SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

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

Date: January 6, 1998 Revised: _____ _____ _____ _____

Subject: Statewide Provider and Subscriber Assistance Program

	Analyst	Staff Director	Reference	Action
1.	Carter	Wilson	HC	Favorable
2.	Johnson	Deffenbaugh	BI	Favorable/CS
3.			WM	
4.				
5.				

I. Summary:

Committee Substitute for Senate Bill 162, clarifies what types of grievances filed by subscribers and providers of managed care are within the jurisdiction of the Statewide Provider and Subscriber Assistance Program. The bill establishes general, expedited, and emergency procedures for the review of grievances by the panel.

The bill maintains the current exemption from chapter 120, F.S., for this process. The bill provides that the panel shall make written findings of fact and written recommendations to the Agency for Health Care Administration (agency or AHCA) or the Department of Insurance (department), and establishes a set period of time for the agency or the department to consider the panel's recommendations and findings of fact. The agency or the department may adopt such recommendations or the findings of fact in a proposed order or an emergency order. The agency or department is authorized to issue a proposed order or an emergency order, as provided in chapter 120, F.S., imposing fines or sanctions. The agency and the department's actions are subject to chapter 120, F.S. The bill also provides that if an order only involves the panel's recommendations, the order shall be subject to a summary proceeding under s. 120.574, F.S., unless both parties agree otherwise.

The bill appropriates 6 full-time-equivalent positions and $308,830 from the Health Care Trust Fund to AHCA for the implementation of the bill's provisions during fiscal year 1998-99.

The bill amends ss. 408.7056 and 641.511, Florida Statutes.

II. Present Situation:

As of June 1997, more than 4.2 million Florida residents were receiving their health care coverage through commercial, Medicare, or Medicaid health maintenance organizations (HMOs). Even more state residents were receiving health care coverage through other managed care entities such as exclusive provider organizations (EPO) and preferred provider organizations (PPO). It is estimated that in 1995, nationally, approximately 25 million people received health care through a PPO and approximately 4.6 million people received health care through an EPO.

Regulation of Health Maintenance Organizations and Prepaid Health Clinics

The regulation of HMOs is divided between the Department of Insurance and AHCA, as provided in chapter 641, F.S. The Department of Insurance regulates HMO finances, contracting, and marketing activities under part I of chapter 641, F.S. Health maintenance organizations must directly provide or actively manage the delivery of services to their subscribers. The department is responsible for ensuring that these entities are financially solvent and conduct their marketing activities in accordance with guidelines specified in chapter 641, F.S. A major role the department performs in the regulation of HMOs is to ensure that the contracts for the provision of services do not contain terms that are inconsistent, ambiguous, or misleading. Additionally, the department is charged with ensuring that premium rates charged to subscribers are not excessive, inadequate, or unfairly discriminatory. The department is delegated similar authority relating to the regulation of prepaid health clinics under part II of chapter 641, F.S. The department is authorized to impose an administrative fine, in lieu of suspension or revocation, if one or more grounds exist for the revocation or suspension of a certificate issued under this part.
Such fines may not exceed $2,500 per nonwillful violation and an aggregate amount of $25,000 nonwillful violations arising out of the same action. With respect to knowing and willful violations, such fines may not exceed $20,000 per violation and $250,000 in aggregate amount for all knowing and willful violations arising out the same action.

The Agency for Health Care Administration regulates the quality of care provided by HMOs and prepaid health clinics under part III of chapter 641, F.S. The quality-of-care requirements under part III of chapter 641, F.S., include: demonstrating, to AHCA's satisfaction, that the HMO or the prepaid health clinic is capable of providing health care of a quality consistent with prevailing professional standards of health care delivery; establishing an ongoing internal quality assurance program; ensuring the right of HMO subscribers to receive a second medical opinion, as specified; providing grievance reporting and resolution requirements; establishing an internal risk management program; and accrediting these entities. Subsection 641.495(9), F.S., requires every HMO to establish a subscriber grievance procedure that must provide guidelines for disenrollment for cause. All master group and individual contracts, any certificate (comparable to an insurance policy), and any handbook issued by an HMO to subscribers must outline this procedure.

The agency is authorized to impose an administrative fine of up to $2,500 (or $10,000 in aggregate for the same noncompliance action), upon a determination thorough a formal investigation that a managed care entity has failed to comply with statutory and regulatory quality of health care services standards.

Section 641.52, F.S., authorizes the agency to suspend the authority of an organization to enroll new subscribers, revoke the provider certificate, or order compliance within a certain period of time, if certain conditions exist. One of these conditions is that the organization has violated any lawful rule or order of the agency or any provision of this part. The agency may also impose a fine for violations in this section, in lieu of revocation or suspension of the certificate issued under part III, of chapter 641, F.S. The amount of the fine for each nonwillful violation is $2,500 and $20,000 for each knowing and willful violation. The aggregate amount of a fine for violations arising out the same action, the amount of fine for each nonwillful violation may not exceed $25,000 and $250,000 for each knowing and willful violation.

Requirements Relating to Grievances for Health Maintenance Organizations and Prepaid Health Clinics

Requirements relating to HMO and prepaid health clinic subscriber grievance reporting and resolution are specified in s. 641.511, F.S. An HMO must maintain records of all grievances and submit a report to AHCA annually that delineates the total number of grievances handled, a categorization of the cases underlying the grievances, and the resolution of the grievances. Also, HMOs are required to send AHCA quarterly reports required for the Statewide Provider and Subscriber Assistance Program under s. 408.7056(3), F.S. The Agency for Health Care Administration is required to investigate unresolved quality-of-care grievances received from HMO annual and quarterly grievance reports as well as subscriber appeals of grievances that have been through the subscriber's HMO's full grievance procedure. Although AHCA may investigate a subscriber complaint prior to completion of an HMO's consideration through its grievance procedure, AHCA must advise subscribers that it is unable to review such a complaint as a grievance until the HMO's internal grievance process has been completed. If a subscriber's grievance is unresolved to the satisfaction of the subscriber after completion of their HMO's internal grievance procedure, AHCA may then review the grievance and refer it to the Statewide Provider and Subscriber Assistance Program for review and recommendations.

Requirements Relating to Grievances for Exclusive Provider Organizations and Medicaid Managed Care

Exclusive provider organizations are required to provide a grievance procedure for their subscribers under subsection 627.6472(12), F.S. Grievances must be written and may be subject to arbitration. Subsection 409.912(22), F.S., directs AHCA to use the statewide health maintenance organization complaint hotline for receiving complaints about Medicaid managed care providers, investigating and resolving such complaints, maintaining a record of complaints and confirmed problems, and receiving disenrollment requests made by Medicaid recipients. Exclusive provider organization subscribers and Medicaid recipients enrolled in a Medicaid managed care plan may submit grievances to the Statewide Provider and Subscriber Assistance Program, as provided in s. 408.7056, F.S.

The Statewide Provider and Subscriber Assistance Program

The Statewide Subscriber Assistance Program was created in 1985. The program was designed to operate through a panel which is composed of members employed by DOI and the Department of Health and Rehabilitative Services (HRS). The program was moved from HRS to AHCA in 1993, and was renamed the Statewide Provider and Subscriber Assistance Program.

Section 76 of chapter 93-129, Laws of Florida, redesignated s. 641.311, F.S., as s. 408.7056, F.S., renamed the program, and transferred rulemaking authority from DOI to AHCA. These revisions in the law also expanded the program to include providers with accountable health partnership's, entities created under s. 77 of chapter 93-129, Laws of Florida, to deliver health care services to employees of employer members of community health purchasing alliances. The proceedings of the program panel are not subject to the Administrative Procedure Act. The program is required to widely disseminate information about itself to the general public.

Pursuant to s. 408.7056(2), F.S., the review panel consists of members employed by the agency and members employed by the department. Historically, the program panel has been comprised of three employees from the agency and three employees from the department. Additionally, AHCA may contract with a medical director from a state-licensed HMO and a primary care physician to provide the program panel with technical expertise. The program panel convenes periodically to review and consider information relating to unresolved grievances arising between a subscriber or a provider (on behalf of a subscriber) and an accountable health partnership, an HMO, a prepaid health clinic, a Medicaid prepaid health plan, or an exclusive provider organization. Following its review, the program panel may recommend to the agency actions that the department or the agency should take concerning a case heard by the program panel and may notify the agency of the types of grievances which have not been satisfactorily resolved after subscribers or providers have followed the full grievance procedure of the managed care entity in which the subscribers or providers participate.

Five restrictions are placed on the program panel in statute. The program panel may not consider grievances which:

- Relate to an accountable health partnership, an HMO, a prepaid health clinic, a Medicaid prepaid health plan, or an exclusive provider organization's refusal to accept a provider into its network of providers;
- Are a part of a reconsideration appeal through the Medicare appeals process;
- Are 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;
- Are related to appeals by in-plan suppliers and providers, unless related to quality of care provided by the plan; or
- Are part of a Medicaid fair hearing pursued under federal law.

Managed care entities subject to the Statewide Provider and Subscriber Assistance Program must comply with quality-of-care-health-services standards established in chapter 409, F.S., relating to Medicaid; chapter 627, F.S., relating to insurance regulation of exclusive provider organizations and other providers; or chapter 641, F.S., relating to prepaid health clinics and HMOs. They are required to submit a quarterly report of all unresolved subscriber and provider grievances to the agency and the department. These reports must include a listing of the number and the nature of all subscriber and provider grievances not resolved to the subscriber's or provider's satisfaction after the grievance has been completely processed through the managed care entity's internal grievance procedure. The agency is required to notify all subscribers and providers included in the quarterly reports of their right to file an unresolved grievance with the panel. Identifying information that relates to a subscriber or the spouse, relative, or guardian of a subscriber that is contained in reports obtained from the department is confidential and exempt from the Public Records Law.

The Administrative Procedure Act

Chapter 120, F.S., the Administrative Procedure Act governs agency adjudication and rulemaking. When an agency conducts investigations, grants or denies licenses or permits, or disciplines employees and licensees, it is performing executive functions. The Legislature, however, may delegate to an agency the power to adopt rules. When an agency promulgates rules, the agency performs a quasi-legislative function.

During the 1996 Regular Legislative Session, the Administrative Procedure Act was reorganized and substantially revised. The 1996 revision of the Act attempted to limit the authority of agencies to adopt rules by modifying some judicial standards that had developed over the years. These revisions provide for uniform rules of procedure. Section 120.54(5), F.S., required the Administration Commission to adopt one or more sets of uniform rules of procedure by July 1, 1997. Agencies are required to comply with the uniform rules by July 1, 1998, unless the Administration Commission grants an exception to an agency.

In addition to full administrative review and mediation, s. 120.574, F.S., provides for summary hearings. Within 5 business days of the receipt of a petition or request for hearing, the Division of Administrative Hearings must issue an order assigning the case to a specific administrative law judge. This order also must advise that a summary hearing is available upon agreement of all parties. Upon agreement of all parties in writing, the summary proceeding must be conducted within 30 days of the agreement. In summary proceedings the types of motions, discovery, and the record are limited.

III. Effect of Proposed Changes:

Section 1. Amends s. 408.7056, F.S., which establishes the Statewide Provider and Subscriber Assistance Program.

The bill defines *managed care entity* to mean an HMO, a prepaid health clinic, a Medicaid prepaid health plan, or an exclusive provider organization. The bill defines *panel* to mean the statewide provider and subscriber assistance panel.

The bill provides that this panel shall meet as often as necessary to consider grievances by subscribers and providers on behalf of the subscriber or provider, and make written findings of fact and written recommendations to the department as well as to the agency. The bill specifies that the recommendations shall consist of recommended actions the department or agency should take concerning an individual case heard by the panel.

The bill clarifies that the panel shall hear every grievance filed by subscribers and providers on behalf of the subscriber, unless the grievance:

- Relates to a managed care entity's refusal to accept a provider into its network;
- Is part of reconsideration of Medicare appeals which do not involve quality of care issues;
- Is related to a health plan not regulated by the state;
- Is related to appeals by in-plan suppliers and providers, unless related to quality of care;
- Is part of a Medicaid fair hearing pursuant to federal rules;
- Is the basis for action pending in state or federal court;
- Is related to an appeal by nonparticipating providers involved in the care provided to the subscriber, unless related to quality of care issues and the provider is involved in the care provided to the subscriber;
- Has been filed before the subscriber or provider has completed the entire internal grievance procedure and the internal procedure is proceeding timely;
- Has been resolved to the subscriber or provider's satisfaction or withdrawn, unless the underlying action by the managed care entity is egregious or indicates a pattern of inappropriate behavior;
- Is limited to damages for pain and suffering, lost wages, and other incidental expenses;
- Is limited to the conduct of a provider, facility, or employee that is grounds for disciplinary action; or
- Is withdrawn by the subscriber or provider.

The bill requires the agency to review each grievance within 60 days of receipt and make a determination as to whether it should be heard by the panel pursuant to the criteria contained in this section.

Once referred, the panel must hear the grievance within 120 days after the date it is filed with the agency. This 120 days includes the 60 days the agency has to refer the grievance to the panel. The agency is required to notify the parties, in writing, facsimile transmission, or by telephone, of the time and location of the hearing. The panel may hear the grievance in the network area or by teleconference. After the hearing, the panel must issue a written recommendation supported by findings of fact to the provider or subscriber and the managed care entity, and to the agency or department no later than 15 working days after the hearing. This time is tolled if the panel

requests information that is necessary to the panel's recommendation. The panel's proceeding is exempt from chapter 120, F.S.

The bill authorizes the panel to take testimony under oath, request certified copies of documents, and to take similar actions to collect information and documentation that will assist the panel to make findings of fact and a recommendation.

If the agency requests medical records from a health care provider or managed care entity, the provider or entity has 10 days to provide the records. After the initial 10 days, the agency is authorized to impose a fine of up to $500 for each day that the records are not produced.

The bill provides for two expedited hearing processes for grievances that pose an immediate and serious threat to the subscriber's health. The first is for grievances determined by the agency to pose an immediate and serious threat to a subscriber's health. These grievances are given priority over the other types of grievances. The bill requires the panel to meet within 45 days after the grievance is filed with the agency, unless the subscriber waives the time. If the subscriber's life is in imminent and emergent jeopardy, the panel may convene within 24 hours after notification to the managed care entity and to the subscriber. These grievances need not have been heard by the internal grievance procedure of the managed care entity.

The bill requires the panel to refer its recommendations and findings of fact to the agency or the department, whichever is appropriate. The bill sets a time period within which a managed care entity, subscriber, or provider may furnish the agency or the department with written evidence in opposition to the recommendation or findings of fact of the panel.

The agency or the department is required by the bill to consider the panel's recommendations and findings of fact within a certain period of time of issuance. The time period varies in the bill (10-30 days), depending upon the threat of harm to the subscriber's health. The bill authorizes the agency or the department to adopt the panel's recommendations or findings of fact in any proposed agency action or emergency order. Once the panel's recommendations and findings of fact are received by the agency, the process is subject to chapter 120, F.S. The agency or department is also authorized to issue a proposed order or emergency order, as provided in chapter 120, F.S., imposing fines or sanctions.

The agency's or department's order may impose fines or sanctions, including those contained in ss. 641.25 and 641.52, F.S. Any fines collected are to be deposited into the Health Care Trust Fund. In determining any fine or sanction, the agency or the department shall consider:

- The severity of the noncompliance, in particular the harm to the subscriber;
- Any action taken by the accountable health partnership, HMO, prepaid health clinic, prepaid health plan, or exclusive provider organization to resolve the quality of care issues;
- Any previous history of noncompliance by the accountable health partnership, HMO, prepaid health clinic, prepaid health plan, or exclusive provider organization; or

- Any other relevant factors the agency or department deems appropriate in a particular grievance.

The bill requires the agency and the department to notify each subscriber or provider that has an unresolved grievance with a managed care entity of the right to file the unresolved grievance with the panel.

The bill requires that if a proposed order of the agency or the department only requires the managed care entity to take a specific action as recommended by the panel, the order is subject to a summary hearing pursuant to s. 120.574, F.S., unless both parties agree otherwise. The agency or the department will not have final order authority in such cases, instead the final order will be issued by an administrative law judge in the Division of Administrative Hearings. If the managed care entity does not prevail, it is required to pay reasonable costs and attorney's fees of the agency or the department.

The bill deletes a provision authorizing the agency to impose an administrative fine (up to $2,500 per violation or an aggregate amount of $10,000 for the same noncompliance action, based on the results of a formal investigation) on an entity due to its failure to comply with quality of health services standard set forth in statute or rule. Other existing provisions within chapter 641, F.S., authorize the agency and the department to impose fines.

Section 2. Amends s. 641.511, F.S., to conform a cross-reference to the bill and requires a managed care entity to submit only quarterly, (instead of quarterly and annual) grievance reports to the agency.

Section 3. Appropriates 6 full-time-equivalent positions and $308,830 from the Health Care Trust Fund for implementing the provisions of this Act in fiscal year 1998-99.

Section 4. Provides an effective date of July 1, 1998.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Section 24(a) of Article 1 of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Section 19(f) of the Florida Constitution.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

In the current law, the panel's hearings are exempt from chapter 120, F.S. This supports the informality of the panel's proceedings. In a panel hearing, subscribers are free to present to a panel of representatives of both the agency and the department any evidence or argument the subscriber feels is relevant to their case without need for counsel.

Under the bill, the agency conducts an initial investigation before the grievance is referred to the panel. After the panel's hearing, the panel makes its recommendations to the agency and the department, and the process becomes subject to chapter 120, F.S. Under this bill, the agency or the department can use the panel's recommendations and findings, in addition to information gathered in the initial investigation, as a basis for proposed agency action; however, the agency must follow all of the requirements of chapter 120, F.S., relating to agency actions affecting a party's substantial interests. If the panel's recommendation is part of an emergency order pursuant to s.120.569, F.S., the emergency order must meet the same standards applicable to any other emergency order, and may be appealed or enjoined from the date rendered.

The bill does give additional strength to the panel's recommendation. If the agency or the department adopts the panel's findings or recommendation as a part of an order and the order does not include sanctions or fines, the order is subject to a summary hearing pursuant to s. 120.574, F.S., unless both parties agree otherwise. The agency or the department will not have final order authority in such cases; instead the final order will be issued by the Division of Administrative Hearing administrative law judge. If the managed care entity does not prevail, it is required to pay reasonable costs and attorney's fees of the agency or the department. The public purpose for such immediate referral is that these will be cases involving the quality of care provided to the subscriber. Generally these will be cases where the subscriber did not prevail in an internal grievance procedure and, after a hearing, the panel and the agency or the department are in agreement with the subscriber. Staff has been informed that this may result in three to four cases a year.

Staff has also been advised by the AHCA that the panel finds for the subscriber approximately 60 percent of the time, and for the managed care entity approximately 40 percent of the time.

C. Government Sector Impact:

AHCA Non-recurring Expenditures		**Amount Year 1 (FY 98-99)**	**Amount Year 2 (FY 99-2000)**
Agency for Health Care Administration	**FTE**		
Operating Capital Outlay		**$19,082**	
Senior Attorney	**1**	**2,132**	**$0**
RN Consultant	**1**	**2,132**	**0**
Medical Health Care Program Analyst	**3**	**6,396**	**0**
Administrative Secretary	**1**	**1,469**	**0**
	0	**0**	**0**
	0	**0**	**0**
Total Non-recurring	**6**	**$31,211**	**$0**
AHCA Recurring Expenditures			
Expenditures:			
Salaries and Benefits	**6**	**$218,847**	**$291,796**
Expenses (FTE)		**$55,625**	**$74,166**
Expense (additional)		**15,276**	**15,276**
Total Health Care Trust Fund	**6**	**289,748**	**381,238**
BUDGET CATEGORY:			
Salary and Benefits		**$218,847**	**$291,795**
Expenses		**70,901**	**89,442**
OCO		**19,082**	**89,442**
Total AHCA Recurring Expenditures		**$308,830**	**$381,238**

According to the agency, the preference in the bill for a summary hearing for certain types of cases may result in an additional three to four cases a year for DOAH. The agency and the department will be compensated for their costs and attorney's fees if they prevail in the summary hearing.

The agency will avoid the expense of conducting a second and separate investigation into a grievance that has been presented to the panel. The agency is required by this bill to consider the panel's recommendations and findings within a certain time frame. Afterwards, the agency or the department can issue its proposed agency action or conduct an investigation, whichever is more cost effective.

The panel is presently taking sworn testimony and collecting documents; so, the provision of the bill authorizing such activities will not require an additional expense for the panel. However, the panel will expend more resources by having to draft the findings of fact upon which it bases its recommendations.

VII. Related Issues:

None.

VIII. Amendments:

None.