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.)

BILL: CS/SB 162

SPONSOR: Health, Aging and Long-Term Care Committee and Senator Cowin

SUBJECT: Grounds for Disciplinary Actions Against Allopathic and Osteopathic Physicians; Modifying Requirements Relating to Rendering of Adverse Determinations by Managed Care Organizations

DATE: February 9, 2000 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Carter/Munroe	Wilson	HC	Favorable/CS
2.			BI	
3.				
4.				
5.				

I. Summary:

Committee Substitute for Senate Bill 162 makes a medical physician or osteopathic physician subject to discipline by his or her board for the rendering of an adverse determination, as defined in s. 641.47(1), *Florida Statutes* (F.S.), which is inconsistent with the level of care, skill, and treatment that is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances. Also, the bill restricts a managed care organization's authority to render an adverse determination for any services provided by a *Florida-licensed* medical or osteopathic physician to only those adverse determinations rendered by a *Florida-licensed* medical physician or osteopathic physician on behalf of the managed care organization. Such adverse determinations must be supported by written, signed facts and documentation. The facts and documentation regarding an adverse determination must be provided to the subscriber and the provider requesting services or benefits on behalf of the subscriber within 2 working days after the subscriber or provider is notified of the adverse determination. The managed care organization must also supply information about the process for appealing an adverse determination along with the facts and documentation.

This bill substantially amends sections 458.331, 459.015, and 641.51, F.S.

II. Present Situation:

Regulation of the Practice of Medicine and the Practice of Osteopathic Medicine

Chapter 458, F.S., provides for the regulation of medical physicians by the Board of Medicine within the Department of Health. Section 458.305, F.S., defines the "practice of medicine" to mean the diagnosis, treatment, operation, or prescription for any human disease, pain, injury, deformity, or other physical or mental condition. Section 458.303, F.S., provides exceptions to the "practice of medicine" for: other duly licensed health care practitioners acting within their

scope of practice authorized by statute; licensed out-of-state physicians when meeting in consultation with Florida licensed physicians; medical officers of the United States Armed Forces and of the United States Public Health Service; medical residents; persons furnishing emergency medical assistance; the domestic administration of recognized family remedies; the practice of the religious tenets of any church in Florida; and any person or manufacturer who, without the use of drugs or medicine, mechanically fits or sells lenses, artificial eyes or limbs, or other apparatus or appliances, or is engaged in the mechanical examination of the eyes for the purpose of constructing or adjusting spectacles, eyeglasses, or lenses.

Three basic levels of regulation are used to regulate professions. The least restrictive level of occupational regulation is registration. Under registration, practitioners are only required to file certain information as it relates to services that they offer the public. An intermediate level of occupational regulation is regulation by a title act. Under a title act, the use of certain titles or descriptions is limited to a group of practitioners who have met certain minimum qualifications. A title act, however, does not prohibit anyone from offering comparable services to those offered by the practitioners licensed under the title act. A practice act limits the performance of certain activities to those licensed to practice.

Chapter 458, F.S., the medical practice act, requires any person who performs acts which are comparable to those within the definition of the "practice of medicine" to be licensed or otherwise exempt. The medical practice act provides criminal penalties for any person who performs acts comparable to the definition of the "practice of medicine" who is not licensed or otherwise exempt from the medical licensure requirements. Under s. 458.327(1), F.S., any person who practices medicine or attempts to do so, without being licensed or otherwise exempt from the licensure requirements, is subject to a third degree felony punishable by imprisonment of up to 5 years and a fine up to $5,000. Subsection (2) of s. 458.327, F.S., subjects any person who leads the public to believe that person is licensed as a medical doctor, or is engaged in the licensed practice of medicine, without holding a valid active license to practice medicine, to a first degree misdemeanor punishable by imprisonment of up to 1 year and a fine up to $1,000.

Section 458.331, F.S., specifies grounds for which a medical physician may be subject to discipline by the Board of Medicine. A medical physician is subject to discipline for any act in violation of applicable standards of practice which include gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances. Pursuant to subsection 458.331(3), F.S., in any administrative action against a physician which does not involve revocation or suspension of his or her license, the division (Department of Health) shall have the burden, by the greater weight of the evidence, to establish the existence of grounds for disciplinary action. The division shall establish grounds for revocation or suspension of a license by clear and convincing evidence. A medical physician may be subject to discipline for aiding, assisting, procuring, or advising any unlicensed person to practice medicine contrary to the medical practice act or to any administrative rule adopted by the Department of Health or the Board of Medicine.

Chapter 459, F.S., the osteopathic medical practice act, similarly provides for the regulation of osteopathic physicians by the Board of Osteopathic Medicine in the Department of Health. Section 459.003, F.S., defines the "practice of osteopathic medicine" to mean the diagnosis,

treatment, operation, or prescription for any human disease, pain, injury, deformity, or other physical or mental condition, which practice is based in part upon educational standards and requirements which emphasize the importance of the musculoskeletal structure and manipulative therapy in the maintenance and restoration of health. Chapter 459, F.S., contains provisions relating to the definition of practice, exceptions to the licensure requirements, discipline of licensed osteopathic physicians, and criminal violations for unlicensed persons which are comparable to those in the medical practice act.

Part II, ch. 455, F.S., provides the general regulatory provisions for health care professions regulated under the Department of Health. Section 455.637, F.S., authorizes the Department of Health to issue and deliver a notice of cease and desist to any person when the department has probable cause to believe that that person is not licensed by the department or the appropriate regulatory board, and has violated any provision of part II, ch. 455, F.S., or any statute that relates to the practice of a profession regulated by the department, or any administrative rule adopted thereto. Section 455.634, F.S., requires the Department of Health or the appropriate board to report any criminal violation of any statute relating to the practice of a profession regulated by the department or appropriate board to the proper prosecuting authority for prompt prosecution.

Regulatory Requirements for Quality Assurance Programs and Second Medical Opinion for Managed Care Organizations

Health maintenance organizations (HMO) and prepaid health clinics (PHC), with other types of organizations collectively referred to as “managed care organizations,” are regulated under ch. 641, F.S., by the Department of Insurance (DOI) and the Agency for Health Care Administration (AHCA). Generally, DOI regulates contractual, financial, and other operational requirements relating to managed care organizations under parts I and II, respectively, of ch. 641, F.S., while AHCA regulates HMO and PHC quality-of-care practices under part III of ch. 641, F.S. Quality requirements for managed care organizations under part III of ch. 641, F.S., include, among others: an internal quality assurance program; accreditation; and demonstration, to AHCA's satisfaction, of the HMO’s or PHC’s capability to provide health care services of a quality consistent with the prevailing standards of medical practice in the community.

As specified in s. 641.51, F.S., the internal quality assurance program must, at a minimum, provide:

- a written statement of goals and objectives which stress health outcomes as the principal criteria for the evaluation of the quality of care rendered to subscribers;
- a written statement describing how state-of-the-art methodology has been incorporated into an ongoing system for monitoring of care which is individual case oriented and, when implemented, can provide interpretation and analysis of patterns of care rendered to individual patients by individual providers;
- written procedures for taking appropriate remedial action whenever, as determined under the quality assurance program, inappropriate or substandard services have been provided or services which should have been furnished have not been provided; and
- a written plan for providing review of physicians and other licensed medical providers which includes ongoing review within the organization.

In addition to the quality assurance program requirements, s. 641.51, F.S., explicitly prohibits managed care organizations, their respective boards of directors, officers, and administrators from modifying the proper course of treatment of a subscriber as determined through the professional judgment of a Florida-licensed physician. Such treatment may, however, be modified if it is determined that the treatment is inconsistent with the prevailing standards of medical practice in the community or with an organization's utilization management program.

Managed care organizations are required to give their subscribers *the right* to a second medical opinion when the subscriber disputes denial of the reasonableness or necessity for surgical procedures or is subject to a serious injury or illness. A subscriber may select a physician under contract with or employed by the managed care organization or a noncontract physician who is located in the same geographical service area of the organization. The organization may charge the subscriber fees for the services of a contracted or staff physician rendering a second medical opinion that are consistent with fees for referral contract physicians and must pay all charges which are usual, reasonable, and customary in the community for services by a noncontract physician rendering a second medical opinion. The subscriber may be required to pay up to 40 percent of the amount due a noncontract physician. The organization may conduct any tests that are deemed necessary for the subscriber by a noncontract physician. Organizations are authorized to deny reimbursement when the subscriber seeks more than three second medical opinions in a year if such subsequent referral costs are deemed by the organization as evidence that the subscriber has unreasonably over utilized the second opinion privilege, and the subscriber may appeal the denial of reimbursement through the internal and external grievance processes. Once the organization's physician, having factored in the second medical opinion, renders his or her professional judgment concerning the treatment of the subscriber, it is controlling as to the treatment obligations of the organization. The subscriber is responsible for any unauthorized treatment obtained.

Other subscriber protections provided under s. 641.51, F.S., include requiring organizations to: (1) develop and maintain a policy for determining when exceptional referrals to out-of-network specially qualified providers should be provided for unique medical needs, subject to financial arrangements being agreed to prior to the rendering of services; (2) develop and maintain written policies and procedures for standing referrals to subscribers with chronic and disabling conditions which require ongoing specialty care; (3) allow for completion of active treatment of a condition for which a subscriber is receiving care when a contract between the organization and the subscriber's treating physician is terminated for any reason other than for cause until the subscriber (unless abusive, noncompliant, or in arrears in payments) selects another treating provider, or during the organization's next open enrollment period, whichever is longer, but not longer than 6 months after termination of the contract, or through completion of postpartum care for a subscriber who has initiated a course of prenatal care, such treatment is governed by terms of the terminated contract provided that changes made within 30 days before termination must be mutually agreed to for the continuing treatment period; (4) release certain specified indicator data to AHCA, in accordance with agency data reporting requirements, relating to access and quality of care; (5) adopt, by specified dates, recommendations for preventive pediatric health care consistent with health checkups for children who receive services through the Medicaid program; and (6) allow female subscribers, without prior authorization, but coordination with the primary

care physician may be required, to visit a contracted obstetrician/gynecologist for one annual visit and medically necessary followup care detected at that visit.

Adverse Determinations by Managed Care Organizations

Subsection 641.47(1), F.S., defines the term "adverse determination" to mean

> *a coverage determination by an organization [HMO or PHC] 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. Requirements relating to the managed-care-organization subscriber grievance reporting and resolution process 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. Managed care organization subscribers, or providers on behalf of subscribers, who want to challenge an adverse determination must first appeal the decision through the managed care organization's grievance procedure. Once the internal grievance process has been exhausted without satisfaction, subscribers, or providers on behalf of subscribers, may appeal the adverse determination through the state's external grievance process administered through the Statewide Provider and Subscriber Assistance Panel, created under s. 408.7056, 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 reviewed 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.

Current state law restricts who may render an "adverse determination" only for commercial insurers that are not operating a self-insurance fund or service companies providing worker's compensation benefits or operating as insurance administrators. These restrictions are imposed on certain private utilization review agents, as regulated by s. 395.0199, F.S. As provided in subparagraph 395.0199(5)(b)1., F.S., *at least* a licensed practical nurse or licensed registered nurse, or other similarly qualified medical records or health care professionals, may perform *initial review* when information is necessary from the physician or hospital to determine the medical necessity or appropriateness of hospital services. Subparagraph 395.0199(5)(b)2., F.S., requires that *at least* a licensed physician, or a licensed physician practicing in the field of psychiatry for

review of mental health services, [make] an *initial denial determination prior to a final denial determination by the health insurer* which shall include the written evaluation and findings of the reviewing physician. However, subsection 395.0199(8), F.S., expressly *exempted* from the personnel requirements established by s. 395.0199, F.S., utilization review organizations or peer review organizations acting under contract on behalf of the Medicaid Program, Medicare Program, state employees group insurance plan, worker's compensation plan, or private self-insured funds or service companies operating as insurance administrators.

Accreditation Requirements Relating to Adverse Determinations

A managed care organization regulated under part III of ch. 641, F.S., is required as a condition of doing business in Florida to be accredited within 1 year of receiving its certificate of authority from DOI. Accreditation must be maintained as a condition of doing business in the state. Such organizations must undergo an accreditation assessment at least every 2 years or more frequently if AHCA deems additional assessments necessary.

Accreditation through the National Committee for Quality Assurance, a national accreditation organization, generally, requires a managed care organization to meet certain specific requirements relating to denial notices. Denials are one type of adverse determination. An accredited organization must document *and* communicate the reasons for each denial. To this end, managed care organizations must: (1) make a physician reviewer available, to discuss with the subscriber's provider by telephone, determinations based on medical necessity; (2) send written notification to members and practitioners of the reasons for each denial, including specific utilization review criteria or benefits provisions used in the determination; and (3) include information about the appeal process in all denial notifications.

Consumer Backlash Against Managed Care

Managed care is predicated on improving health care quality, eliminating wasteful service utilization, limiting the size of physician networks in order to achieve maximum efficiency, and controlling costs through administrative efficiencies. Managed care organizations, initially HMOs and later preferred provider organizations as well as exclusive provider organizations, were designed to contain once rapidly escalating health care costs. Federal law enacted during the 1970's helped these organizations to develop by authorizing startup money to nonprofit HMO's and preempting states from adopting legislation that would interfere with their existence. The overall business concept for such organizations is to contain health care costs by signing up large numbers of members (subscribers) through whom the organization gains group purchasing power for the purchase of health care services from health care providers and then managing their subscriber's use of health care providers and health care services.

Managed care has become a dominant force in the financing and delivery of health care in this country. Because of the rising concerns that investor-owned managed care organizations are not doing enough to provide and maintain health care quality, numerous measures have been introduced in various legislative bodies throughout the United States, including Congress, that would mandate certain relationship changes between managed care organizations and their providers and subscribers. In general, some of the common features of legislative proposals under consideration or adopted during the past few years include: (1) increased access to specialists; (2)

requirements for the organizations to establish internal and external appeals processes; (3) empowering subscribers to sue the organizations for failure to provide necessary services; (4) elimination of barriers to emergency room access; (5) prohibiting managed care organizations from interfering with the discussion of health care alternatives by prohibiting inclusion of so-called "gag clauses" in the plan contract; and (6) establishing certain due process protections for providers whose contracts are terminated.

III. Effect of Proposed Changes:

Section 1. Amends s. 458.331, F.S., to make a medical physician subject to discipline by the Board of Medicine for *rendering an adverse determination*, as defined in s. 641.47, F.S., relating to covered services and benefits under a managed care organization's health plan, which is inconsistent with the level of care, skill, and treatment that is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances.

Section 2. Amends s. 459.015, F.S., to make an osteopathic physician subject to discipline by the Board of Osteopathic Medicine for *rendering an adverse determination*, as defined in s. 641.47, F.S., relating to covered services and benefits under a managed care organization's health plan, which is inconsistent with the level of care, skill, and treatment that is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances.

Section 3. Amends s. 641.51, F.S., providing quality assurance program and second medical opinion requirements for managed care organizations, to require such organizations to authorize only a Florida-licensed medical or osteopathic physician to render an adverse determination regarding services provided by a Florida-licensed medical or osteopathic physician relating to the delivery of covered services or benefits. A physician who makes an adverse determination must be required to submit written facts and documentation regarding the adverse determination to the subscriber and health care provider requesting the service or product on behalf of the subscriber within 2 working days after the subscriber or provider is notified of the adverse determination. The facts and documentation must include the utilization review criteria or benefits provisions on which the adverse determination is based and must be signed by the physician who renders the adverse determination. The managed care organization is required to include along with the facts and documentation, information about the appeal process for challenging adverse determinations.

Section 4. Provides for an effective date of July 1, 2000.

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 Article I, Subsections 24(a) and (b) 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, Subsection 19(f) of the Florida Constitution.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Any person who renders an adverse determination on behalf of a managed care organization must be a Florida-licensed medical physician or osteopathic physician and may be subject to discipline by his or her board for any act which is inconsistent with the applicable standard of practice when rendering an adverse determination. To the extent any person is liable in tort for the rendering of an adverse determination on behalf of a managed care organization, that person will incur costs relating to their tortious acts.

Any person who currently renders an adverse determination on behalf of a managed care organization who is not a Florida-licensed medical or osteopathic physician, will incur costs to obtain Florida licensure as a medical physician or osteopathic physician, to perform such acts.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The bill’s specialized requirements for a managed care organization’s adverse determination for the services of a Florida-licensed medical or osteopathic physician may encourage other Florida-licensed health care professions to seek similar requirements.

VIII. Amendments:

None.