By Senator Saunders

25-1157A-99

A bill to be entitled

An act relating to health care; amending s. 408.7056, F.S.; revising standards and procedures for hearing grievances under the statewide provider and subscriber assistance program; revising panel membership; providing for the issuance and judicial review of final orders; amending s. 641.51, F.S.; revising requirements for indicators of access and quality of care which health maintenance organizations and prepaid health clinics must submit to the Agency for Health Care Administration; deleting a requirement that each such organization conduct a customer satisfaction survey; revising guidelines relating to recommendations for preventive pediatric health care which must be submitted to the agency; amending s. 641.58, F.S.; revising guidelines for expending moneys from the Health Care Trust Fund; creating the Health Care Information Council within the Agency for Health Care Administration; providing for council membership, terms of office, and election of officers; providing for reimbursement for travel and per diem expenses; providing for an executive director, staff, and consultants; providing duties of the council; providing an effective date.

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

Section 1. Subsections (2), (9), (11), and (14) of section 408.7056, Florida Statutes, 1998 Supplement, are amended to read:

408.7056 Statewide Provider and Subscriber Assistance Program.--

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

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

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

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

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

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

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

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

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

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

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

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

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

(9) No later than 30 days after the issuance of the panel's recommendation and, for an expedited grievance, no later than 10 days after the issuance of the panel's recommendation, the agency or the department may adopt the panel's recommendation or findings of fact in a final ~~proposed~~ order or an emergency order, as provided in chapter 120, which it shall issue to the managed care entity. The agency or department may issue a proposed order or an emergency order, as provided in chapter 120, imposing fines or sanctions, including those contained in ss. 641.25 and 641.52. The agency or the department may reject all or part of the panel's recommendation. All fines collected under this subsection must be deposited into the Health Care Trust Fund.

(11) The panel shall consist of members employed by the agency and members employed by the department, chosen by their respective agencies, a consumer, a physician as a standing member, and rotating physicians who provide specific expertise as appropriate to the case being heard. The agency may contract with a medical director and a primary care physician who shall provide additional technical expertise to the panel. The medical director shall be selected from a health maintenance organization with a current certificate of authority to operate in Florida.

(14) A final ~~proposed~~ order issued by the agency or department which only requires the managed care entity to take a specific action under subsection (7) is subject to judicial review under s. 120.68 ~~a summary hearing in accordance with s. 120.574~~, unless all of the parties agree otherwise. If the

managed care entity does not prevail at judicial review ~~the hearing~~, the managed care entity must pay reasonable costs and attorney's fees of the agency or the department incurred in that proceeding.

Section 2. Subsections (8), (9), and (10) of section 641.51, Florida Statutes, are amended to read:

641.51 Quality assurance program; second medical opinion requirement.--

(8) Each organization shall release to the agency data that ~~which~~ are indicators of access and quality of care. The agency shall develop rules specifying data-reporting requirements for these indicators. The indicators shall include the following characteristics:

(a) They must relate to access and quality of care measures.

(b) They must be consistent with data collected pursuant to accreditation activities and standards.

(c) They must be consistent with frequency requirements under the accreditation process.

(d) They must include chronic disease management measures.

(e) They must relate to preventive health care for adults and children.

(f) They must include prenatal care measures.

(g) They must include child health checkup measures.

The agency shall develop by rule a uniform format for publication of the data for the public which shall contain explanations of the data collected and the relevance of such data. The agency shall publish such data no less frequently than every 2 years.

~~(9) Each organization shall conduct a standardized customer satisfaction survey, as developed by the agency by rule, of its membership at intervals specified by the agency. The survey shall be consistent with surveys required by accrediting organizations and may contain up to 10 additional questions based on concerns specific to Florida. Survey data shall be submitted to the agency, which shall make comparative findings available to the public.~~

(9)~~(10)~~ Each organization shall adopt recommendations for preventive pediatric health care consistent with child health checkup ~~early periodic screening, diagnosis, and treatment~~ requirements developed for the Medicaid program. Each organization shall establish goals to achieve 80-percent compliance by July 1, 1998, and 90-percent compliance by July 1, 1999, for their enrolled pediatric population.

Section 3. Subsection (4) of section 641.58, Florida Statutes, is amended, and subsections (8), (9), (10), and (11) are added to that section, to read:

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

(4) The moneys so received and deposited into the Health Care Trust Fund shall be used to defray the expenses of the agency in the discharge of its administrative and regulatory powers and duties under this part, including the administration of the Health Care Information Council, conducting an annual health maintenance organization member satisfaction survey, contracting with physician consultants for the statewide provider and subscriber assistance panel, the maintaining of offices and necessary supplies, essential equipment and other materials, salaries and expenses of required personnel, and all other legitimate expenses relating

to the discharge of the administrative and regulatory powers and duties imposed under such part.

(8) There is created a Health Care Information Council within the Agency for Health Care Administration. The council is located within the agency for administrative purposes but shall independently exercise the powers and duties assigned to it under this section.

(a) The council shall consist of 11 members, including the director of the Agency for Health Care Administration or the director's designee, the Insurance Commissioner or the commissioner's designee, 3 members appointed by the Governor, 3 members appointed by the President of the Senate, and 3 members appointed by the Speaker of the House of Representatives. The appointments must be made so as to achieve a balance among managed care organizations, providers, and consumers.

(b) Council members shall be appointed for staggered terms of no more than 2 years. Any member who is appointed to fill a vacancy occurring because of a member's death, resignation, or ineligibility for membership shall serve only for the remainder of the term of his or her predecessor or until a successor is appointed and qualifies. Any member who, without cause, fails to attend two consecutive meetings may be removed by the Governor.

(c) The council shall annually elect its chairperson and vice chairperson. The council shall meet at least quarterly, at the call of its chairperson or at the request of a majority of its membership. A majority of the members of the council constitutes a quorum.

(d) Membership on the council does not disqualify a member from holding any other public office or being employed

by a public entity except that a member of the Legislature may not serve on the council.

(e) Members of the council shall serve without compensation but are entitled to reimbursement for per diem and travel expenses as provided by s. 112.061.

(9) The council shall employ an executive director and such staff as is necessary, within the limits of legislative appropriations. The council may retain such consultants as it considers necessary for accomplishing its mission. Neither the executive director nor any consultant retained by the council may have been a contract vendor of the Department of Insurance or of the Agency for Health Care Administration.

(10) The Health Care Information Council shall act in an advisory capacity to the Governor, the Legislature, the Department of Insurance, and the Agency for Health Care Administration on matters of health care accountability and consumer information. The role of the council includes, but is not limited to:

(a) Contracting with an independent contractor to administer an annual survey of member satisfaction for all health maintenance organizations, including the Medicare, Medicaid, and commercial product lines;

(b) Selecting the instrument and the sampling design to meet the member satisfaction survey requirements of health maintenance organizations' accreditation organizations;

(c) Producing an HMO report card; and

(d) Making comparative survey results available to health maintenance organizations and the public.

(11) In addition to the member satisfaction survey results, the HMO report card must include benefit availability, physician qualifications, payment arrangements,

copayments, and the quality indicators provided in s. 641.51(8)(d), (e), (f), and (g).

Section 4. This act shall take effect upon becoming a law.

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SENATE SUMMARY

Relates to health care. Revises standards and procedures for hearing grievances under the statewide provider and subscriber assistance program. Revises panel membership. Provides for the issuance and judicial review of final orders. Revises requirements for indicators of access and quality of care which health maintenance organizations and prepaid health clinics must submit to the Agency for Health Care Administration. Deletes a requirement that each such organization conduct a customer satisfaction survey. Revises guidelines relating to recommendations for preventive pediatric health care which must be submitted to the agency. Revises guidelines for expending moneys from the Health Care Trust Fund. Creates the Health Care Information Council within the Agency for Health Care Administration. Provides for council membership, terms of office, and election of officers. Provides for reimbursement for travel and per diem expenses. Provides for an executive director, staff, and consultants. Provides duties of the council.