October 1, 1998, must contain a provision that the contract will be canceled upon issuance of an order by the department pursuant to this section.

Section 641.30, F.S., relating to HMO contract construction and relationship to other laws, requires every HMO to accept the standard health claim form prescribed in s. 627.647, F.S., relating to the standard health claim form for HMOs. Provides that, except for the requirements contained in this part, the Florida Insurance Code does not apply to an HMO certificated under this part, however a person, entity, or HMO operating without a subsisting certificate of authority in violation of this part, in addition to being subject to the provisions of this part, is subject to the provisions of the Florida Insurance Code. Provides that solicitation of subscribers by an HMO or its representatives is not to be construed to be violative of any provision of law relating to solicitation or advertising by health professionals if the HMO is operating pursuant to a subsisting certificate of authority. Grants the Division of Insurance Fraud the authority to use its powers granted to it under the Florida Insurance

Code to investigate any violation of this part. Requires all HMOs to comply with s. 627.4301, F.S., relating to genetic information for insurance purposes.

Section 641.3154(4), F.S., relates to organizational liability and prohibitions of provider billing, specifying that a provider under contract with an HMO is prohibited from collecting or attempting to collect money from, maintaining an action against, or reporting to a credit agency a subscriber of an HMO for payment of services for which the HMO is liable, if the provider, in good faith knows or should know that the HMO is liable. Specifies that this prohibition applies during any on-going claim for payment of services, legal proceedings, or dispute resolution process to determine whether the HMO is liable if the provider is informed that such proceedings are taking place. In addition, specifies when it is presumed that a provider does know and should not know that an HMO is liable.

Section 641.3155, F.S, regulates payment of claims for HMOs and relates to HMO provider contracts and payment of claims. Specifically authorized are temporary timeframes for payment of noncontested claims, contesting of claims, prompt payment of claims, and payment reconciliation until adoption of a rule by the Department of Insurance. Rule 4-191.066, F.A.C., provides specific timeframes for the payment of "clean claims" and refers to "clean claims" as "valid undisputed claims." Specific authority for this rule comes from s. 641.36, F.S., relating to the adoption of rules, s. 641.31(12), F.S., relating to health maintenance contracts, and s. 641.3903(5)(c)3., 5., and 6., F.S., relating to unfair methods of competition and unfair or deceptive acts or practices. The current rule requires the following:

- HMOs pay all valid undisputed claims within 35 days of receipt of the claim;
- If additional information is needed, the HMO shall request the additional information in writing within 35 days of receipt of the claim and shall maintain that request in the claim file; and
- If additional information is requested, the HMO shall affirm and pay any valid claim within 30 days of receipt of the additional information.

FEDERAL ACTIVITIES RELATING TO MANAGED CARE

Federal Bipartisan Patient Protection Act – S. 1052 and H.R. 2563

As part of the overall federal reform package addressing "Patient's Rights", both S. 1052 and H.R. 2563 contain identical "prompt payment" requirements for plans and issuers offering group health insurance with respect to covered benefits. Specifically, both bills utilize the Medicare prompt payment requirement and preempt state prompt payment laws inconsistent with this standard.

The Centers for Medicare & Medicaid Services (CMS), formerly known as the Health Care Financing Administration, as part of its administration of the Medicare program, currently requires organizations, including health care providers and institutions, to:

- Pay 95 percent of the "clean claims" within 30 days of receipt if they are submitted by, or on behalf of, an enrollee of Medicare for services that are not furnished under a written agreement between the organization and the provider; and
- Pay interest on clean claims that are not paid within 30 days; and
- All other claims must be approved or denied within 60 calendar days from the date of the request.

A "clean claim" is defined to mean a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment

that prevents timely payment from being made on the claim (Social Security Act, §§ 1816(c)(2)(B) and 1842(c)(2)(B)).

Health Insurance Portability and Accountability Act (HIPAA) of 1996

In 1996, Congress passed the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), commonly known as HIPAA. The statutory deadline for Congress to enact legislation to implement HIPAA was August 21, 1999. However, absent such legislation, DHHS has developed its recently adopted rule. The Administrative Simplification rule was published August 17, 2000. The rule goes into effect on October 16, 2002. Some small organizations have until October 16, 2002, to comply. All others, including all health care providers, must comply with these standards by October 16, 2003. While HIPAA does not contain specific "prompt pay" standards, the standardization of the various transactions from forms to coding is expected to help reduce the volume of claims held up in processing due to plan-specific variations in required data, formatting, coding, or documentation requirements variations that inevitably cause systems problems for providers, plans, and insurers.

The requirements outlined by the law and the regulations promulgated by DHHS for HIPAA are far-reaching, and all health care organizations that maintain or transmit electronic health information must comply. This includes: payors (health plans, health insurers, and health care clearinghouses) and health care providers, from large integrated delivery networks to individual physician offices. All health care providers are required to submit specified transactions in specified formats with standardized transaction codes and all insurance carriers will be required to accept these forms and codes by specified compliance dates.

Currently, there is no federal common standard for the transfer of information between health care providers and payers. As a result, providers have been required by payers to meet many different requirements. For some providers who submit claims to multiple payers, determining which data to submit and on which form has been a difficult and expensive process whether done manually or electronically. HIPAA will ultimately simplify this process by requiring payers to accept specific transaction standards for Electronic Data Interchange (EDI), depending on provider type and service type. [Note: These standards were not imposed by the law, but instead were developed by federal regulation, a process which included significant private sector input.] Providers are given the option of whether to submit the transactions electronically or "on paper," however, if they elect to submit them electronically, they must use the standards agreed upon through the law. Payers are required to accept these transmissions in the standard format in which they are sent and must not delay a transaction or adversely affect a provider who wants to submit the transactions electronically.

The recently adopted HIPAA rules restate definitions contained in previously adopted HIPAA rules. Specifically, the rule establishes transaction standards using the ANSI X12 standard. Transactions covered by this standard include:

- Health care claims or equivalent encounter information;
- Health care payment and remittance advice;
- Coordination of benefits;
- Health care claim status;
- Enrollment and disenrollment in a health plan;
- Eligibility for a health plan;
- Health plan premium payments;
- Referral certification and authorization;
- First report of injury;

- Health claims attachments; and
- Other transactions that the Secretary may prescribe by regulation.

Standard code sets have been defined as including:

- International Classification of Diseases, 9th Edition, Clinical Modification, (ICD-9-CM), Volume 1 and 2 (including the official ICD-9-CM guidelines for Coding and Reporting;
- International Classification of Diseases, 9th Edition, Clinical Modification, Volume 3 Procedures (including the Official ICD-9-CM Guidelines for Coding and Reporting);
- National Drug Codes (NDC);
- Code on Dental Procedures and Nomenclature;
- The combination of Health Care Financing Administration Common Procedure Coding System (HCPCS) and the Current Procedural Terminology, Fourth Edition, (CPT-4); and
- The Health Care Financing Administration Common Procedure Coding System (HCPCS).

Section 1178 of the Social Security Act provides that standards for the transactions will supercede any State law that is contrary to them, but allows for an exception process. The final Privacy Standard Rule was issued April 14, 2001. Most health plans and health care providers that are covered by the new rule must comply with the new requirements by April 2003. In addition to the exceptions for conflicting State laws, an exception may be allowed for the testing of proposed modifications to the standards. An entity wishing to test a different standard may apply for an exception to test the new standard. Instructions for applications are published in the final rule.

Legislation has been in introduced in both the House and Senate to delay implementation of the HIPAA administrative simplification requirements by two years. S. 836 sponsored by Senator Larry Craig (R-Idaho) and H.R. 1975 sponsored by Representative John Shadegg (R-Ariz.) are similar pieces of legislation that would exempt the privacy standard from any changes in implementation requirements and deal only with regulations pertaining to administrative simplification. The legislation would not affect implementation of the medical record privacy regulations that are scheduled to go into effect in 2003.

On December 27, 2001, President Bush signed into law, H.R. 3323. H.R. 3323 (enacted as Public Law 107-105) will delay by one year (to October 16, 2003), the deadline for health providers and health plans to follow uniform national standards for the formats and medical codes used to exchange health care data, provided the covered entities submit to federal officials a summary explaining how they will use the extra year to reach compliance. Absent submission of a summary, the covered entities, including providers, claims clearinghouses, and most payers, must comply with the original October 16, 2002, deadline.

C. EFFECT OF PROPOSED CHANGES:

This bill addresses the concerns raised in the 2001 Legislative Session that concluded that the total deregulation of the CON review process would open the market to new providers, thereby placing existing providers at financial risk; and that placing strict licensure requirements in statute would limit the effectiveness of regulation due to the fact that requirements may or may not keep up with the fast pace of changing medical technology.

The bill creates an exemption for the CON review process for only existing facilities. New providers will continue to be subject to the CON review process. In effect, the bill eliminates the CON review process for facilities utilizing existing licensed bed capacity for new and expanded services. A hospital organization could build a new facility, transferring existing beds to the new location,

provide health services, long-term hospital care and tertiary services, excluding solid organ transplant services, with the approved application for exemption from AHCA.

Rule-making authority is given to AHCA in developing requirements for licensure. Rules shall be developed that will provide:

- Only the services covered in the exemption will be preformed;
- Hospitals will maintain sufficient and appropriate equipment and staffing levels;
- Maintain times and operation for emergencies;
- Provide at a minimum of 10% of its services to charity and Medicaid patients each year; and
- For the first time, establish quality outcome measures for care; and as a base-line for rule making authority, these standards will be at least the 50th percentile of national and state standards.

The bill exempts establishment of adult open-heart surgery program from CON review by adding that service to the list of exemptions contained in s. 408.036(3), F.S.

The bill recognizes that when a problem exists in accessing needed cardiac services, consideration must be given to creating an exemption to the CON process and further recognizes that the exemption needs to be based upon objective criteria. The provisions for the exemption from the CON review process for open heart surgery programs specifies that facilities must meet the following criteria:

- The applicant for exemption must demonstrate that they are referring 300 or more cardiac patients from the hospital for cardiac open heart surgery or that the average wait time for transfer to another facility for treatment for 50% of more of the cardiac patients exceeds four hours.
- The applicant is a general acute care hospital that has been in operation for more than 3 years.
- The applicant is performing more than 500 diagnostic cardiac catheterization procedures per year, a combination of both inpatient and outpatient procedures.
- The applicant must create a formal peer review program with an existing statutory teaching hospital or cardiac program doing 750 open heart cases and that the peer review program will conduct quarterly reviews the first year and biannually the second yeas and subsequent years until either the program reaches 350 cases per year or demonstrates consistency with state adopted quality outcome standards for the service.
- The hospital payor mix, at a minimum reflects the community average for Medicaid, charity care, and self-pay for open heart surgery patients. If the applicant fails to reach the required minimum volume of 300 procedures per year, it must show cause why its exemption should not be revoked.
- Maintain minimum licensure requirements adopted by the Agency governing open-heart programs, including the most current guidelines of the American College of Cardiology and American Heart Association Guidelines for Adult open-heart programs.
- The applicant must certify it will maintain sufficient appropriate equipment and health personnel to ensure quality and safety.
- The applicant shall certify it will maintain sufficient appropriate times of operation and protocols to ensure the availability and appropriate referrals in the event of emergencies.

In addition, an exemption is created for the establishment of a satellite hospital through the relocation of 100 general acute care beds from an existing hospital located in the same district, as defined in s. 408.032(5). Also, certain acute care hospitals will be able to add beds to their facilities without CON review.

The bill also revises various provisions relating to certain health insurers, preferred provider organizations (PPOs), exclusive provider organizations (EPOs), health maintenance organizations (HMOs), and health providers, specific to dispute resolution, claim processing, overpayment, payment, and treatment authorization. It deletes obsolete language and provides a statutory cross-reference. It authorizes direct payment of benefits to certain mental health or substance abuse providers with authorization of insured notwithstanding contrary provisions of the contract. The proposal also requires HMOs which contract with entities to transfer the obligation to pay providers for certain claims remain responsible for any of the entity's violations of specific statutes. Changes are also made in the procedures for referring patients for ophthalmological services.

The bill takes effect on October 1, 2002, except as otherwise provided.

D. SECTION-BY-SECTION ANALYSIS:

Section 1. Amends subsection (3) of s. 408.036, F.S., creating paragraph (t), providing an exemption to the CON review process for providers that offer health services, long-term care hospitals services, new construction, or tertiary health services excluding solid organ transplant services, by an existing hospital provided that the hospital does not exceed the current licensed bed capacity for that facility. The hospital may offer services, utilizing existing bed capacity within the hospital's respective health planning district.

The Agency for Health Care Administration is authorized to develop rules requiring licensure requirements for the services exempted from the CON review process. The rules are to include that the facility maintain sufficient staff, maintain appropriate referrals in the event of an emergency, provide 10% of services to charity and Medicaid patients, and to develop quality outcome measures that must be at least at the 50th percentile of national and state standards for care. In the event the facility fails to meet the required provisions of licensure, the facility will have an opportunity to correct any deficiencies before the expiration of the granted exemption.

If the exemption for a program expires, the Agency may not grant another exemption for a program in the same facility until 2 years following the date of the determination.

The proposed council bill recognizes that when a problem exists in accessing needed cardiac services, consideration must be given to creating an exemption to the CON process and further recognizes that the exemption needs to be based upon objective criteria. The provisions for the exemption from the CON review process for open heart surgery programs specifies that facilities must meet the following criteria:

- The applicant for exemption must demonstrate that they are referring 300 or more cardiac patients from the hospital for cardiac open heart surgery or that the average wait time for transfer to another facility for treatment for 50% of more of the cardiac patients exceeds four hours.
- The applicant is a general acute care hospital that has been in operation for more than 3 years.
- The applicant is performing more than 500 diagnostic cardiac catheterization procedures per year, a combination of both inpatient and outpatient procedures.
- The applicant must create a formal peer review program with an existing statutory teaching hospital or cardiac program doing 750 open heart cases and that the peer review program will conduct quarterly reviews the first year and biannually the second yeas and subsequent years until either the program reaches 350 cases per year or demonstrates consistency with state adopted quality outcome standards for the service.

- The hospital payor mix, at a minimum reflects the community average for Medicaid, charity care, and self-pay for open heart surgery patients. If the applicant fails to reach the required minimum volume of 300 procedures per year, it must show cause why its exemption should not be revoked.
- Maintain minimum licensure requirements adopted by the Agency governing open-heart programs, including the most current guidelines of the American College of Cardiology and American Heart Association Guidelines for adult open-heart programs.
- The applicant must certify it will maintain sufficient appropriate equipment and health personnel to ensure quality and safety.
- The applicant shall certify it will maintain sufficient appropriate times of operation and protocols to ensure the availability and appropriate referrals in the event of emergencies.

In addition, an exemption is created for the establishment of a satellite hospital through the relocation of 100 general acute care beds from an existing hospital located in the same district, as defined in s. 408.032(5).

Section 2. Creates s. 408.043, F.S., "Sole Acute Care Hospital in a High Growth County." Provides that an acute care hospital licensed under chapter 395 may add up to 180 additional beds without agency CON review, provided such hospital is located in a county that has experienced at least a 60% growth rate since 1990, is under construction on January 1, 2002, is the sole acute care hospital in the county, and is located such that there is no other acute care hospital within a 10-mile radius of such hospital.

Section 3. Amends s. 408.7057, F.S., relating to the statewide provider and managed care organization claim dispute resolution program.

Subsection (1), defining the terms used in the section, is amended as follows:

Adds paragraph (a), to define "agency" to mean the Agency for Health Care Administration.

Amends paragraph (b), to define the term "health plan" rather than "managed care organization," and expand the definition to include exclusive provider organizations (s. 627.6472, F.S.), and major medical expense health insurance policy (s. 627.643(2)(3), F.S.), offered by a group or individual health insurer licensed pursuant to chapter 624, F.S., including preferred provider organizations (s. 627.6471, F.S.).

Amends subsection (2), to update references replacing "Agency for Health Care Administration" with "agency" and "managed care organizations" with "health plans."

Adds paragraph (e), to require those seeking dispute resolution to submit supporting documentation within specified timeframes. Authorizes the resolution organization to extend timeframes. Provides that failure to submit supporting documents within the timeframe results in the dismissal of the claim of the submitter.

Adds paragraph (f), to require the resolution organization to require the respondent to submit all documentation in support of its position within 15 days after receiving a request from the dispute resolution organization for supporting documentation. Authorizes the resolution organization to extend the time, if appropriate. Provides that failure to submit the requested documentation within the timeframe will result in a default against the health plan or provider. Provides that, in the event of default, the resolution organization must issue its written recommendation to the Agency that a default be entered against the defaulting entity. The written recommendation must include a recommendation to the Agency that the defaulting entity pay the entity submitting the claim the full

amount of the claim dispute, plus all accrued interest, and must be considered a nonprevailing party for the purposes of this section.

Adds paragraph (g), to require a resolution organization that has reason to believe that a pattern exists on the part of a particular health plan or provider to evaluate the cases to determine whether there is evidence of a pattern of violations, and report its findings and evidence to the appropriate licensure or certification entity.

Amends subsection (3), to update terminology and to specify that the Agency's rules establishing the process to be used by the resolution organization must specify that the written recommendation must be submitted to the Agency within 60 days after the requested information is received by the resolution organization, and prohibits the extension of the timeframes from exceeding 90 days following the receipt of the initial claim dispute.

Adds subsection (5), to require the Agency to notify within 7 days the appropriate licensure or certification entity whenever there is a violation of the final order issued by the Agency pursuant to this section.

Section 4. Creates s. 627.6131, F.S., relating to payment of claims by health insurers, as follows:

Subsection (1) requires health insurance policy contracts to contain specific language relating to payment notice requirements.

Subsection (2) provides a definition of "claim" for institutional and noninstitutional providers, delivered to the insurer's designated location, as follows:

- Noninstutional providers: A paper or electronic billing instrument consisting of the HCFA 1500 data set, or its successor, with all mandatory entries for a physician licensed under chapter 458, chapter 459, chapter 460, chapter 461 or other appropriate billing instrument with all mandatory entries for any other noninstitutional provider.
- Institutional providers: A paper or electronic billing instrument consisting of the UB-92 data set or its successor that all mandatory entries.

Subsection (3) specifies for all claims, electronic or nonelectronic, the following:

- Specifies when claims for payment are considered received.
- Specifies that claims for payments must be mailed or electronically transferred to the insurer within 9 months after completion of the service by the provider.
- Prohibits submission of duplicate claims unless it is determined that the original claim was not received or is lost.

Subsection (4) specifies requirements for electronically submitted claims, as follows:

Paragraph (a) requires that within 24 hours of the beginning of the next business day after the receipt of the claim electronic acknowledgement of the receipt of the claim be provided to the electronic source submitting the claim.

Paragraph (b) requires that within 20 days of the receipt of the claim, the insurer must pay the claim or notify the provider or designee if the claim is denied or contested. Notice of the insurer's action on the claim and payment of the claim is considered to be made on the date notice or payment was mailed or electronically transferred.

Subparagraph (c)1. requires that notification of a contested claim must be accompanied by an itemized list of additional information or documents reasonably necessary for the insurer to process the claim.

Subparagraph (c)2. requires that a provider must submit the requested additional information or documentation within 35 days of receipt of the notification. Failure to provide the requested information or documentation within the 35 days may result in denial of the claim.

Subparagraph (c)3. prohibits an insurer from making more than one request for documents under this paragraph in connection with a claim, unless the provider fails to submit all of the requested documents to process the claim. An additional request for more documents can be made if the documents submitted raise new additional issues which were not included in the original itemization. In such cases, the insurer may allow the provider one additional opportunity to submit additional documents needed to process the claim. Under no circumstances may an insurer request duplicate documents.

Paragraph (d) requires, for the purposes of this section, that electronic means of transmission of claims, notices, documents, forms, and payment must be used to the greatest extent possible by the health insurer and the provider.

Paragraph (e) requires a claim to be paid or denied within 90 days of the receipt of the claim. Provides that failure to pay or deny a claim within 120 days after the receipt of the claim creates an uncontestable obligation to pay the claim.

Subsection (5) specifies requirements for nonelectronically submitted health insurer claims, as follows:

Paragraph (a), beginning November 1, 2003, requires the provision of acknowledgement of the receipt of the claim to the provider within 15 days of receipt of the claim or provide a provider within 15 days of receipt with electronic access to the status of a submitted claim. [Note: The November 1, 2003, effective date only applies to this paragraph.]

Paragraph (b) requires that within 40 days of receipt of the claim, the insurer must pay the claim or notify the provider or the provider's designee that the claim is denied or contested. Notification of a claim or payment of a claim is considered to have been made on the date the notice or payment was mailed or electronically transferred.

Subparagraph (c)1. requires notification of the insurer's determination of a contested claim to be accompanied by an itemized list of additional information or documents reasonably necessary for the insurer to process the claim.

Subparagraph 2. requires a provider to submit the requested additional documentation or information within 35 days of receipt of the notification. Failure to submit by mail or electronically the requested additional information or documentation within the 35 days may result in the denial of the claim.

Subparagraph 3. prohibits an insurer from making more than one request for documents in connection with a claim except when a provider fails to submit all the requested documents or if the documents submitted raise new additional issues not included in the original written request, however, the insurer may provide the provider one additional opportunity to submit the additional documents needed to process the claim. Prohibits the insurer from requesting duplicate documents.

Paragraph (d) requires for the purposes of this subsection, electronic means of transmission of claims, notices, documents, forms, and payment to be used to the greatest extent possible by the health insurer and provider.

Paragraph (e) requires a claim to be paid or denied within 120 days of receipt of the claim. Provides that failure to pay or deny a claim with 140 days of receipt of the claim creates an uncontestable obligation to pay.

Subsection (6) requires an insurer to make a claim for overpayment if it determines that an overpayment has occurred. Requires an insurer to give the provider a written or electronic statement specifying the basis for the retroactive denial or payment. Requires the insurer to identify the claim or claims, or overpayment claim portion of the claim.

Paragraph (a) requires that in the case where an overpayment determination is the result of a retroactive review or audit of coverage decisions or payment levels not related to fraud, the health insurer must do the following:

- Submit the claim for overpayment to the provider within 30 months after the insurer's payment of the claim. The provider must pay, deny, or contest the claim for overpayment within 40 days of the receipt of the claim. Requires all contested claims for overpayment to be paid or denied within 120 days of the receipt of the claim. Failure to pay or deny the claim for overpayment within 140 days of receipt creates an uncontestable obligation to pay the overpayment claim.
- Providers that deny or contest a claim for overpayment or any portion of the claim for overpayment must notify the insurer, in writing, within 35 days after the provider received the claim. The provider's notice that the overpayment claim is being denied or contested must include a request for additional information. The provider's notice must identify the contested portion of the overpayment claim and the specific reason for contesting or denying the overpayment claim. If contested, the notice must include a request for additional information. If the insurer submits the additional information, the insurer must provide the information within 35 days after the receipt of the request and must mail or electronically transfer the information to the provider within that time. The provider must pay or deny the overpayment claim within n45 days after receipt of the information. Notice is considered made on the date the notice is mailed or electronically transferred by the provider.
- Failure to respond to a provider's contestment of the overpayment claim or request for additional information within the 35 days after receipt of the claim may result in the denial of the claim by the provider.
- An insurer is prohibited from reducing payment to a provider for other services unless the provider has agreed to the reduction in writing or has failed to respond to the insurer's overpayment claim, as required by this paragraph.
- Payment of an overpayment claim is considered made on the date the payment was mailed or electronically transferred. An overdue overpayment claim bears simple interest of 12 percent per year. Interest begins to accrue when the claim should have been paid, denied, or contested.

Paragraph (b) prohibits claims for overpayment beyond 30 months after the insurer's payment of a claim unless the provider has been convicted of fraud pursuant to s. 817.234, F.S., relating to false and fraudulent insurance claims.

Subsection (7) provides that payment of a claim is considered made on the date the payment was mailed or electronically transferred. Provides than an overdue payment bears simple interest at a

rate of 12 percent per year. Interest on an overdue payment for a claim or for any portion of claim begins to accrue when the claim should have been paid, denied, or contested. Requires the interest to be paid with the payment of the claim.

Subsection (8) requires, for all contracts entered into or renewed on or after October 1, 2002, an insurer's internal dispute resolution process related to a denied claim not under active review by a mediator, arbitrator, or third-party dispute entity to be finalized within 60 days of the receipt of the provider's request for review or appeal.

Subsection (9) prohibits providers or provider's designee from billing an insured or attempting to collect money, maintain a cause of action, or report to a credit reporting agency when the health insurer contests or denies a provider's claim or portion of a claim and specifies the time of the prohibition not to exceed 60 days.

Subsection (10) prohibits the provisions of this section from being waived, voided, or nullified by contract.

Subsection (11) prohibits retroactive denial of a claim due to insured ineligibility more than 1 year after the date of the payment of the claim.

Subsection (12) requires the health insurer to pay a contracted primary care or admitting physician, pursuant to the contract, for providing inpatient services in a contracted hospital to the insured if the services are determined by the insurer to be medically necessary and covered.

Subsection (13) requires an insurer, upon written notification by an insured, to investigate any claim of improper billing by a provider. Requires the insurer to determine if the insured was properly billed. If the insured was improperly billed, the insurer must notify the insured and the provider and must reduce the amount of the payment to the provider by the amount which was improperly billed. If a reduction is made due to the insured's notification, the insurer must pay the insured 20 percent of the amount of the reduction up to $500.

Subsection (14) specifies a permissive error ratio of 5 percent for the purposes of determining claims payment violations. Specifies method of calculation of error ratio, with fines for violations and such violations create an uncontestable obligation to pay a claim. Prohibits the department from assessing a fine for a violation which the department determines was due to circumstances beyond the insurer's control.

Subsection (15) limits the applicability of this section to major medical expense health insurance policies, as defined by statute, or individual health insurers licensed pursuant to statute, including specified preferred provider policies, exclusive provider organizations and group or individual dental insurance contracts.

Section 5. Creates s. 627.6135, F.S., relating to treatment authorization, as follows:

Subsection (1) specifies what an "authorization" is and specifies that each authorization request from a provider must be assigned a unique identification number by the health insurer.

Subsection (2) requires submitted authorization to be acknowledged and responded to based on a determination within a reasonable time appropriate to medical circumstances. Specifies that urgent care requests must take into account medical exigencies.

Subsection (3) requires each authorization to be assigned an identification number and must include: the date of the request; timeframe of the authorization; length of stay, if applicable; identification number of the authorization; place of service; and type of service.

Subsection (4) prohibits the denial of a claim for treatment if the provider follows the authorization process and receives authorization for a covered service of an eligible insured, unless the provider provided information with the intention to misinform the insurer.

Subsection (5) requires a health insurer making material changes to authorization procedures or requirements to notify all contracted providers at least 30 days prior to the implementation of the change and all noncontracted providers upon request, and provides that a health insurer that makes such procedures accessible to providers and insureds electronically at least 30 days prior to the implementation of the material change shall be deemed to be in compliance with this requirement.

Section 6. Amends s. 627.651(4), F.S., relating to group contracts, to correct a cross-reference.

Section 7. Amends and renumbers s. 627.662, F.S., relating to other provisions applicable to group health insurance, blanket health insurance, and franchise health insurance, to make applicable to such coverage the payment of claims and authorization requirements specified in the bill.

Section 8. Amends subsection (2) of s. 627.638, F.S., relating to direct payment for hospital and medical services, to specify that notwithstanding any contrary provisions contained in the insurance contract, payments must be made directly to the hospital, physician, or other licensed provider for services for the treatment of mental health or substance abuse, including drug and alcohol treatment if,

- The benefit is covered under the terms of the policy;
- The claim is limited to treatment of mental health or substance abuse, including drug and alcohol abuse; and
- The insured authorized the insurer, in writing, as part of the claim to make a direct payment to the recognized hospital, physician, or other licensed provider.

Section 9. Adds subsection (4) to s. 641.234, F.S, relating to health care service programs administrative, provider, and management contracts, as follows:

Requires an HMO which through a health care risk contract, transfers the HMO's obligation to pay any provider for any claims arising from services provided to or for the benefit of any subscriber of the HMO to any entity to remain responsible for any violations of the requirements related to payment of claims (s. 641.3155, F.S.) and requirements related to adverse determinations (s. 641.51(4), F.S.). Applies the provisions of ss. 624.418-624.4211, F.S., relating to various provisions of the Florida Insurance Code, to such violations. Provides the following definitions:

- "Health care risk contract" means a contract in which an entity receives compensation in exchange for providing to the HMO a provider network or other services. Such services may include administrative services.
- "Entity" does not include any provider or group practice (s. 456.053, F.S.), which provides services under the scope of the license of the provider or the members of the group practice.

Section 10. Amends subsection (1) of s. 641.30, F.S., relating to HMO contract construction and relationship to other laws, to delete obsolete language and provide a cross-reference relating to HMO claim forms pursuant to s. 641.3155, F.S.

Section 11. Adds paragraph (d) of subsection (4) of s. 641.3154, F.S., relating to HMO liability and timeframes of the prohibition from collecting money from a subscriber, maintaining a cause of action against a subscriber, or reporting to a credit agency of a subscriber, adding to the existing presumptions of a provider to know that an HMO is liable when the Agency issues a final order of the claim dispute resolution organization requiring the HMO to pay for services pursuant to s. 408.7057, F.S.

Section 12. Substantially rewrites s. 641.3155, F.S., relating to HMO payment of claims, as follows:

Subsection (1) provides definition of "claim" for institutional and noninstitutional providers, delivered to the HMO's designated location, as follows:

- Noninstutional providers: A paper or electronic billing instrument consisting of the HCFA 1500 data set, or its successor, with all mandatory entries for a physician licensed under chapter 458, chapter 459, chapter 460, chapter 461 or other appropriate billing instrument with all mandatory entries for any other noninstitutional provider.
- Institutional providers: A paper or electronic billing instrument consisting of the UB-92 data set or its successor that all mandatory entries.

Subsection (2) specifies for all claims, electronic or nonelectronic, the following:

- Specifies when claims for payment are considered received.
- Specifies that claims for payments must be mailed or electronically transferred to the HMO within 9 months after completion of the service by the provider.
- Prohibits submission of duplicate claims unless it is determined that the original claim was not received or is lost.

Subsection (3) specifies requirements for electronically submitted HMO claims, as follows:

Paragraph (a) requires that within 24 hours of the beginning of the next business day after the receipt of the claim electronic acknowledgement of the receipt of the claim be provided to the electronic source submitting the claim.

Paragraph (b) requires that within 20 days of the receipt of the claim, the HMO must pay the claim or notify the provider or designee if the claim is denied or contested. Notice of the HMO's action on the claim and payment of the claim is considered to be made on the date notice or payment was mailed or electronically transferred.

Subparagraph (c)1. requires that notification of a contested claim must be accompanied by an itemized list of additional information or documents reasonably necessary for the HMO to process the claim.

Subparagraph (c)2. requires that a provider must submit the requested additional information or documentation within 35 days of receipt of the notification. Failure to provide the requested information or documentation within the 35 days may result in denial of the claim.

Subparagraph (c)3. prohibits an HMO from making more than one request for documents under this paragraph in connection with a claim, unless the provider fails to submit all of the requested documents to process the claim. An additional request for more documents can be made if the documents submitted raise new additional issues which were not included in the original itemization. In such cases, the HMO may allow the provider one additional opportunity to submit additional documents needed to process the claim. Under no circumstances may an HMO request duplicate documents.

Paragraph (d) requires, for the purposes of this section, that electronic means of transmission of claims, notices, documents, forms, and payment must be used to the greatest extent possible by the HMO and the provider.

Paragraph (e) requires a claim to be paid or denied within 90 days of the receipt of the claim. Provides that failure to pay or deny a claim within 120 days after the receipt of the claim creates an uncontestable obligation to pay the claim.

Subsection (4) specifies for nonelectronically submitted HMO claims, as follows:

Paragraph (a), beginning November 1, 2003, requires the provision of acknowledgement of the receipt of the claim to the provider within 15 days of receipt of the claim or provide a provider within 15 days of receipt with electronic access to the status of a submitted claim. [Note: The November 1, 2003, effective date only applies to this paragraph.]

Paragraph (b) requires that within 40 days of receipt of the claim, the HMO must pay the claim or notify the provider or the provider's designee that the claim is denied or contested. Notification of a claim or payment of a claim is considered to have been made on the date the notice or payment was mailed or electronically transferred.

Subparagraph (c)1. requires notification of the HMO's determination of a contested claim to be accompanied by an itemized list of additional information or documents reasonably necessary for the HMO to process the claim.

Subparagraph 2. requires a provider to submit the requested additional documentation or information within 35 days of receipt of the notification. Failure to submit by mail or electronically the requested additional information or documentation within the 35 days may result in the denial of the claim.

Subparagraph 3. prohibits an HMO from making more than one request for documents in connection with a claim except when a provider fails to submit all the requested documents or if the documents submitted raise new additional issues not included in the original written request, however, the HMO may provide the provider one additional opportunity to submit the additional documents needed to process the claim. Prohibits the HMO from requesting duplicate documents.

Paragraph (d) requires for the purposes of this subsection, electronic means of transmission of claims, notices, documents, forms, and payment to be used to the greatest extent possible by the HMO and provider.

Paragraph (e) requires all claims to be paid or denied within 120 days after receipt of the claim. Creates an uncontestable obligation to pay the claim if the claim is not paid or denied within 140 days after the receipt of the claim.

Subsection (5) requires an HMO to make a claim for overpayment if it determines that an overpayment has occurred. Requires an HMO to give the provider a written or electronic statement

specifying the basis for the retroactive denial or payment. Requires the HMO to identify the claim or claims, or overpayment claim portion of the claim.

Paragraph (a) requires that in the case where an overpayment determination is the result of a retroactive review or audit of coverage decisions or payment levels not related to fraud, the HMO must do the following:

- Submit the claim for overpayment to the provider within 30 months after the HMO's payment of the claim. The provider must pay, deny, or contest the claim for overpayment within 40 days of the receipt of the claim. Requires all contested claims for overpayment to be paid or denied within 120 days of the receipt of the claim. Failure to pay or deny the claim for overpayment within 140 days of receipt creates an uncontestable obligation to pay the overpayment claim.
- Providers that deny or contest a claim for overpayment or any portion of the claim for overpayment must notify the HMO, in writing, within 35 days after the provider received the claim. The provider's notice that the overpayment claim is being denied or contested must include a request for additional information. The provider's notice must identify the contested portion of the overpayment claim and the specific reason for contesting or denying the overpayment claim. If contested, the notice must include a request for additional information. If the HMO submits the additional information, the HMO must provide the information within 35 days after the receipt of the request and must mail or electronically transfer the information to the provider within that time. The provider must pay or deny the overpayment claim within 45 days after receipt of the information. Notice is considered made on the date the notice is mailed or electronically transferred by the provider.
- Failure to respond to a provider's contestment of the overpayment claim or request for additional information within the 35 days after receipt of the claim may result in the denial of the claim by the provider.
- An HMO is prohibited from reducing payment to a provider for other services unless the provider has agreed to the reduction in writing or has failed to respond to the HMO's overpayment claim, as required by this paragraph.
- Provides that a payment for an overpayment claim is considered made on the date the payment was mailed or electronically transferred. Provides that an overdue payment for a claim for overpayment bears a simple interest rate of 12 percent per year. Provides that interest begins to accrue on an overdue payment for claim on the date when the claim should have been paid, denied, or contested.

Paragraph (b) prohibits claims for overpayment beyond 30 months after the HMO's payment of a claim unless the provider has been convicted of fraud pursuant to s. 817.234, F.S., relating to false and fraudulent insurance claims.

Subsection (6) provides that payment of a claim is considered made on the date the payment was mailed or electronically transferred. Provides than an overdue payment bears simple interest at a rate of 12 percent per year. Interest on an overdue payment for a claim or for any portion of claim begins to accrue when the claim should have been paid, denied, or contested. Requires the interest to be paid with the payment of the claim.

Paragraph (7)(a) requires, for all contracts entered into or renewed on or after October 1, 2002, an HMO's internal dispute resolution process related to a denied claim not under active review by a mediator, arbitrator, or third-party dispute entity to be finalized within 60 days of the receipt of the provider's request for review or appeal.

Paragraph (b) requires all HMO claims begun after October 1, 2000, which are not under active review by a mediator, arbitrator, or third-party dispute entity, to have a final decision on the clam by the HMO by January 2, 2003, for the purposes of the statewide provider and managed care organization claim dispute resolution program pursuant to s. 408.7057, F.S.

Subsection (8) prohibits providers or provider's designee from billing a subscriber or attempting to collect money, maintain a cause of action, or report to a credit reporting agency when the HMO contests or denies a provider's claim or portion of a claim and specifies the time of the prohibition not to exceed 60 days.

Subsection (9) prohibits the provisions of this section from being waived, voided, or nullified by contract.

Subsection (10) prohibits retroactive denial of a claim due to subscriber ineligibility more than 1 year after the date of the payment of the claim.

Subsection (11) requires the HMO to pay a contracted primary care or admitting physician, pursuant to the contract, for providing inpatient services in a contracted hospital to the subscriber if the services are determined by the HMO to be medically necessary and covered.

Subsection (12) requires an HMO, upon written notification by an HMO, to investigate any claim of improper billing by a provider. Requires the HMO to determine if the subscriber was properly billed. If the HMO was improperly billed, the HMO must notify the subscriber and the provider and must reduce the amount of the payment to the provider by the amount which was improperly billed. If a reduction is made due to the subscriber's notification, the HMO must pay the subscriber 20 percent of the amount of the reduction up to $500.

Subsection (13) specifies a permissive error ratio of 5 percent for the purposes of determining claims payment violations. Specifies method of calculation of error ratio, with fines for violations and such violations create an uncontestable obligation to pay a claim. Prohibits the department from assessing a fine for a violation which the department determines was due to circumstances beyond the HMO's control.

Section 13. Amends s. 641.3156, F.S., relating to treatment authorization and payment of claims, as follows:

Amends subsection (1) to specify, for the purposes of this section, an "authorization" is "any requirement of a provider to obtain prior approval or to provide documentation relating to the necessity of a covered medical treatment or service as a condition for reimbursement for treatment or service prior to the treatment or service." Specifies that each authorization request from a provider must be assigned an identification number by the HMO. Deletes existing language requiring an HMO to pay any hospital service or referral service claim for treatment of an eligible subscriber if it was authorized by a provider empowered by contract with the HMO to authorize or direct the patient's use of health care services which was in accordance with the HMO's current and communicated procedures, except if the provider provided information with the willful intent to misinform the HMO.

Adds new subsection (3) to require submitted authorization to be acknowledged and responded to based on a determination within a reasonable time appropriate to medical circumstances. Specifies that urgent care requests must take into account medical exigencies.

Adds subsection (4) to require each authorization to be assigned an identification number and to include: the date of the request; timeframe of the authorization; length of stay, if applicable; identification number of the authorization; place of service; and type of service.

Adds subsection (5) to prohibit the denial of a claim for treatment if the provider followed the authorization process and receives authorization for a covered service of an eligible subscriber, unless the provider provided information with the intention to misinform the insurer. Requires a health maintenance organization making material changes to authorization procedures or requirements to notify all contracted providers at least 30 days prior to the implementation of the change and all noncontracted providers upon request, and provides that a health maintenance organization that makes such procedures accessible to providers and subscribers electronically at least 30 days prior to the implementation of the material change shall be deemed to be in compliance with this requirement.

Renumbers subsection (3) as subsection (6), relating to emergency services.

Section 14. Specifies that, except as otherwise provided, this act takes effect October 1, 2002, and applies to all claims for services rendered after that date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

According to AHCA:	Year 1 FY 02-03	Year 2 FY 03-04
Licenses:	$0	$0
Fees:	$(352,000)	$(352,000)
Grants:	$0	$0
Transfers In/ Another Agency	$0	$0
Total Recurring Revenues	**$(352,000)**	**$(352,000)**

2. Expenditures:

The Department of Insurance will incur costs relating to monitoring activities.

The bill may result in increased costs in providing health benefits coverage to employees.

According to the Agency for Health Care Administration: The bill has a direct fiscal impact on the Agency because it permits all health insurers licensed under Chapter 627, F.S., to access the Statewide Provider and Managed Care Claim Dispute Resolution Program. Currently, only managed care organizations licensed under Chapter 641, F.S., can access the program. The Agency is responsible for issuing final orders for all claim disputes submitted to the Statewide Provider and Managed Care Claim Dispute Resolution Program. While the current caseload has been very low and far below the expectations of the Agency, the inclusion of additional health insurance providers under this program, may increase the caseload.

Fiscal Impact on the Agency for Health Care Administration

Expenditures – Non-Recurring	**Amount Year 1 (FY 02-03)**	**Amount Year 2 (FY 03-04)**
Expense	$ 2,59	$0

OCO	$ 1,389	$0
Total Non-Recurring Expenditures	**$ 4,048**	**$0**
Expenditures – Recurring		
1 Senior Attorney (PG 230)		
(Lapsed for 10/01/02 effective date)		
Salaries	$45,386	$60,515
Expense (Agency standard package)	$ 8,293	$11,057
Total Recurring Expenditures	**$53,679**	**$71,572**
Subtotal Non-Recurring Expenditures	$ 4,048	$0
Subtotal Recurring Expenditures	$53,679	$71,572
Total Expenditures	**S57,727**	**$71,572**

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

This bill may result in increased costs in providing health benefits coverage to employees.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Hospitals meeting the requirements of providing 10% of services to Medicaid and Charity patients would no longer be required to apply for a CON for hospital services, long-term care hospital services, tertiary services excluding solid organ transplants, thereby eliminating the CON application fees (statutorily defined fee based at a minimum of $5,000 and which is capped at $22,000), any related cost of preparing the applications, and possible legal cost if the Agency's action is challenged. It is unknown whether the Agency's grant of an exemption would result in a legal challenge from a competing hospital.

According to AHCA, if new programs take patients away from the existing programs, and if exemptions would authorize more programs than the amended current review requirements, then the annual revenue from lucrative programs could be reduced at existing facilities.

Providers of health care services should receive more timely reimbursement and potentially greater reimbursement under the provisions of this bill.

The provisions of this bill may result in increased costs to health insurers and HMOs as a result of the following:

- Numerous opportunities for an uncontestable obligation for an HMO or health insurer to pay a claim which can occur when an HMO or health insurer misses a timeframe, regardless whether the service or treatment is covered or medically necessary.
- An HMO or health insurer may, at times, pay for services or treatment twice as the HMO and health insurer are ultimately responsible for the payment of these services to providers even when the HMO or health insurer have contracted with entities to provide such services.

D. FISCAL COMMENTS:

AHCA anticipates a reduction in CON application reviews for services that were previously subject to CON review. There may be a need to reduce staff or expenses in relation to the reduced volume of activity of CON reviews. However, there would be an increase in exemption reviews and it is unclear weather or not the decrease in CON reviews will provide for greater activity of exemption review.

Hospitals meeting the provisions set forth in the bill as it relates to the exemption of a CON for Open Heart Surgery Programs will no longer be required to apply for a CON for an open heart surgery program, thereby eliminating the CON application fees (statutorily defined fee based at a minimum of $5,000 and which is capped at $22,000), any related cost of preparing the applications, and possible legal cost if the Agency's action is challenged. It is unknown whether the Agency's grant of an exemption would result in a legal challenge from a competing hospital.

According to AHCA, assuming that new programs take patients away from the existing programs, and assuming that exemptions would authorize more new adult open heart surgery programs than the amended current review requirements, then the annual revenue from open heart surgery programs could be reduced at existing facilities.

According to the Agency for Health Care Administration, the bill has a fiscal impact on health insurers and HMOs by shortening payment timeframes, shortening treatment authorization periods, and implementing stricter penalties for any violation of the prompt pay provisions.

The bill appears to have a direct fiscal impact on the Department of Insurance. Under the provisions of this bill, the department is required to expand its monitoring activities. In addition, the bill provides for a permissive error rate of 5 percent which can only be determined by department monitoring of insurers and HMOs, thereby requiring additional enforcement activities by the department.

III. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not require counties or municipalities to spend funds or to take actions requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce the authority that municipalities or counties have to raise revenues in the expenditure of funds.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of state tax shared with counties or municipalities.

IV. COMMENTS:

A. CONSTITUTIONAL ISSUES:

None.

B. RULE-MAKING AUTHORITY:

This bill gives AHCA the authority to promulgate rules for the exemption of services.

C. OTHER COMMENTS:

Provisions of open heart surgery programs at medical facilities require specialized medical and nursing professionals. Competition among hospitals for the limited number of professionals with specialized training may result in an increase demand for such professionals, thereby increasing the hospital's cost for salary and wages.

V. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

None.

VI. SIGNATURES:

COUNCIL FOR HEALTHY COMMUNITIES:

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