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: October 27, 1997 Revised: _____ _____ _____ _____

Subject: Statewide Provider and Subscriber Assistance Program

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

I. Summary:

Senate Bill 162, clarifies which grievances filed by subscribers and providers of managed care entities are within the jurisdiction of the Statewide Provider and Subscriber Assistance Program. The bill establishes both normal and expedited procedures for referral of grievances and review by the panel. The bill maintains the current exemption from chapter 120, F.S., for this process. The bill requires the panel to issue recommendations to the Agency for Health Care Administration or the Department of Insurance. Both agencies have a set period of time to consider the panel's recommendations. The Agency for Health Care Administration or the Department of Insurance may adopt such recommendations in a proposed order or an emergency order. The agency's and the department's actions are subject to chapter 120, F.S. However, 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 5 full-time-equivalent positions and $247,396 from the Health Care Trust Fund to the Agency for Health Care Administration for the implementation of the bill's provisions.

The bill amends ss. 408.7056 and 641.511, F.S., and creates s. 408.7057, F.S.

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.

The number of Florida residents receiving health care coverage through managed care entities has steadily increased since the early 1980's when the state's HMO industry began to grow. Since 1988, the number of commercial HMOs has decreased from a high of 47 to the current 34, however, enrollment has increased. Enrollment in most other types of managed care entities continues to increase as well. Regulation of HMOs is divided between the Department of Insurance (department or DOI) and the Agency for Health Care Administration (agency or AHCA).

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 was 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 Statewide Provider and Subscriber Assistance Program is administered under rules 59A-12.014 and 59A-12.015, *Florida Administrative Code*. 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.

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. The panel is authorized to impose an administrative fine of up to $2,500 upon a determination that a managed care entity has failed to comply with statutory and regulatory quality of health care services standards.

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 Statewide Provider and Subscriber Assistance Program conducts four hearings around the state annually. Statistics reflecting the past activities of the program are difficult to generate in a manner that accurately depicts caseload because of insufficient data processing technology. The agency is in the process of upgrading the program's computer technology so that reliable statistical documentation and analyses can be available in the future.

Regulation Under Chapter 641, F.S., Relating to Health Maintenance Organizations and Prepaid Health Clinics

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 contained in chapter 641, F.S. A major role the department performs in the regulation of HMOs is to ensure that the contracts under which these entities provide services do not contain terms that are inconsistent, ambiguous, or misleading. Additionally, the

department is charged with ensuring that 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 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: accreditation; 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; and establishing an internal risk management program. 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 document), and any handbook issued by an HMO to subscribers must outline this procedure.

Requirements relating to HMO and prepaid health clinic subscriber grievance reporting and resolution are contained in s. 641.511, F.S. Under this section, 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. Under this provision, grievances must be written and may be subjected 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 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, and 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, simplified, 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 to the Act 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 by July 1, 1997. Agencies are required to comply with the uniform rules by July 1, 1998. Exceptions to the uniform rules are permitted, but a petition must be filed with, and approved by, the Administration Commission.

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, to define the term “managed care entity” to mean an accountable health partnership, an HMO, a prepaid health clinic, a Medicaid prepaid health plan, or an exclusive provider organization and the term “panel” to mean the statewide provider and subscriber assistance panel.

The bill provides that the panel shall meet as often as necessary to timely review, consider, and hear grievances by subscribers and providers on behalf of subscribers. The bill requires the panel to recommend actions the department or agency should take as to an individual case heard by the panel. The bill revises and expands the limitations on the panel’s authority to hear grievances. It provides that the panel shall hear every grievance filed by subscribers and providers on behalf of subscribers, 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 that 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 obligations of the managed care entity and the provider is involved in the care provided to the subscriber;
- Was filed before the subscriber or provider had completed the entire internal grievance procedure of the managed care entity, the internal grievance procedure is proceeding timely, and the subscriber's life is not in imminent and emergent jeopardy;
- Has been resolved to the subscriber's 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 health care provider or facility, staff member, or employee of a managed care entity which constitutes grounds for disciplinary action by the health regulation section of the agency or the appropriate professional licensing board and is not indicative of a pattern of inappropriate behavior, and the agency or the department has reported such conduct to the appropriate regulatory authority; or
- Is withdrawn by the subscriber or provider; failure of the subscriber or the provider to attend the hearing is to be considered to be a withdrawal of the grievance.

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. After 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 is required to hear the grievance in the managed care entity's network area or by teleconference no later than 120 days after the grievance is filed. This 120 days includes the 60 days the agency has to refer the grievance to the panel. The panel must issue its recommendation no later than 15 days after hearing the grievance. However, if at the hearing the panel requests additional documentation or additional records, the time for issuing a recommendation is delayed until the information or documentation is provided. The agency can request medical records from

the managed care entity and the provider. The panel's proceedings are exempted from the Administrative Procedure Act.

If, along with proper patient authorization and 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 is allowed 10 days to provide the records. Failure to provide the requested records may result in the imposition of a fine of up to $500 and each day that the records are not produced is considered a separate violation.

The bill provides for two expedited hearing processes for grievances. The first provision for an expedited hearing is for grievances determined by the agency to pose an immediate and serious threat to a subscriber's health. These grievances are to be given priority over the other grievances. The bill requires the panel to meet within 45 days after the grievance is filed with the agency, unless the subscriber waives the shortened time frame. The panel must issue its recommendation to the department or the agency within 10 days after hearing the expedited grievance.

The second provision for an expedited hearing is when the agency determines that the subscriber's life is in imminent and emergent jeopardy. The chair of the panel may convene an emergency hearing to hear the grievance within 24 hours after notification to the managed care entity and to the subscriber. Such grievances need not have completed the internal grievance procedure of the managed care entity. After hearing the grievance, the panel must issue an emergency recommendation to the managed care entity, 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 receiving the panel's emergency recommendation, the agency or the department may issue an emergency order to the managed care entity. If an emergency order is issued, it is to remain in force and effect until:

- The grievance has been resolved by the managed care entity;
- Medical intervention is no longer necessary; or
- The panel has conducted a full hearing and issued a recommendation to the agency or the department, and the agency or the department has issued a final order.

After hearing a grievance, the panel must 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. The bill sets a 10-day time limit after receipt of the panel's recommendation or 72-hour time limit after receipt of an expedited grievance recommendation within which a managed care entity, subscriber, or provider that is affected by a panel recommendation may furnish the agency or the department with written evidence in opposition to the recommendation of the panel.

The agency or the department may adopt the panel's recommendation in an order that it shall issue to the managed care entity no later than 30 days after the panel issues a non-expedited

grievance recommendation and no later than 10 days after the panel issues an expedited grievance recommendation. The agency's or the department's order may impose fines or sanctions, including fines or sanctions authorized under chapter 641, F.S., relating to HMO regulation, and may base such fines or sanctions on the following revised and expanded criteria:

- The severity of the noncompliance, including 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;
- Actions taken by the managed care entity to resolve or remedy any quality-of-care grievance;
- Any previous incidents of noncompliance by the managed care entity;
- Any other relevant factors the agency or department deems appropriate in a particular grievance.

All fines collected must be deposited into the Health Care Trust Fund. In contrast, the agency or the department is authorized to reject all or a portion of the panel's recommendation if the recommendation:

- Violates state or federal law, rules, or regulations;
- Is inconsistent with previous agency or department interpretations of state laws or rules regulating managed care entities; or
- Is determined by the agency or the department to be unsupported by the facts.

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.

Section 2. Creates s. 408.7057, F.S., which provides for hearings appealing orders of the department or agency based on recommendations of the statewide provider and subscriber assistance panel, to subject to summary hearings, as authorized under s. 120.574, F.S., certain orders issued by the agency or the department, as authorized under s. 408.7056, F.S., which require a managed care entity to take specific action. However, an order that imposes fines or sanctions, in addition to requiring the managed care entity to take specific action, must be bifurcated so that the portion of the order requiring specific action is subject to a summary hearing under the Administrative Procedure Act and the portion of the order imposing a fine or sanction is subject to full administrative review under the Administrative Procedure Act. In a summary hearing proceeding in which the managed care entity does not prevail, the managed care entity is required to pay the reasonable costs and attorney's fees incurred by the agency or the department. All other agency or department orders that are based on panel recommendations are

not subject to summary hearing or payment of costs and attorney's fees. Instead, they are subject to full administrative review under the Administrative Procedure Act.

Section 3. Amends s. 641.511, F.S., to conform a cross-reference to a change made in the bill.

Section 4. Appropriates to the agency for fiscal year 1998-1999 five full-time-equivalent positions and $247,396 from the Health Care Trust Fund; $25,912 is nonrecurring. This amount is to fund 9 months of implementation of the provisions of this bill.

Section 5. 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:

Managed care entities are at risk of incurring liabilities for reasonable costs and attorney's fees of AHCA or DOI relating to summary hearings before the Division of Administrative Hearings in which they challenge an agency order requiring them to take specific actions pertaining to resolution of a subscriber or provider grievance. Such costs will be incurred when the AHCA or DOI order is upheld.

Consumers of services provided by managed care entities can be anticipated to benefit from the provisions in the bill that provide for expedited consideration and resolution of their

grievances. Theoretically, such expedited resolutions and the more specific time frames provided for normal consideration and resolution could be anticipated to provide for more efficient and, therefore, cost effective delivery of health care services.

C. Government Sector Impact:

Five full-time-equivalent positions and $247,396 are appropriated from the Health Care Trust Fund to AHCA for 9 months of implementation of the provisions of the bill. Of the $247,396 appropriated, $25,912 is designated as nonrecurring.

FISCAL & APPROPRIATIONS DETAILS Funds appropriated from the Health Care Trust Fund Source: Agency for Health Care Administration		
NON-RECURRING EXPENDITURES	**AMOUNT Year 1 (FY 1998-1999)**	**AMOUNT Year 2 (FY 1999-2000)**
Non-recurring expenses for 4 professional FTEs @ $2,132	$ 8,528	0
Non-recurring expenses for 1 non-professional FTE @ $1,469	1,469	0
Total Non-recurring Expenses	$ 9,997	0
Operating Capital Outlay for 4 professional FTEs @$3,167	$12,668	0
Operating Capital Outlay for 1 non-professional FTE @ $3,247	3,247	0
Total Operating Capital Outlay Expenses	15,915	0
TOTAL NON-RECURRING EXPENDITURES	$25,912	0
RECURRING EXPENDITURES	**AMOUNT Year 1 (FY 1998-1999)** [9 months]	**AMOUNT Year 2 (FY 1999-2000)**
Salary and benefits for 1 FTE: senior attorney	$ 35,916	$ 47,888
Salaries and benefits for 3 FTEs: medical/health care program analysts	113,384	151,178

RECURRING EXPENDITURES	AMOUNT Year 1 (FY 1998-1999) [9 months]	AMOUNT Year 2 (FY 1999-2000)
Salary and benefits for 1 FTE: administrative secretary	18,705	24,940
Total Salaries and Benefits	$168,005	$224,006
Recurring expenses for 4 professional FTEs @ $11,057	$ 33,171	$ 44,228
Recurring expenses for 1 non-professional FTE @ $6,752	5,064	6,752
Expenses for additional hearings	15,244	15,244
Total Recurring Expenses	$ 53,479	$ 66,224
TOTAL RECURRING EXPENDITURES	$221,484	$290,230

The preference in the bill for a summary hearing for certain types of cases may result in an estimated additional three to four cases a year for the Division of Administrative Hearings. The agency and the department will have their costs and attorney's fees paid by managed care entities if they prevail in the summary hearings.

VI. Technical Deficiencies:

Page 2, lines 10 and 11 should be redrafted to read:

organization or a prepaid health clinic certified under chapter 641, a prepaid health plan authorized under s. 409.912, or

Page 5, line 31 could express a more beneficial and appropriate purpose than "*deferring* the imminent and emergent jeopardy" for the panel to issue an emergency recommendation such as *preventing* or *ending* such a threat. If the panel, an agent of the state, determines or recognizes conduct by a managed care entity to be a hazard to a subscriber, should it be allowed to resume such conduct after deferment?

Page 6, line 2 makes it permissive for the agency or the department to issue an emergency order once the panel issues an emergency recommendation. In light of a panel recommendation for emergency action, it would appear that the agency or the department should be compelled to intervene or, if other alternatives are available and would be more appropriate, they should be clearly stated.

Page 10, line 4 the reference to the "Department of Insurance" should be changed to "department" for consistency with other modifications to references to the department in this statutory provision, as revised in this bill.

VII. Related Issues:

Under 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. Therefore, providing for the continued exemption from the Administrative Procedure Act for the panel's proceedings appears to serve a public benefit.

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 or the department, and from that point on the grievance process becomes subject to the Administrative Procedure Act. The agency or the department can use the panel's recommendations, in addition to information gathered in the initial investigation, as a basis for proposed agency action; however, the agency must prove its case in a *de novo* (new and separate) hearing in the Division of Administrative Hearings. It is therefore no different from any other proposed agency action. If the panel's recommendation is part of an emergency order, the emergency order must meet the same standards applicable to any other emergency order, and may be appealed or enjoined from the date rendered. For these reasons, the procedures set forth in this bill appear to continue to provide a public service without giving any party an unfair advantage.

The bill does give additional strength to the panel's recommendation. If the agency or the department adopts the panel's 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., if all parties agree to such a proceeding. The agency or the department will not have final order authority in such cases; instead the final order will be issued by a Division of Administrative Hearing administrative law judge. If the managed care entity does not prevail, it will have to pay the 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 that require a managed care entity to take specific action. 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. Such proceedings are estimated to likely result in three to four cases a year. It is estimated that the panel decides in favor of subscribers 60 percent of the time, and for the managed care entity 40 percent of the time.

VIII. Amendments:

None.