By the Committee on Health, Aging and Long-Term Care

317-836-02

A bill to be entitled

An act relating to the Subscriber Assistance Program; amending s. 408.7056, F.S.; redesignating the Statewide Provider and Subscriber Assistance Program as the Subscriber Assistance Program; requiring the Subscriber Assistance Panel to hold the record of a grievance hearing open for a specified period after the hearing; revising the Agency for Health Care Administration's authority to obtain records associated with subscriber grievances; requiring the Agency for Health Care Administration to impose a fine for each violation relating to the production of records from a health care provider or managed care entity; specifying procedures for handling a tie vote by the the Subscriber Assistance Panel; specifying circumstances under which the agency or the Department of Insurance may delay issuance of a proposed final order or emergency order recommended by the panel; requiring that the Agency for Health Care Administration develop a training program for panel members; amending ss. 641.3154, 641.511, 641.58, F.S.; redesignating the Statewide Provider and Subscriber Assistance Panel as the Subscriber Assistance Panel; requiring that a subscriber or the provider acting on behalf of a subscriber be notified of the right to submit a written grievance if a case is unresolved; providing an effective date.

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

Section 1. Section 408.7056, Florida Statutes, is amended to read:

408.7056 ~~Statewide Provider and~~ Subscriber Assistance Program.--

(1) As used in this section, the term:

(a) "Agency" means the Agency for Health Care Administration.

(b) "Department" means the Department of Insurance.

(c) "Grievance procedure" means an established set of rules that specify a process for appeal of an organizational decision.

(d) "Health care provider" or "provider" means a state-licensed or state-authorized facility, a facility principally supported by a local government or by funds from a charitable organization that holds a current exemption from federal income tax under s. 501(c)(3) of the Internal Revenue Code, a licensed practitioner, a county health department established under part I of chapter 154, a prescribed pediatric extended care center defined in s. 400.902, a federally supported primary care program such as a migrant health center or a community health center authorized under s. 329 or s. 330 of the United States Public Health Services Act that delivers health care services to individuals, or a community facility that receives funds from the state under the Community Alcohol, Drug Abuse, and Mental Health Services Act and provides mental health services to individuals.

(e) "Managed care entity" means a health maintenance organization or a prepaid health clinic certified under chapter 641, a prepaid health plan authorized under s.

409.912, or an exclusive provider organization certified under s. 627.6472.

(f) "Panel" means a ~~statewide provider and~~ subscriber assistance panel selected as provided in subsection (11).

(2) The agency shall adopt and implement a program to provide assistance to subscribers and providers, including those whose grievances are not resolved by the managed care entity to the satisfaction of the subscriber or provider. The program shall consist of one or more panels that meet as often as necessary to timely review, consider, and hear grievances and recommend to the agency or the department any actions that should be taken concerning individual cases heard by the panel. The panel shall hear every grievance filed by subscribers and providers on behalf of subscribers, unless the grievance:

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

(b) Is part of an internal grievance in a Medicare managed care entity or a reconsideration appeal through the Medicare appeals process which does not involve a quality of care issue;

(c) Is related to a health plan not regulated by the state such as an administrative services organization, third-party administrator, or federal employee health benefit program;

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

(e) Is part of a Medicaid fair hearing pursued under 42 C.F.R. ss. 431.220 et seq.;

(f) Is the basis for an action pending in state or federal court;

(g) Is related to an appeal by nonparticipating providers, unless related to the quality of care provided to a subscriber by the managed care entity and the provider is involved in the care provided to the subscriber;

(h) Was filed before the subscriber or provider completed the entire internal grievance procedure of the managed care entity, the managed care entity has complied with its timeframes for completing the internal grievance procedure, and the circumstances described in subsection (6) do not apply;

(i) Has been resolved to the satisfaction of the subscriber or provider who filed the grievance, unless the managed care entity's initial action is egregious or may be indicative of a pattern of inappropriate behavior;

(j) Is limited to seeking damages for pain and suffering, lost wages, or other incidental expenses, including accrued interest on unpaid balances, court costs, and transportation costs associated with a grievance procedure;

(k) Is limited to issues involving conduct of a health care provider or facility, staff member, or employee of a managed care entity which constitute grounds for disciplinary action by the appropriate professional licensing board and is not indicative of a pattern of inappropriate behavior, and the agency or department has reported these grievances to the appropriate professional licensing board or to the health facility regulation section of the agency for possible investigation; or

(l) Is withdrawn by the subscriber or provider. Failure of the subscriber or the provider to attend the hearing shall be considered a withdrawal of the grievance.

(3) The agency shall review all grievances within 60 days after receipt and make a determination whether the grievance shall be heard. Once the agency notifies the panel, the subscriber or provider, and the managed care entity that a grievance will be heard by the panel, the panel shall hear the grievance either in the network area or by teleconference no later than 120 days after the date the grievance was filed. The agency shall notify the parties, in writing, by facsimile transmission, or by phone, of the time and place of the hearing. The panel may take testimony under oath, request certified copies of documents, and take similar actions to collect information and documentation that will assist the panel in making findings of fact and a recommendation. A managed care entity, subscriber, or provider may within 5 working days after the hearing of the grievance submit additional information to supplement the record before the panel. Five working days after the hearing of the grievance, the record shall be closed.The panel shall issue a written recommendation, supported by findings of fact, to the provider or subscriber, to the managed care entity, and to the agency or the department no later than 10 ~~15~~ working days after the record is closed ~~hearing the grievance~~. If at the hearing the panel requests additional documentation or additional records, the time for issuing a recommendation is tolled until the information or documentation requested has been provided to the panel. Except as provided in this section,the proceedings of the panel are not subject to chapter 120. In the event of a tie vote by the panel, the tie shall be decided

by a second vote and additional votes if necessary. In the event of a deadlock, defined as three consecutive votes resulting in a tie vote, such deadlock shall result in a recommendation by the panel that no further action should be taken by the agency or department.

(4) If, upon receiving a proper patient authorization along with a properly filed grievance, the agency requests medical records from a health care provider or managed care entity, the health care provider or managed care entity that has custody of the records has 10 days to provide the records to the agency. Records 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. ~~Failure to provide requested medical records may result in the imposition of a fine of up to $500.~~ Each day that records are not produced is considered a separate violation.

(5) Grievances that the agency determines pose an immediate and serious threat to a subscriber's health must be given priority over other grievances. The panel may meet at the call of the chair to hear the grievances as quickly as possible but no later than 45 days after the date the grievance is filed, unless the panel receives a waiver of the time requirement from the subscriber. The panel shall issue a written recommendation, supported by findings of fact, to the department or the agency within 10 days after hearing the expedited grievance.

(6) When the agency determines that the life of a subscriber is in imminent and emergent jeopardy, the chair of the panel may convene an emergency hearing, within 24 hours after notification to the managed care entity and to the subscriber, to hear the grievance. The grievance must be heard notwithstanding that the subscriber has not completed the internal grievance procedure of the managed care entity. The panel shall, upon hearing the grievance, issue a written emergency recommendation, supported by findings of fact, to the managed care entity, to the subscriber, and to the agency or the department for the purpose of deferring the imminent and emergent jeopardy to the subscriber's life. Within 24 hours after receipt of the panel's emergency recommendation, the agency or department may issue an emergency order to the managed care entity. An emergency order remains in force until:

(a) The grievance has been resolved by the managed care entity;

(b) Medical intervention is no longer necessary; or

(c) The panel has conducted a full hearing under subsection (3) and issued a recommendation to the agency or the department, and the agency or department has issued a final order.

(7) After hearing a grievance, the panel shall make a recommendation to the agency or the department which may include specific actions the managed care entity must take to comply with state laws or rules regulating managed care entities.

(8) A managed care entity, subscriber, or provider that is affected by a panel recommendation may within 10 days after receipt of the panel's recommendation, or 72 hours after

receipt of a recommendation in an expedited grievance, furnish to the agency or department written exceptions ~~evidence~~ in opposition to the recommendation or findings of fact of the panel.

(9) No later than 30 days after the issuance of the panel's recommendation and, for an expedited grievance, no later than 10 days after the issuance of the panel's recommendation, the agency or the department shall issue ~~may adopt the panel's recommendation or findings of fact in~~ a proposed final order or an emergency order, as provided in chapter 120, which it shall issue to the managed care entity. However, 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's recommendation or findings of fact have been improvidently issued by the panel. The agency or department may issue a proposed final order or an emergency order, as provided in chapter 120, imposing fines or sanctions, including those contained in ss. 641.25 and 641.52. The agency or the department may reject all or part of the panel's recommendation or amend the panel's findings of fact based upon:

(a) Written exceptions provided in opposition to the panel's recommendation or findings of fact;

(b) Facts that the agency or department has discovered at such times when additional investigative information is required; or

(c) The agency's or department's finding that the panel's recommendation or findings of fact have been improvidently issued.

All fines collected under this subsection must be deposited into the Health Care Trust Fund.

(10) In determining any fine or sanction to be imposed, the agency and the department may consider the following factors:

(a) The severity of the noncompliance, including the probability that death or serious harm to the health or safety of the subscriber will result or has resulted, the severity of the actual or potential harm, and the extent to which provisions of chapter 641 were violated.

(b) Actions taken by the managed care entity to resolve or remedy any quality-of-care grievance.

(c) Any previous incidents of noncompliance by the managed care entity.

(d) Any other relevant factors the agency or department considers appropriate in a particular grievance.

(11) The panel shall consist of members employed by the agency and members employed by the department, chosen by their respective agencies; a consumer appointed by the Governor; a physician appointed by the Governor, as a standing member; and physicians who have expertise relevant to the case to be heard, on a rotating basis. The agency may contract with a medical director and a primary care physician who shall provide additional technical expertise to the panel. The medical director shall be selected from a health maintenance organization with a current certificate of authority to operate in Florida. The agency shall develop a training program for persons appointed to membership on the panel. The program shall 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.

(12) Every managed care entity shall submit a quarterly report to the agency and the department listing the number and the nature of all subscribers' and providers' grievances that ~~which~~ have not been resolved to the satisfaction of the subscriber or provider after the subscriber or provider follows the entire internal grievance procedure of the managed care entity. The agency shall notify all subscribers and providers included in the quarterly reports of their right to file an unresolved grievance with the panel.

(13) Any information that ~~which~~ would identify a subscriber or the spouse, relative, or guardian of a subscriber and that ~~which~~ is contained in a report obtained by the Department of Insurance pursuant to this section is confidential and exempt from ~~the provisions of~~ s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

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

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

agency pursuant to this section is confidential and exempt from ~~the provisions of~~ s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

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

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

Section 2. Subsection (4) of section 641.3154, Florida Statutes, is amended to read:

641.3154 Organization liability; provider billing prohibited.--

(4) A provider or any representative of a provider, regardless of whether the provider is under contract with the health maintenance organization, may not collect or attempt to

collect money from, maintain any action at law against, or report to a credit agency a subscriber of an organization for payment of services for which the organization is liable, if the provider in good faith knows or should know that the organization is liable. This prohibition applies during the pendency of any claim for payment made by the provider to the organization for payment of the services and any legal proceedings or dispute resolution process to determine whether the organization is liable for the services if the provider is informed that such proceedings are taking place. It is presumed that a provider does not know and should not know that an organization is liable unless:

(a) The provider is informed by the organization that it accepts liability;

(b) A court of competent jurisdiction determines that the organization is liable; or

(c) The department or agency makes a final determination that the organization is required to pay for such services subsequent to a recommendation made by the ~~Statewide Provider and~~ Subscriber Assistance Panel pursuant to s. 408.7056.

Section 3. Subsection (1), paragraphs (b) and (e) of subsection (3), paragraph (d) of subsection (4), paragraph (g) of subsection (6), and subsections (9), (10), and (11) of section 641.511, Florida Statutes, are amended to read:

641.511 Subscriber grievance reporting and resolution requirements.--

(1) Each ~~Every~~ organization must have a grievance procedure available to its subscribers for the purpose of addressing complaints and grievances. Each ~~Every~~ organization must notify its subscribers that a subscriber must submit a

grievance within 1 year after the date of occurrence of the action that initiated the grievance, and may submit the grievance for review to the ~~Statewide Provider and~~ Subscriber Assistance Program panel as provided in s. 408.7056 after receiving a final disposition of the grievance through the organization's grievance process. An organization shall maintain records of all grievances and shall report annually to the agency the total number of grievances handled, a categorization of the cases underlying the grievances, and the final disposition of the grievances.

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

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

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

(4)

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

(6)

(g) In any case in which ~~when~~ the expedited review ~~process~~ does not resolve a difference of opinion between the organization and the subscriber or the provider acting on behalf of the subscriber, the subscriber or the provider acting on behalf of the subscriber may submit a written grievance to the ~~Statewide Provider and~~ Subscriber Assistance Program. In the letter of final decision for any case in which the expedited review does not resolve a difference of opinion between the organization and the subscriber or the provider acting on behalf of the subscriber, the organization must notify the subscriber or the provider acting on behalf of the subscriber of the right to submit the written grievance to the Subscriber Assistance Program.

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

(b) Requiring completion of the organization's grievance process before the ~~Statewide Provider and~~ Subscriber Assistance Program panel's review does not preclude the agency from investigating any complaint or grievance before the organization makes its final determination.

(10) Each organization must notify the subscriber in a final decision letter that the subscriber may request review of the organization's decision concerning the grievance by the ~~Statewide Provider and~~ Subscriber Assistance Program, as provided in s. 408.7056, if the grievance is not resolved to the satisfaction of the subscriber. The final decision letter must inform the subscriber that the request for review must be made within 365 days after receipt of the final decision letter, must explain how to initiate such a review, and must include the addresses and toll-free telephone numbers of the agency and the ~~Statewide Provider and~~ Subscriber Assistance Program.

(11) Each organization, as part of its contract with any provider, must require the provider to post a consumer assistance notice prominently displayed in the reception area of the provider and clearly noticeable by all patients. The consumer assistance notice must state the addresses and toll-free telephone numbers of the Agency for Health Care Administration, the ~~Statewide Provider and~~ Subscriber Assistance Program, and the Department of Insurance. The consumer assistance notice must also clearly state that the address and toll-free telephone number of the organization's grievance department shall be provided upon request. The agency may adopt ~~is authorized to promulgate~~ rules necessary to administer ~~implement~~ this section.

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

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

(4) The moneys received and deposited into the Health Care Trust Fund shall be used to defray the expenses of the

agency in the discharge of its administrative and regulatory powers and duties under this part, including conducting an annual survey of the satisfaction of members of health maintenance organizations; contracting with physician consultants for the ~~Statewide Provider and~~ Subscriber Assistance Panel; maintaining offices and necessary supplies, essential equipment, and other materials, salaries and expenses of required personnel; and discharging the administrative and regulatory powers and duties imposed under this part.

Section 5. This act shall take effect July 1, 2002.

STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN COMMITTEE SUBSTITUTE FOR Senate Bill 256

The bill deletes a requirement for the Agency for Health Care Administration (AHCA or agency) to adopt rules governing the grievance hearings conducted by the Subscriber Assistance Panel. The bill establishes procedures for handling a tie vote in the event of a deadlock by the Subscriber Assistance Panel. The bill revises post-hearing procedures used by the panel for grievances by providing that the record for a subscriber grievance is closed 5 working days after the hearing of a grievance and by requiring the panel to issue a written recommendation no later than 10 working days after the record is closed. The agency's authority to obtain records associated with subscriber grievances is expanded.

The bill revises procedures for AHCA's or the Department of Insurance's (DOI) review of the panel's recommendations for a managed care entity to take specific actions in resolution of a subscriber's grievance. With specified exceptions, 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.