A bill to be entitled

An act relating to health care grievances; amending s. 641.511, F.S.; retaining the requirement that any health maintenance organization and any prepaid health clinic must have a grievance procedure available to subscribers to address complaints and grievances; deleting provisions that require, specify, or provide for certain reports, procedures, processes, notifications, reviews, deadlines, or administrative penalties relating to such required grievance procedure; repealing s. 408.7056, F.S., relating to the Subscriber Assistance Program; deleting authority for the Subscriber Assistance Program, adopted and implemented by the Agency for Health Care Administration, to provide assistance to subscribers whose grievances are not resolved by a managed care entity to the satisfaction of the subscriber and deleting procedures, processes, and requirements with respect thereto; amending ss. 220.1845, 376.30781, 376.86, 409.818, 409.91211, 641.185, 641.3154, 641.51, 641.515, and 641.58, F.S.; conforming cross-references; providing an effective date.

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

Section 1. Section 641.511, Florida Statutes, is amended to read:

641.511 Subscriber grievance <u>procedure</u> ~~reporting and~~

~~resolution requirements~~.—

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

~~(2) When an organization receives an initial complaint from a subscriber, the organization must respond to the complaint within a reasonable time after its submission. At the time of receipt of the initial complaint, the organization shall inform the subscriber that the subscriber has a right to file a written grievance at any time and that assistance in preparing the written grievance shall be provided by the organization.~~

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

~~(a) An explanation of how to pursue redress of a grievance.~~

~~(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 Subscriber Assistance Program and its toll-free telephone number.~~

~~(c) The description of the process through which a subscriber may, at any time, contact the toll-free telephone hotline of the agency to inform it of the unresolved grievance.~~

~~(d) A procedure for establishing methods for classifying grievances as urgent and for establishing time limits for an expedited review within which such grievances must be resolved.~~

~~(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 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.~~

~~(f) A process whereby the grievance manager acknowledges the grievance and investigates the grievance in order to notify the subscriber of a final decision in writing.~~

~~(g) A procedure for providing individuals who are unable to submit a written grievance with access to the grievance process, which shall include assistance by the organization in preparing the grievance and communicating back to the subscriber.~~

~~(4)(a) With respect to a grievance concerning an adverse determination, an organization shall make available to the~~

~~subscriber a review of the grievance by an internal review panel; such review must be requested within 30 days after the organization's transmittal of the final determination notice of an adverse determination. A majority of the panel shall be persons who previously were not involved in the initial adverse determination. A person who previously was involved in the adverse determination may appear before the panel to present information or answer questions. The panel shall have the authority to bind the organization to the panel's decision.~~

~~(b) An organization shall ensure that a majority of the persons reviewing a grievance involving an adverse determination are providers who have appropriate expertise. An organization shall issue a copy of the written decision of the review panel to the subscriber and to the provider, if any, who submits a grievance on behalf of a subscriber. In cases where there has been a denial of coverage of service, the reviewing provider shall not be a provider previously involved with the adverse determination.~~

~~(c) An organization shall establish written procedures for a review of an adverse determination. Review procedures shall be available to the subscriber and to a provider acting on behalf of a subscriber.~~

~~(d) In any case 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 Subscriber Assistance Program.~~

~~(5) Except as provided in subsection (6), the organization shall resolve a grievance within 60 days after receipt of the grievance, or within a maximum of 90 days if the grievance involves the collection of information outside the service area. These time limitations are tolled if the organization has notified the subscriber, in writing, that additional information is required for proper review of the grievance and that such time limitations are tolled until such information is provided. After the organization receives the requested information, the time allowed for completion of the grievance process resumes. The Employee Retirement Income Security Act of 1974, as implemented by 29 C.F.R. s. 2560.503-1, is adopted and incorporated by reference as applicable to all organizations that administer small and large group health plans that are subject to 29 C.F.R. s. 2560.503-1. The claims procedures of the regulations of the Employee Retirement Income Security Act of 1974, as implemented by 29 C.F.R. s. 2560.503-1, shall be the minimum standards for grievance processes for claims for benefits for small and large group health plans that are subject to 29 C.F.R. s. 2560.503-1.~~

~~(6)(a) An organization shall establish written procedures for the expedited review of an urgent grievance. A request for an expedited review may be submitted orally or in writing and shall be subject to the review procedures of this section, if it meets the criteria of this section. Unless it is submitted in writing, for purposes of the grievance reporting requirements in subsection (1), the request shall be considered an appeal of a utilization review decision and not a grievance. Expedited~~

~~review procedures shall be available to a subscriber and to the provider acting on behalf of a subscriber. For purposes of this subsection, "subscriber" includes the legal representative of a subscriber.~~

~~(b) Expedited reviews shall be evaluated by an appropriate clinical peer or peers. The clinical peer or peers shall not have been involved in the initial adverse determination.~~

~~(c) In an expedited review, all necessary information, including the organization's decision, shall be transmitted between the organization and the subscriber, or the provider acting on behalf of the subscriber, by telephone, facsimile, or the most expeditious method available.~~

~~(d) In an expedited review, an organization shall make a decision and notify the subscriber, or the provider acting on behalf of the subscriber, as expeditiously as the subscriber's medical condition requires, but in no event more than 72 hours after receipt of the request for review. If the expedited review is a concurrent review determination, the service shall be continued without liability to the subscriber until the subscriber has been notified of the determination.~~

~~(e) An organization shall provide written confirmation of its decision concerning an expedited review within 2 working days after providing notification of that decision, if the initial notification was not in writing.~~

~~(f) An organization shall provide reasonable access, not to exceed 24 hours after receiving a request for an expedited review, to a clinical peer who can perform the expedited review.~~

~~(g) In any case 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 Subscriber Assistance Program.~~

~~(h) An organization shall not provide an expedited retrospective review of an adverse determination.~~

~~(7) Each organization shall send to the agency a copy of its quarterly grievance reports submitted to the office pursuant to s. 408.7056(12).~~

~~(8) The agency shall investigate all reports of unresolved quality of care grievances received from:~~

~~(a) Annual and quarterly grievance reports submitted by the organization to the office.~~

~~(b) Review requests of subscribers whose grievances remain unresolved after the subscriber has followed the full grievance procedure of the organization.~~

~~(9)(a) The agency shall advise subscribers with grievances to follow their organization's formal grievance process for resolution prior to review by the 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 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 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 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 Subscriber Assistance Program, and the Department of Financial Services. 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 rules to implement this section.~~

~~(12) The agency may impose administrative sanction, in accordance with s. 641.52, against an organization for noncompliance with this section.~~

Section 2. Section 408.7056, Florida Statutes, is repealed.

Section 3. Paragraph (k) of subsection (2) of section 220.1845, Florida Statutes, is amended to read:

220.1845 Contaminated site rehabilitation tax credit.—

(2) AUTHORIZATION FOR TAX CREDIT; LIMITATIONS.—

(k) In order to encourage the construction and operation of a new health care facility as defined in s. 408.032 or s. 408.07, or a health care provider as defined in s. 408.07 or former s. 408.7056, on a brownfield site, an applicant for a tax credit may claim an additional 25 percent of the total site rehabilitation costs, not to exceed $500,000, if the applicant meets the requirements of this paragraph. In order to receive this additional tax credit, the applicant must provide documentation indicating that the construction of the health care facility or health care provider by the applicant on the brownfield site has received a certificate of occupancy or a license or certificate has been issued for the operation of the health care facility or health care provider.

Section 4. Paragraph (f) of subsection (3) of section 376.30781, Florida Statutes, is amended to read:

376.30781 Tax credits for rehabilitation of drycleaning-solvent-contaminated sites and brownfield sites in designated brownfield areas; application process; rulemaking authority; revocation authority.—

(3)

(f) In order to encourage the construction and operation of a new health care facility or a health care provider, as defined in s. 408.032, s. 408.07, or former s. 408.7056, on a brownfield site, an applicant for a tax credit may claim an additional 25 percent of the total site rehabilitation costs, not to exceed $500,000, if the applicant meets the requirements

of this paragraph. In order to receive this additional tax credit, the applicant must provide documentation indicating that the construction of the health care facility or health care provider by the applicant on the brownfield site has received a certificate of occupancy or a license or certificate has been issued for the operation of the health care facility or health care provider.

Section 5. Subsection (1) of section 376.86, Florida Statutes, is amended to read:

376.86 Brownfield Areas Loan Guarantee Program.—

(1) The Brownfield Areas Loan Guarantee Council is created to review and approve or deny, by a majority vote of its membership, the situations and circumstances for participation in partnerships by agreements with local governments, financial institutions, and others associated with the redevelopment of brownfield areas pursuant to the Brownfields Redevelopment Act for a limited state guaranty of up to 5 years of loan guarantees or loan loss reserves issued pursuant to law. The limited state loan guaranty applies only to 50 percent of the primary lenders loans for redevelopment projects in brownfield areas. If the redevelopment project is for affordable housing, as defined in s. 420.0004, in a brownfield area, the limited state loan guaranty applies to 75 percent of the primary lender's loan. If the redevelopment project includes the construction and operation of a new health care facility or a health care provider, as defined in s. 408.032, s. 408.07, or former s. 408.7056, on a brownfield site and the applicant has obtained documentation in accordance with s. 376.30781 indicating that

the construction of the health care facility or health care provider by the applicant on the brownfield site has received a certificate of occupancy or a license or certificate has been issued for the operation of the health care facility or health care provider, the limited state loan guaranty applies to 75 percent of the primary lender's loan. A limited state guaranty of private loans or a loan loss reserve is authorized for lenders licensed to operate in the state upon a determination by the council that such an arrangement would be in the public interest and the likelihood of the success of the loan is great.

Section 6. Paragraph (d) of subsection (3) of section 409.818, Florida Statutes, is amended to read:

409.818 Administration.—In order to implement ss. 409.810-409.821, the following agencies shall have the following duties:

(3) The Agency for Health Care Administration, under the authority granted in s. 409.914(1), shall:

(d) Establish a mechanism for investigating and resolving complaints and grievances from program applicants, enrollees, and health benefits coverage providers, and maintain a record of complaints and confirmed problems. ~~In the case of a child who is enrolled in a health maintenance organization, the agency must use the provisions of s. 641.511 to address grievance reporting and resolution requirements.~~

The agency is designated the lead state agency for Title XXI of the Social Security Act for purposes of receipt of federal funds, for reporting purposes, and for ensuring compliance with federal and state regulations and rules.

Section 7. Paragraph (q) of subsection (3) of section 409.91211, Florida Statutes, is amended to read:

409.91211 Medicaid managed care pilot program.—

(3) The agency shall have the following powers, duties, and responsibilities with respect to the pilot program:

(q) To implement a grievance resolution process for Medicaid recipients enrolled in a capitated managed care network under the pilot program modeled after the subscriber assistance panel, as created in former s. 408.7056. This process shall include a mechanism for an expedited review of no greater than 24 hours after notification of a grievance if the life of a Medicaid recipient is in imminent and emergent jeopardy.

Section 8. Paragraph (j) of subsection (1) of section 641.185, Florida Statutes, is amended to read:

641.185 Health maintenance organization subscriber protections.—

(1) With respect to the provisions of this part and part III, the principles expressed in the following statements shall serve as standards to be followed by the commission, the office, the department, and the Agency for Health Care Administration in exercising their powers and duties, in exercising administrative discretion, in administrative interpretations of the law, in enforcing its provisions, and in adopting rules:

(j) A health maintenance organization should receive timely and, if necessary, urgent review by an independent state external review organization for unresolved grievances and appeals ~~pursuant to s. 408.7056~~.

Section 9. Paragraph (c) of 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:

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

Section 10. Paragraph (c) of subsection (5) of section 641.51, Florida Statutes, is amended to read:

641.51 Quality assurance program; second medical opinion requirement.—

(5)

(c) For second opinions provided by contract physicians the organization is prohibited from charging a fee to the subscriber in an amount in excess of the subscriber fees established by contract for referral contract physicians. The organization shall pay the amount of all charges, which are usual, reasonable, and customary in the community, for second opinion services performed by a physician not under contract with the organization, but may require the subscriber to be responsible for up to 40 percent of such amount. The organization may require that any tests deemed necessary by a noncontract physician shall be conducted by the organization. The organization may deny reimbursement rights granted under this section in the event the subscriber seeks in excess of three such referrals per year if such subsequent referral costs are deemed by the organization to be evidence that the subscriber has unreasonably overutilized the second opinion privilege. A subscriber thus denied reimbursement under this section shall have recourse to grievance procedures as specified in ss. ~~408.7056,~~ 641.495~~,~~ and 641.511. The organization's physician's professional judgment concerning the treatment of a subscriber derived after review of a second opinion shall be controlling as to the treatment obligations of the health maintenance organization. Treatment not authorized by the health maintenance organization shall be at the subscriber's expense.

Section 11. Subsection (1) of section 641.515, Florida Statutes, is amended to read:

641.515 Investigation by the agency.—

(1) ~~The agency shall investigate further any quality of~~

~~care issue contained in recommendations and reports submitted pursuant to ss. 408.7056 and 641.511.~~ The agency shall ~~also~~ investigate further any information that indicates that the organization does not meet accreditation standards or the standards of the review organization performing the external quality assurance assessment pursuant to reports submitted under s. 641.512. Every organization shall submit its books and records and take other appropriate action as may be necessary to facilitate an examination. The agency shall have access to the organization's medical records of individuals and records of employed and contracted physicians, with the consent of the subscriber or by court order, as necessary to carry out the provisions of this part.

Section 12. 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 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 13. This act shall take effect July 1, 2012.