SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

BILL: CS/SB 256

SPONSOR: Health, Aging and Long-Term Care Committee

SUBJECT: Statewide Provider and Subscriber Assistance Program

DATE: January 9, 2002 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Munroe	Wilson	HC	Favorable/CS
2.	Johnson	Deffenbaugh	BI	Favorable
3.			AHS	
4.			AP	
5.				
6.				

I. Summary:

The committee substitute redesignates the Statewide Provider and Subscriber Assistance Program (SPSAP) as the Subscriber Assistance Program and the Statewide Provider and Subscriber Assistance Panel as the Subscriber Assistance Panel. A managed care entity, subscriber, or provider is authorized to submit additional information to supplement the record before the Subscriber Assistance Panel within 5 working days after the hearing of a grievance. The committee substitute provides that the record for a subscriber grievance is closed 5 working days after the hearing of a grievance and requires the Subscriber Assistance Panel to issue a written recommendation no later than 10 working days after the record is closed. The committee substitute establishes procedures for handling a tie vote in the event of a deadlock by the Subscriber Assistance Panel.

The Agency for Health Care Administration's (AHCA) authority to obtain records from health care providers and managed care entities associated with subscriber grievances is expanded to include all medical records, all telephone communication logs associated with the grievance both to and from the subscriber, and any other contents of the internal grievance file associated with the complaint filed with the Subscriber Assistance Program. The agency must impose a fine of up to $500 for each day that the requested records are not produced.

The committee substitute revises procedures for AHCA's or the Department of Insurance's (DOI or department) review of the panel's recommendations for a managed care entity to take specific actions in resolution of a subscriber's grievance. The agency or DOI is required to issue a proposed final order or an emergency order no later than 30 days after the issuance of the panel's recommendation and for an expedited grievance, no later than 10 days after the issuance of the panel's recommendation. The agency or department may delay issuance of a proposed final order or emergency order if the agency or department finds that additional investigative information is

needed to resolve the subscriber's grievance or if the agency or department finds that the panel has improvidently issued the panel's recommendation or findings of fact. The agency or department may reject all or part of the panel's recommendation or amend the panel's findings of fact based upon: written exceptions provided in opposition to the panel's recommendation or findings of fact; facts that the agency or department has discovered at such times when additional investigative information is required; or the agency's or department's finding that the panel's recommendation or findings of fact have been improvidently issued.

The committee substitute requires AHCA to develop a training program for panel members. The committee substitute clarifies that managed care organizations must give subscribers notice of the right to seek resolution of an urgent grievance when a difference of opinion exists.

This committee substitute substantially amends sections 408.7056, 641.3154, 641.511 and 641.58, Florida Statutes.

II. Present Situation:

Florida's External Review Process

Section 641.47(1), F.S., defines the term "adverse determination" to mean a coverage determination by a health maintenance organization (HMO) or prepaid health clinic that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the organization's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and coverage for the requested service is therefore denied, reduced, or terminated. An adverse determination may be the basis for a grievance. A subscriber who chooses to challenge an adverse determination or file another type of grievance is required, under Florida law, to first go through the managed care entity's internal grievance procedure. Once a final decision is rendered through this process, if the decision is unsatisfactory to the subscriber, then the subscriber may appeal through a binding arbitration process provided by the managed care entity or to the Statewide Provider and Subscriber Assistance Program.

Internal Grievance Procedures for HMOs

Section 641.511, F.S., specifies requirements for HMO subscriber grievance reporting and resolution. An HMO must maintain records of all grievances and annually submit a report to AHCA that delineates the total number of grievances handled, a categorization of the cases underlying the grievances, and the resolution of the grievances. Additionally, HMOs are required to send to AHCA and DOI quarterly reports, which are forwarded to the SPSAP under s. 408.7056, F.S., that list the number and nature of all grievances that have not been resolved to the subscriber's or provider's satisfaction after the entire internal grievance procedure of the HMO has been completed.

The internal grievance procedure of an HMO begins with submission of an initial complaint by a subscriber. Organizations are required to respond to an initial complaint within a reasonable time after its submission; advise subscribers of their right to file a written grievance; and establish a procedure for addressing urgent grievances, including the use of expedited review of such

grievances. Also, Florida law provides for emergency review within 24 hours, as a part of the external review process through the SPSAP, when AHCA determines that the life of a subscriber is in imminent and emergent jeopardy.

Each HMO must: 1) advise subscribers of their right to file a written grievance with the HMO within 365 days after the date of occurrence of the incident on which the grievance is based; 2) inform subscribers that the organization must assist in the preparation of the written grievance; and 3) advise that, following the organization's final disposition of the grievance, the subscriber, if not satisfied with the outcome, may submit the grievance to the SPSAP. When a grievance concerns an adverse determination, the HMO is required to make available to the subscriber a review of the grievance by an internal review panel. The subscriber, or provider acting on the subscriber's behalf, must request the review within 30 days after the HMO's transmittal of the final determination notice of the adverse determination. The majority of the review panel must be comprised of persons not previously involved in rendering the adverse determination and the HMO must ensure that a majority of the persons reviewing a grievance involving an adverse determination are health care providers who have appropriate expertise. A person involved in rendering the adverse determination may appear before the panel. The HMO to bind the entity to the review panel's decision must give the review panel. Voluntary binding arbitration, as provided under the terms of the contract under which services are provided, if offered by the HMO, may be used as an alternative to the SPSAP. HMOs must notify subscribers that use of the arbitration option may result in costs to the subscriber. HMOs are subject to administrative sanctions for not complying with the grievance procedure.

The Agency for Health Care Administration must investigate unresolved quality-of-care grievances received from HMO annual and quarterly grievance reports as well as subscriber appeals of grievances that have gone through the HMO's full grievance procedure. Although AHCA may investigate a subscriber's grievance before completion of an HMO's consideration through its grievance procedure, AHCA must advise the subscriber that it is unable to take action on the complaint until the HMO's internal grievance process has been exhausted. If a subscriber's grievance is not resolved to the satisfaction of the subscriber after completion of the HMO's internal grievance procedure, AHCA staff may then act on the grievance and refer it to the SPSAP for review.

Statewide Provider and Subscriber Assistance Program

Section 408.7056, F.S., requires AHCA to implement the SPSAP to assist subscribers of managed care entities with grievances that have not been satisfactorily resolved through the managed care entity's internal grievance process. The program can hear grievances of subscribers of health maintenance organizations, prepaid health clinics, and exclusive provider organizations.

Section 408.7056(11), F.S., provides that the panel must consist of members employed by AHCA and members employed by DOI, chosen by their respective agencies; a consumer appointed by the Governor; a physician appointed by the Governor, as a standing member; and physicians who have expertise relevant to the case to be heard, on a rotating basis. The agency may contract with a medical director and a primary care physician who may provide additional expertise. The medical director must be selected from a Florida licensed HMO.

Currently, the 7-member panel consists of three members employed or contracted by AHCA (the manager of the AHCA Managed Care Commercial Compliance Unit, a physician consultant employed by the Department of Health, and a senior management analyst from AHCA); three members employed by DOI (the DOI chief of staff, the deputy insurance commissioner, and the consumer advocate); and a consumer appointed by the Governor. Additionally, physicians who have expertise relevant to the case under consideration must be appointed on a rotating basis. The specialist physician is chosen from a list of qualified physicians who have agreed to participate as needed. The agency may contract with a physician to provide the program panel with technical expertise.

The agency must review a case within 60 days after its receipt of the grievance from a subscriber. If AHCA determines the panel must hear the grievance, it must be heard in person or by phone within 120 days after the grievance was filed. The agency must notify the subscriber in writing, by facsimile, or by telephone of the time and place that a hearing has been scheduled. The panel must issue its written recommendations to the subscriber, AHCA, DOI, and the managed care entity within 15 working days after the hearing occurred, unless additional information has been requested, in which case, the 15 day time is tolled until the information is received.

Under certain circumstances the time periods for hearing and recommendation are expedited. In cases in which there is an immediate and serious threat to the subscriber's health, such a grievance is designated urgent and is given priority over the panel's pending caseload. The panel must hear an urgent grievance within 45 days after AHCA receives it as an expedited hearing. The agency or department must decide whether or not to issue a final order within 10 days after the receipt of the panel's recommendation and issue such an order, if it is determined to be appropriate. An "emergency" hearing may be convened within 24 hours when the life of the subscriber is in imminent and emergent jeopardy. The panel will hear the emergency grievance, by telephone conference call, even though the HMO's formal grievance procedure has not been completed. The agency or department may issue an emergency order to the HMO within 24 hours after the panel completes an emergency hearing.

All panel hearings are conducted by videoconference in Tallahassee to major metropolitan areas of the state. Hearings are public, unless the subscriber requests a closed hearing or a portion of a meeting may be closed by the panel when deliberating information of a sensitive personal nature such as information from medical records. The panel meets as often as necessary to timely review, consider, and hear grievances about disputes between a subscriber, or a provider on behalf of a subscriber, and a managed care entity. Following its review, the panel must make a recommendation to AHCA or DOI. The recommendation may include specific actions the managed care entity must take to comply with state laws or rules regarding such entities. The proceedings of the panel are not subject to the requirements of the Administrative Procedure Act. The agency has not adopted administrative rules to establish practices and procedures for the panel.

If the panel rules in favor of the subscriber, the panel attorney drafts a recommendation. The affected managed care entity, subscriber, or provider may within 10 days after receipt of the recommendation file written evidence in opposition to the panel's recommendation or findings.

The agency or department has the discretion to adopt all, part, or none of the panel's recommendation within 30 days after the panel issues the recommendation or findings of fact by issuing a proposed order or an emergency order. Such an order may impose a fine or sanctions, as prescribed by state law, on the managed care entity against which the grievance was filed. Although AHCA or DOI may accept or reject the panel's recommendations within 30 days after the issuance of the panel's recommendation, neither agency is affirmatively required to take any action within a specified time period.

A managed care entity may appeal to the Division of Administrative Hearings (DOAH) a proposed or emergency order issued by AHCA or DOI against it when the order only requires the entity to take a specific action, unless all parties agree otherwise. The division must hold a summary hearing for consideration of such orders. If the managed care entity does not prevail in its appeal to DOAH, it must pay AHCA's or DOI's reasonable costs and attorney's fees incurred as a result of the proceeding. Subscribers are not permitted to appeal the panel recommendations to DOAH when the recommendations are subsequently adopted as an order by AHCA or DOI.

Senate Interim Project Report 2002-138

Staff reviewed the SPSAP and recommended a number of minor substantive and technical changes to improve the program. Staff's findings and recommendation are detailed in *Interim Project Report 2002-138*.

III. Effect of Proposed Changes:

The committee substitute redesignates the Statewide Provider and Subscriber Assistance Program (SPSAP) as the Subscriber Assistance Program and the Statewide Provider and Subscriber Assistance Panel as the Subscriber Assistance Panel. A managed care entity, subscriber, or provider is authorized to submit additional information to supplement the record before the Subscriber Assistance Panel within 5 working days after the hearing of a grievance. The committee substitute provides that the record for a subscriber grievance is closed 5 working days after the hearing of a grievance and requires the Subscriber Assistance Panel to issue a written recommendation no later than 10 working days after the record is closed. The committee substitute establishes procedures for handling a tie vote in the event of a deadlock by the Subscriber Assistance Panel. The committee substitute clarifies that, except as provided in s. 408.7056, F.S., the proceedings of the panel are not subject to the Administrative Procedure Act.[1]

The Agency for Health Care Administration's authority to obtain records from health care providers and managed care entities associated with subscriber grievances is expanded to include all medical records, all telephone communication logs associated with the grievance both to and from the subscriber, and any other contents of the internal grievance file associated with the complaint filed with the Subscriber Assistance Program. The agency must impose a fine of up to $500 for each day that the requested records are not produced. Presently, the agency has the discretionary authority to impose a fine.

[1] Chapter 120, F.S.

The committee substitute requires AHCA or DOI to issue a proposed final order or an emergency order no later than 30 days after the issuance of the panel's recommendation and for an expedited grievance, no later than 10 days after the issuance of the panel's recommendation. The agency or department may delay issuance of a proposed final order or emergency order if the agency or department finds that additional investigative information is needed to resolve the subscriber's grievance or if the agency or department finds that the panel has improvidently issued the panel's recommendation or findings of fact. The agency or department may reject all or part of the panel's recommendation or amend the panel's findings of fact based upon: 1) written exceptions provided in opposition to the panel's recommendation or findings of fact; 2) facts that the agency or department has discovered at such times when additional investigative information is required; or 3) the agency's or department's finding that the panel's recommendation or findings of fact have been improvidently issued.

The committee substitute requires AHCA to develop a training program for persons appointed to membership on the panel. The program must familiarize such persons with the substantive and procedural laws and rules regarding their responsibilities on the panel, including training with respect to the panel's past recommendations and any subsequent agency action by the agency or department in such cases.

The committee substitute amends s. 641.511, F.S., to clarify that managed care organizations must give subscribers notice of the right to seek resolution of an urgent grievance when a difference of opinion exists.

The effective date of the committee substitute is July 1, 2002.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

None.