The Florida Senate

Interim Project Report 2002-138 *September 2001*

Committee on Health, Aging and Long-Term Care Senator Burt L. Saunders, Chairman

REVIEW OF THE IMPLEMENTATION OF THE STATEWIDE PROVIDER AND SUBSCRIBER ASSISTANCE PROGRAM

SUMMARY

The Statewide Provider and Subscriber Assistance Program (SPSAP) in Florida provides an external review of disputes between managed care entities and their subscribers, when subscribers have exhausted their managed care entity's internal review process, without satisfaction. Florida is the only state that allows subscribers to give a personal presentation before a panel to resolve disputes between the subscriber and the managed care entity. The Florida external review process affords consumers greater protection than similar processes in other states because reviewers may investigate and resolve disputes involving multiple contractual coverage and clinical issues relating to medical necessity in a single forum. The program's review panel includes a specialty physician consultant and panel members who are state regulators with wide areas of expertise.

Staff recommends the following improvements to the SPSAP as administered by Agency for Health Care Administration (AHCA). The agency should establish, by rule, pursuant to its authority under s. 408.15(8), F.S., procedures for the panel's deliberations, including: imposition of a quorum requirement on the SPSAP for its deliberations of subscriber grievances; requirements for parties to be sworn in prior to presenting their case; limitations on the time allotted for each party to give a presentation and rebuttal; a mechanism to resolve tie votes; and the election of a chair to preside over the panel's deliberations. The agency should consider establishing formal training requirements for panel members regarding their responsibilities on the panel, including training on the panel's past recommendations and any subsequent agency action by AHCA or DOI in such cases.

The Legislature should adopt a statutory standard of review for the modification or rejection of the panel's proposed order (recommendation) by AHCA or the Department of Insurance (DOI), as appropriate; adopt a performance measure which measures the efficiency of the regulatory action taken by AHCA or DOI after the panel makes its recommendation; establish a statutory mechanism for the panel to reconsider cases rejected by AHCA or DOI for lack of evidence or substantive concerns, or cases in which the findings were improvidently found as determined by AHCA or DOI; and amend s. 641.511, F.S., to clarify that a managed care entity must timely provide a notice to subscribers with urgent grievances of the right for the subscriber to submit a written grievance to the Statewide Provider and Subscriber Assistance Program in any case when the HMO's expedited review process does not resolve a difference of opinion between a managed care entity and the subscriber, to the subscriber's satisfaction.

The Legislature should also continue to monitor federal efforts to extend patient protections that may preempt or weaken Florida's external review process for consumer disputes with managed care entities and communicate its concerns to Florida's congressional delegation.

BACKGROUND

Managed care has become a dominant force in the financing and delivery of health care in this country. Managed care refers to a variety of methods of financing and organizing the delivery of comprehensive health care in which an attempt is made to control costs and improve quality by controlling the provision of services. Managed care, in varying degrees, integrates the financing and delivery of medical care through contracts with selected physicians, hospitals, and other health care providers that provide comprehensive health care services to enrolled members for a predetermined monthly premium. The term managed care organization or entity includes health maintenance organizations, exclusive

provider organizations, prepaid health clinics and Medicaid prepaid health plans. In addition, a health insurer that sells a preferred provider contract may be considered to be a "managed care" plan.

Since 1973 under federal law,[1] health maintenance organizations (HMOs) have been required to establish and provide meaningful procedures for hearing and resolving grievances between the HMO and members of the organization. Medical groups and other health care delivery entities providing health care services for the organization must also be afforded grievance procedures under the federal law. Grievance procedures provide a mechanism to ensure that subscribers have a means of receiving further consideration of an HMO's decisions that deny care, treatment, or services. Under state law, such mechanisms are extended to adverse decisions of other types of managed care entities.

Health insurance regulators have also had a substantial role in helping to resolve disputes arising between consumers and their health insurance carriers and health plans.[2] The types of disputes that regulators consider relate to decisions to deny or limit coverage and judgments about medical necessity or appropriateness of care.

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 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 SPSAP.

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 which 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. 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: 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; inform subscribers that the organization must assist in the preparation of the written grievance; and 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 providers who have appropriate expertise. A person involved in rendering the adverse

[1] Health Maintenance Organization Act of 1973, Pub. L. 93-222, Dec/ 29, 1973, 87 Stat. 914 (Title 42, Sec. 300e et seq.) Pub. L.95-626, title I, Sec. 102(b)(2), Nov. 10, 1978, 92 Stat. 3551 1973

[2] *External Review of Health Plan Decisions: An Overview of Key Program Features in the States and Medicare*, prepared for Kaiser Family Foundation by K. Pollitz, G Dallek, and N. Tapay, Institute for Health Care Research and Policy, November 1998.

determination may appear before the panel. The review panel must be given the authority by the HMO to bind the entity to the review panel's decision. 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 non-compliance 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 grievance before completion of an HMO's consideration through its grievance procedure, AHCA must advise subscribers 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 unresolved 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.

Exclusive provider organizations must provide a grievance procedure for their subscribers under s. 627.6472, F.S. Grievances must be written and may be subject to arbitration. Section 409.912, F.S., directs AHCA to: use the statewide health maintenance organization hotline for receiving complaints about Medicaid managed care providers; investigate and resolve such complaints; maintain a record of complaints and confirmed problems; and receive disenrollment requests made by Medicaid recipients. Subscribers of exclusive provider organizations and Medicaid recipients enrolled in a Medicaid managed care plan may submit grievances to the SPSAP, as provided in s. 408.7056, F.S., for external review.

Statewide Provider and Subscriber Assistance Program

In 1985, Florida became the second state, following Michigan (1978), to provide a mechanism for consumers to resolve managed care disputes through a state-administered external review process. The Florida program was moved from the Department of Health and Rehabilitative Services (HRS) to AHCA in 1993, and renamed the Statewide Provider and Subscriber Assistance Program.

Section 408.7056, F.S., requires AHCA to implement the SPSAP to assist consumers 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.

Hearings are public, unless a closed hearing is requested by the subscriber or a portion of a hearing may be closed by the panel when deliberating information of a sensitive personal nature such as medical records. In addition to the hearings, the panel must meet 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 agency or department may adopt all or some of the panel's recommendations and may impose administrative sanctions on the managed care entity.

External Review of Grievances in Other States

As of March 2001, according to a recent report[3] by the American Association of Health Plans, approximately 39 states have enacted laws requiring independent medical review. The report defines "independent medical review" as a process to resolve disagreements between health plans and consumers about whether a particular medical service should be covered. State independent medical review laws generally: provide criteria for the types of claims eligible for independent review; establish timeframes for completing independent medical review, including requirements

[3] *Independent Medical Review of Health Plan Coverage Decisions: A framework for Excellence,* American Association of Health Plans, April 2001.

for dealing with emergency medical conditions; set procedures for selecting independent review organizations (IROs) and reviewers, to avoid potential conflicts of interest and assure that reviewers have the appropriate expertise; and specify a standard that reviewers must apply when making a decision regarding coverage. In many cases independent reviewers are physicians, but in some instances they include a mix of state regulators and physicians.

A 1998 report commissioned by the Kaiser Foundation[4] notes that at least 20 states had adopted some form of external grievance procedure that is imposed on managed care entities authorized to do business in their respective jurisdictions. These procedures vary in terms of their scope and features. Michigan was the first state to enact a type of external review requirement when in 1978 it established a system using independent medical experts to help resolve disputes arising between health plans and patients about medical necessity and appropriateness of care. Although the features adopted for external review processes differ in the various states, they are similar in concept, operation, and objectives. States may require consumers to exhaust a health plan's internal review before filing a claim with its external review process.

Issues that are subject to external appeal include: disagreements regarding medical necessity; newly popularized treatments; cosmetic surgery; out-of-network specialists; requests for services in excess of plan limits; requests for experimental and investigational treatments; requests for non-formulary drugs; requests for surgeries, when the patient has not yet tried a less invasive alternative; and requests for services expressly excluded by contract.

Some states limit review of disputes to medical issues and others hear all types of claims. Michigan is one of three states (Florida and Pennsylvania) that has established an external review process to resolve all types of consumer disputes with health plans regulated under its law. Other states that had established external review processes prior to 1998 limit review to disputes involving medical necessity or appropriateness and resolve other types of disputes through a different process in another forum. Proponents of external review processes designed to hear all disputes claim that consumers are afforded greater protection because the reviewers may investigate and resolve the disputes that involve multiple issues of contractual coverage and clinical issues relating to medical necessity in a single forum.

Since October 2000, Michigan has used IRO staff in lieu of state regulators for its external review. Consumers who have completed the internal review process of their health plan are given notice of the external review process with the final adverse determination. The consumer files documentation, including a release of medical records, with the Michigan Office of Financial and Insurance Services (OFIS) which after a preliminary screening determines whether the consumer is covered, and if so, forwards the request to an IRO. The IRO reviews the consumer's medical information and the denial from his or her health insurance company and then OFIS staff review the independent review. Within 35 days of the request for review, OFIS staff contact the consumer with a final decision regarding the denial. Expedited external review may be completed within 72 hours. Michigan officials contacted indicated that the IRO program was recently implemented and therefore comparative data on cost and other factors for IRO review and review done exclusively by state regulators was not yet available.

Texas authorizes external review of determinations of medical necessity and appropriateness by health plans with utilization review. An IRO review is unavailable for claims where: the health care plan refuses to pay for a service not covered by the plan; treatments have already been received and the plan determines that the treatment was not medically necessary or appropriate; or if a Medicaid, Medicare, or Medicare HMO provides coverage. After denying an appeal, a participating plan or utilization review agent must give the patient notice of his or her rights to an IRO review and notify the Texas Department of Insurance. The Texas Department of Insurance then assigns the case to an IRO and the patient's health plan must send the IRO the information and medical records needed for its review within three business days after the review request. The IRO must reach a decision within 15 business days after receiving the necessary information or 20 business days after the IRO receives its assignment. In cases involving life-threatening conditions, the IRO has eight calendar days to issue a decision. The IRO is typically a certified independent utilization review agent who works under the direction of a licensed physician. According to Texas officials, the costs for review involving a physician reviewer are

[4] *External Review of Health Plan Decisions: An Overview of Key Program Features in the States and Medicare*, prepared for Kaiser Family Foundation by K. Pollitz, G Dallek, and N. Tapay, Institute for Health Care Research and Policy, November 1998.

$650 and for non-physician reviewers is $450 plus any costs for the records. The health plan pays for the review by the IRO and the decision is binding on the health plan. The consumer is not given an opportunity to present information at a hearing. About 50 percent of cases have been resolved in favor of the subscriber.

California recently enacted a patients' rights law which guarantees a patient access to second opinions, an independent review of claim denials, and the right to sue health plans. California has two separate and distinct review processes: a grievance review process that applies to any type of dispute with the health plan, including coverage disputes; and an independent medical review process designed to assist consumers with denials based on lack of medical necessity. Consumers who have received a denial from a managed care entity based on medical necessity have the right to an independent medical review. Health plans pay for the reviews which range in cost from $395 to $25,000. Contracted IROs are used to complete reviews and the IRO must be free of any conflict of interest. The IRO must render a decision within 30 days from the receipt of a request, unless the director of the department decides additional time is necessary. A special timeline is available for qualified expedited reviews. If the health plan's decision was based solely on the terms of coverage or a limitation of benefits, it will not be eligible for independent medical review. Such complaints are resolved through the department's internal complaint resolution process. The California Department of Managed Care screens the complaints to see if they involve medical necessity and, if so, they are referred for an independent medical review. Consumers are not required to complete the HMO's internal grievance process, if the complaint involves the denial of experimental or investigational treatment or an imminent serious threat to health. In California, an independent review board has been in place since January 1, 2001. As of June, 2001, the California Department of Managed Care reports that the board has heard about 200 disputes between managed care plans and patients. About 65 percent of the cases have been resolved in favor of the health plan according to the department. A total of 195 cases went to an independent review board of physicians and 110 were decided in favor of the health plan and 58 in favor of the patient.

Federal Preemption of State External Review Processes

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that preempts state laws relating to employee health benefit plans. One federal court in Texas recently held that a state law requiring external review of decisions of state regulated health plans was preempted by ERISA.[5] The court found that provisions of the Texas Health Care Liability Act establishing an independent external review process for adverse benefit determinations were preempted by ERISA because they were an improper mandate of benefit administration. The court's decision hinged largely on its characterization of HMOs and other managed care entities as not being insurers. The decision was upheld on appeal. The issue of ERISA preemption of state external review laws is not settled. Other federal decisions have held that HMOs are in the business of insurance, which support a state's right to regulate. Texas officials have continued to implement the external review process under their law pending appeal of the decision.

In addition, Congress has recently debated several bills calling for a 'patients bill of rights' providing health care protection which may preempt state external review of managed care decisions. On July 29, 2001, the United States Senate passed a patients' rights bill (S. 1052) which includes a provision that saves state laws that are "substantially compliant" with patient protections established in the Act and that do not prevent the application of the other provisions of the Act. The term, "substantially compliant" is defined as it pertains to state law as a state law that has the same or similar features as the patient protection requirements and has a similar effect. The Act further provides that state laws that provide greater protections than those provided by the Act may be certified. Under S. 1052, a state must certify to the Secretary of Health and Human Services that a state law or a number of state laws are substantially compliant with federal patient protections established in the Act, within 60 days of the effective date of the Act.

On August 2, 2001, the United States House of Representatives passed HR 2563. Under the House and Senate bills, states may ask the federal government for permission to enforce certain state laws that "substantially comply" with the new federal standards. But under the House bill, state independent review

[5] *Corporate Health Insurance , Inc. v. Texas Department of Insurance*, 12 F.Supp.2d 597, (S.D.Tex. September 18, 1998) Affirmed in Part, Reversed in Part by *Corporate Health Insurance v. Texas Dept. of Ins.*, 215 F.3d 526 (5th Cir. (Texas) June 20, 2000) Rehearing and Rehearing en Banc Denied by *Corporate Health Ins. Inc. v. Texas Department of Ins.*, 220 F.3d 641, (5th Cir. (Tex.) July 27, 2000), Petition for Ceriorari Filed October 24, 2000.

laws are not eligible for such certification. Several state officials have publicly expressed that HR 2563 would preempt state laws that provide for external review, the right to sue managed care entities, and other consumer protections. The resolution of the issue of federal preemption of state external review will largely depend on the compromise between the Senate and House patients' rights bills.

METHODOLOGY

Committee staff gathered relevant information from the Agency for Health Care Administration and the Department of Insurance and attended a hearing of the Statewide Provider and Subscriber Assistance Panel. Staff solicited comments from interested stakeholders concerning the program. In addition, staff surveyed literature and other relevant information relating to external review processes involving health plans.

FINDINGS

The Statewide Provider and Subscriber Assistance Program was originally designed to operate through a panel composed of six persons employed by DOI and HRS. Today, grievances are submitted to the program for review by a 7-member panel which 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.

There are no formal requirements for periodic training for panel members as it relates to their responsibilities on the panel. The composition of the current panel consists of a significant number of members who have sat on the panel since its inception, but as new members are added there is a greater need for formal training regarding the panel's recommendations in similar cases and any subsequent action by AHCA or DOI. There is no quorum requirement for the panel's deliberations or any formal mechanism established to resolve a vote on a case submitted to the panel resulting in a tie. The panel is advised by an attorney employed by AHCA who is also responsible for completing the panel's recommendations.

The SPSAP is funded from fees and fines collected from regulated managed care entities deposited into the Health Care Trust Fund maintained by AHCA. In fiscal year 2000-2001, $604,124 was budgeted and in fiscal year 2001-2002, $601,497 was budgeted to fund the administration of SPSAP.

The agency must review a case within 60 days after its receipt of the grievance from a subscriber. If AHCA determines the grievance must be heard by the panel, 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 before the panel 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. The agency or department may issue its order within 30 days.

Under certain circumstances the time periods for hearing and recommendation are shortened. 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. An urgent grievance must be heard by the panel 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 a closed hearing is requested by the subscriber 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. 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.

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 regulating such entities. 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 and must do so 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.

Section 408.7056, F.S., does not specify a standard of review for DOI or AHCA to accept or reject the panel's recommendations. Officials at AHCA and DOI have acknowledged that occasionally the panel's recommendations may need additional evidence or facts that are not in the record or later found to be difficult to obtain. The current statutes do not expressly provide a mechanism for either agency to send the recommendation back to the panel for reconsideration or for additional deliberation or information in support of the panel's recommendation. Either agency, at that point, may opt to independently investigate the alleged violation of law or rule on a de novo basis.

Under s. 408.7056, F.S., 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. A managed care entity or provider must provide patient records for the hearing or it will be subject to a daily fine of up to $500. The panel does not have subpoena authority to compel any party to submit any additional information needed for the case. The agency reports that the average days to close a case was 59 days. The agency reports that it has had only two emergency hearings. One case was heard in January, 1999 and closed within 2 days; the other case was heard on September 1, 1999, and at the request of the subscriber, was held up for an additional 9 days.

Although performance-based program budget measures exist for the timeliness of the external review process, from both the subscriber and managed care entity's perspective, a more effective measure may be the efficiency of AHCA's or DOI's resolution of the subscriber's grievance after the panel has made its recommendation.

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 subsequently adopted as an order by AHCA or DOI. According to AHCA staff, managed care entities appealed 11 orders, and seven of those appeals were filed after December 1, 1998.

The panel must hear every grievance that is properly submitted to it, except under ten specified circumstances outlined in s. 408.7056, F.S. The Agency for Health Care Administration received a total of 498 cases during fiscal year 1999-2000, and 311 cases during fiscal year 2000-2001, and reports that about 60 percent of the cases were found in favor of the subscriber.

Among the state external grievance processes reviewed, Florida is the only state that allows consumers to give personal presentations before a review panel. The SPSAP provides a thorough external review because it incorporates features of an IRO by including a specialty physician consultant, but also uses panel members who are state regulators with wide areas of expertise and a personal presentation by the aggrieved subscriber. When a consulting physician is utilized on the appropriate medical cases, he or she provides a written opinion and also participates at the hearing as a voting panel member. In comparison, the use of an IRO provides an impersonal, paper review, usually by a single reviewer, whose decision is

generally final. As an alternative to the current panel composed of regulators, a number of states are contracting with IROs to complete external reviews of consumer grievances solely involving medical necessity and appropriateness by health plans. Those states that have chosen to contract with private reviewers have had to establish the appropriate mechanisms to assure critical independence of the decision-making process and avoidance of conflicts of interests. Industry officials have expressed concerns regarding the lack of qualified independent reviewing organizations in the private sector from which to choose. Representatives of managed care entities have also voiced concerns about the potential bias of a panel composed primarily of regulators.

RECOMMENDATIONS

Staff does not recommend modifying Florida's external grievance process to incorporate the use of private reviewers by contract. Under the SPSAP, reviewers may investigate and resolve the disputes that involve multiple issues of contractual coverage and clinical issues relating to medical necessity in a single forum. The SPSAP provides a more personalized response to subscriber's grievances and a more thorough review by multiple individuals with different expertise.

Staff recommends that AHCA establish, by rule, pursuant to its authority under s. 408.15(8), F.S., procedures for the panel's deliberations, including: imposition of a quorum requirement on the SPSAP for its deliberations of subscriber grievances; requirements for parties to be sworn in prior to presenting their case; limitations on the time allotted for each party to give a presentation and rebuttal; a mechanism to resolve tie votes; and the election of a chair to preside over the panel's deliberations. The agency should consider establishing formal training requirements for panel members regarding their responsibilities on the panel, including training on the panel's past recommendations and any subsequent agency action by AHCA or DOI in such cases.

Staff recommends that the Legislature adopt a statutory standard of review for the modification or rejection of the SPSAP's proposed order (recommendation) by AHCA or DOI, as appropriate.

The Legislature should consider adopting a performance measure which measures the efficiency of AHCA's or DOI's resolution of the subscriber's grievance after the panel has made its recommendation.

The Legislature should establish a statutory mechanism for AHCA or DOI to have the panel reconsider cases rejected for lack of evidence or for substantive concerns that arise that require additional deliberation by the panel, or cases in which the findings were improvidently found.

Section 641.511, F.S., should be amended to require the managed care entity to give the subscriber notice of the right to seek resolution of an urgent grievance by submission of a written grievance to the SPSAP when a difference of opinion exists between the subscriber and managed care entity after completion of the entity's expedited review of the subscriber's urgent grievance.

The Legislature should monitor congressional proposals that would preempt or weaken Florida's external review process and communicate its concerns to Florida's congressional delegation.