CHAPTER 97-159

Committee Substitute for Committee Substitute for House Bill Nos. 297 and 325

An act relating to managed health care entities; amending s. 636.003, F.S.; providing an exemption from the definition of "prepaid limited health service organization"; amending s. 641.315, F.S.; prohibiting provider contracts from restricting a provider's ability to communicate certain information to subscribers; creating s. 641.316, F.S.; providing for regulation of fiscal intermediary services organizations; providing requirements and restrictions; requiring a bond; requiring registration with the Department of Insurance; providing exemptions; providing for rules; creating the Florida Commission on Integrated Health Care Delivery Systems; providing membership and duties; requiring recommendations to the Legislature; providing for future repeal; amending s. 641.47, F.S.; providing definitions; amending s. 641.495, F.S.; requiring designation of a licensed physician as medical director; amending s. 641.51, F.S.; requiring development of policies relating to out-of-network referrals; requiring written procedures for standing referrals for individuals who require ongoing specialty care for chronic and disabling conditions; requiring certain continued access to terminated treating providers for subscribers with a life-threatening or a disabling and degenerative condition, and for certain pregnant subscribers; providing limitations; requiring report to the Agency for Health Care Administration of access, quality of care, and customer satisfaction data; requiring publication of data; requiring adoption of certain recommendations and goals for preventive pediatric health care; amending s. 641.511, F.S.; specifying procedures, requirements, and timeframes for addressing subscriber grievances; requiring certain notice to subscribers; providing for review of adverse determinations; providing for certain referral to the Statewide Provider and Subscriber Assistance Program; providing for expedited review of urgent grievances; authorizing administrative sanctions for noncompliance with grievance procedure requirements; amending s. 641.54, F.S.; requiring disclosure to subscribers, upon request, of certain policies, procedures, and processes relating to authorization and referral for services, determination of medical necessity, quality of care, prescription drug benefits, confidentiality of medical records, approval or denial of experimental or investigational treatments, addressing the needs of non-English-speaking subscribers, and examining qualifications of and the credentialing of providers; requiring report to the agency of changes in authorization and referral criteria or the process used to determine medical necessity; providing effective dates.

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

Section 1. Paragraph (c) is added to subsection (9) of section 636.003, Florida Statutes, to read:

636.003 Definitions.—As used in this act, the term:

(9) "Prepaid limited health service organization" means any person, corporation, partnership, or any other entity which, in return for a prepayment, undertakes to provide or arrange for, or provide access to, the provision of a limited health service to enrollees through an exclusive panel of providers. Prepaid limited health service organization does not include:

(a) An entity otherwise authorized pursuant to the laws of this state to indemnify for any limited health service; ~~or~~

(b) A provider or entity when providing limited health services pursuant to a contract with a prepaid limited health service organization, a health maintenance organization, a health insurer, or a self-insurance plan; or~~.~~

(c) Any person who, in exchange for fees, dues, charges or other consideration, provides access to a limited health service provider without assuming any responsibility for payment for the limited health service or any portion thereof.

Section 2. Subsection (8) is added to section 641.315, Florida Statutes, 1996 Supplement, to read:

641.315 Provider contracts.—

(8) A contract between a health maintenance organization and a provider of health care services shall not contain any provision restricting the provider's ability to communicate information to the provider's patient regarding medical care or treatment options for the patient when the provider deems knowledge of such information by the patient to be in the best interest of the health of the patient.

Section 3. Section 641.316, Florida Statutes, is created to read:

641.316 Fiscal intermediary services.—

(1) It is the intent of the Legislature, through the adoption of this section, to ensure the financial soundness of fiscal intermediary services organizations established to develop, manage, and administer the business affairs of health care professional providers such as medical doctors, doctors of osteopathy, doctors of chiropractic, doctors of podiatric medicine, doctors of dentistry, or other health professionals regulated by the Department of Health.

(2)(a) The term "fiduciary" or "fiscal intermediary services" means reimbursements received or collected on behalf of health care professionals for services rendered, patient and provider accounting, financial reporting and auditing, receipts and collections management, compensation and reimbursement disbursement services, or other related fiduciary services pursuant to health care professional contracts with health maintenance organizations.

(b) The term "fiscal intermediary services organization" means a person or entity which performs fiduciary or fiscal intermediary services to health care professionals who contract with health maintenance organizations

other than a fiscal intermediary services organization owned, operated, or controlled by a hospital licensed under chapter 395, an insurer licensed under chapter 624, a third-party administrator licensed under chapter 626, a prepaid limited health organization licensed under chapter 636, a health maintenance organization licensed under chapter 641, or physician group practices as defined in s. 455.236(3)(f).

(3) A fiscal intermediary services organization which is operated for the purpose of acquiring and administering provider contracts with managed care plans for professional health care services, including, but not limited to, medical, surgical, chiropractic, dental, and podiatric care, and which performs fiduciary or fiscal intermediary services shall be required to secure and maintain a fidelity bond in the minimum amount of $10 million. This requirement shall apply to all persons or entities engaged in the business of providing fiduciary or fiscal intermediary services to any contracted provider or provider panel. The fidelity bond shall provide coverage against misappropriation of funds by the fiscal intermediary or its officers, agents, or employees; must be posted with the department for the benefit of managed care plans, subscribers, and providers; and must be on a form approved by the department. The fidelity bond must be maintained and remain unimpaired as long as the fiscal intermediary services organization continues in business in this state and until the termination of its registration.

(4) A fiscal intermediary services organization may not collect from the subscriber any payment other than the copayment or deductible specified in the subscriber agreement.

(5) Any fiscal intermediary services organization, other than a fiscal intermediary services organization owned, operated, or controlled by a hospital licensed under chapter 395, an insurer licensed under chapter 624, a third-party administrator licensed under chapter 626, a prepaid limited health organization licensed under chapter 636, a health maintenance organization licensed under chapter 641, or physician group practices as defined in s. 455.236(3)(f), must register with the department and meet the requirements of this section. In order to register as a fiscal intermediary services organization, the organization must comply with ss. 641.21(1)(c) and (d) and 641.22(6). Should the department determine that the fiscal intermediary services organization does not meet the requirements of this section, the registration shall be denied. In the event that the registrant fails to maintain compliance with the provisions of this section, the department may revoke or suspend the registration. In lieu of revocation or suspension of the registration, the department may levy an administrative penalty in accordance with s. 641.25.

(6) The department shall promulgate rules necessary to implement the provisions of this section.

Section 4. (1) (1) The Florida Commission on Integrated Health Care Delivery Systems is created to conduct an analysis of the various arrangements by which providers, as defined in s. 641.19, Florida Statutes, may contract with insurers, health maintenance organizations, and other health care purchasers or potential purchasers for the provision of health care

goods and services. The commission shall also analyze how such arrangements or potential arrangements fit into Florida's current regulatory structure. The commission shall be composed of 13 members, four selected by the President of the Senate; four by the Speaker of the House of Representatives; three by the Insurance Commissioner, of which two shall represent consumers; the Director of Health Care Administration, or a designee; and the Secretary of Health, or a designee. Members of the commission, other than the Insurance Commissioner's members, shall be selected from entities regulated by the Department of Insurance and the Agency for Health Care Administration and professionals regulated by the Department of Health or from associations of such professionals and entities. Persons appointing commission members, other than the Insurance Commissioner, shall make at least one appointment from each category specified.

(2) The commission shall report its findings to the President of the Senate and the Speaker of the House of Representatives by January 1, 1998. The commission shall include in its report proposed draft legislation that it deems necessary to implement the findings and recommendations contained in its report. The commission may recommend regulatory requirements, including whether and to what extent various arrangements should be regulated and what quality of care standards should be met.

(3) The Department of Insurance shall provide any necessary staff support for the commission. Private-sector members of the commission, except consumer members, are not eligible for per diem or travel expenses.

(4) The commission is abolished and this section expires on the last day of the 1998 Regular Session of the Legislature.

(2) This section shall take effect upon becoming a law.

Section 5. Section 641.47, Florida Statutes, 1996 Supplement, is amended to read:

641.47 Definitions.—As used in this part, the term:

(1) "Adverse determination" means a coverage determination by an organization 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.

(2)~~(1)~~ "Agency" means the Agency for Health Care Administration.

(3) "Clinical peer" means a health care professional in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review.

(4) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by the organization to determine, for coverage purposes, the necessity and appropriateness of health care services.

(5) "Complaint" means any expression of dissatisfaction by a subscriber, including dissatisfaction with the administration, claims practices, or provision of services, which relates to the quality of care provided by a provider pursuant to the organization's contract and which is submitted to the organization or to a state agency. A complaint is part of the informal steps of a grievance procedure and is not part of the formal steps of a grievance procedure unless it is a grievance as defined in subsection (10).

(6) "Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

(7)~~(2)~~ "Emergency medical condition" means:

(a) A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Serious jeopardy to the health of a patient, including a pregnant woman or a fetus.

2. Serious impairment to bodily functions.

3. Serious dysfunction of any bodily organ or part.

(b) With respect to a pregnant woman:

1. That there is inadequate time to effect safe transfer to another hospital prior to delivery;

2. That a transfer may pose a threat to the health and safety of the patient or fetus; or

3. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

(8)~~(3)~~ "Emergency services and care" means medical screening, examination, and evaluation by a physician or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists, and if it does, the care, treatment, or surgery for a covered service by a physician necessary to relieve or eliminate the emergency medical condition within the service capability of a hospital.

(9)~~(4)~~ "Geographic area" means the county or counties, or any portion of a county or counties, within which the health maintenance organization provides or arranges for comprehensive health care services to be available to its subscribers.

(10) "Grievance" means a written complaint submitted by or on behalf of a subscriber to an organization or a state agency regarding the:

(a) Availability, coverage for the delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

(b) Claims payment, handling, or reimbursement for health care services; or

(c) Matters pertaining to the contractual relationship between a subscriber and an organization.

A grievance does not include a written complaint submitted by or on behalf of a subscriber eligible for a grievance and appeals procedure provided by an organization pursuant to contract with the Federal Government under Title XVIII of the Social Security Act.

(11)~~(5)~~ "Health care services" means comprehensive health care services, as defined in s. 641.19, when applicable to a health maintenance organization, and means basic services, as defined in s. 641.402, when applicable to a prepaid health clinic.

(12)~~(6)~~ "Minimum services" includes any of the following: emergency care, inpatient hospital services, physician care, ambulatory diagnostic treatment, and preventive health care services.

(13)~~(7)~~ "Organization" means any health maintenance organization as defined in s. 641.19 and any prepaid health clinic as defined in s. 641.402.

(14)~~(8)~~ "Provider" means any physician, hospital, or other institution, organization, or person that furnishes health care services and is licensed or otherwise authorized to practice in the state. To submit or pursue a grievance on behalf of a subscriber, a provider must previously have been directly involved in the treatment or diagnosis of the subscriber.

(15) "Retrospective review" means a review, for coverage purposes, of medical necessity conducted after services have been provided to a patient.

(16)~~(9)~~ "Subscriber" means an individual who has contracted, or on whose behalf a contract has been entered into, with a health maintenance organization for health care services.

(17) "Urgent grievance" means an adverse determination when the standard timeframe of the grievance procedure would seriously jeopardize the life or health of a subscriber or would jeopardize the subscriber's ability to regain maximum function.

Section 6. Subsection (11) is added to section 641.495, Florida Statutes, 1996 Supplement, to read:

641.495 Requirements for issuance and maintenance of certificate.—

(11) The organization shall designate a medical director who is a physician licensed under chapter 458 or chapter 459.

Section 7. Subsections (5), (6), (7), (8), (9), and (10) are added to section 641.51, Florida Statutes, to read:

641.51 Quality assurance program; second medical opinion requirement.—

(5) Each organization shall develop and maintain a policy to determine when exceptional referrals to out-of-network specially qualified providers should be provided to address the unique medical needs of a subscriber. All financial arrangements for the provision of these services shall be agreed to prior to the services being rendered.

(6) Each organization shall develop and maintain written policies and procedures for the provision of standing referrals to subscribers with chronic and disabling conditions which require ongoing specialty care.

(7) Each organization shall allow subscribers to continue care for 60 days with a terminated treating provider when medically necessary, provided the subscriber has a life-threatening condition or a disabling and degenerative condition. Each organization shall allow a subscriber who is in the third trimester of pregnancy to continue care with a terminated treating provider until completion of postpartum care. The organization and the provider shall continue to be bound by the terms of the contract for such continued care. This subsection shall not apply to treating providers who have been terminated by the organization for cause.

(8) Each organization shall release to the agency data 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.

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.

(10) Each organization shall adopt recommendations for preventive pediatric health care consistent with 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 8. Section 641.511, Florida Statutes, is amended to read:

641.511 Subscriber grievance reporting and resolution requirements.—

(1) Every organization must have a grievance procedure available to its subscribers for the purpose of addressing complaints and grievances. Every organization must notify its subscribers that a subscriber must submit a grievance within 1 year after the date of occurrence of the action that initiated the grievance, and may submit the grievance for review to the Statewide Provider and Subscriber Assistance Program panel as provided in s. 408.7056 after receiving a final disposition of the grievance through the organization's grievance process. An ~~The health maintenance~~ organization shall maintain records of all grievances and shall report annually to the agency ~~department a description of~~ the total number of grievances handled, a categorization of the cases underlying the grievances, and the final disposition ~~resolution~~ of the grievances.

(2) When an organization receives an initial complaint from a subscriber, the organization must respond to the complaint within a reasonable time after its submission. At the time of receipt of the initial complaint, the organization shall inform the subscriber that the subscriber has a right to file a written grievance at any time and that assistance in preparing the written grievance shall be provided by the organization.

(3) Each organization's grievance procedure, as required under subsection (1), must include, at a minimum:

(a) An explanation of how to pursue redress of a grievance.

(b) The names of the appropriate employees or a list of grievance departments that are responsible for implementing the organization's grievance procedure. The list must include the address and the toll-free telephone number of each grievance department, the address of the agency and its toll-free telephone hotline number, and the address of the Statewide Provider and Subscriber Assistance Program and its toll-free telephone number.

(c) The description of the process through which a subscriber may, at any time, contact the toll-free telephone hotline of the agency to inform it of the unresolved grievance.

(d) A procedure for establishing methods for classifying grievances as urgent and for establishing time limits for an expedited review within which such grievances must be resolved.

(e) A notice that a subscriber may voluntarily pursue binding arbitration in accordance with the terms of the contract if offered by the organization, after completing the organization's grievance procedure and as an alternative to the Statewide Provider and Subscriber Assistance Program. Such notice shall include an explanation that the subscriber may incur some costs if the subscriber pursues binding arbitration, depending upon the terms of the subscriber's contract.

(f) A process whereby the grievance manager acknowledges the grievance and investigates the grievance in order to notify the subscriber of a final decision in writing.

(g) A procedure for providing individuals who are unable to submit a written grievance with access to the grievance process, which shall include assistance by the organization in preparing the grievance and communicating back to the subscriber.

(4)(a) With respect to a grievance concerning an adverse determination, an organization shall make available to the subscriber a review of the grievance by an internal review panel; such review must be requested within 30 days after the organization's transmittal of the final determination notice of an adverse determination. A majority of the panel shall be persons who previously were not involved in the initial adverse determination. A person who previously was involved in the adverse determination may appear before the panel to present information or answer questions. The panel shall have the authority to bind the organization to the panel's decision.

(b) An organization shall ensure that a majority of the persons reviewing a grievance involving an adverse determination are providers who have appropriate expertise. An organization shall issue a copy of the written decision of the review panel to the subscriber and to the provider, if any, who submits a grievance on behalf of a subscriber. In cases where there has been a denial of coverage of service, the reviewing provider shall not be a provider previously involved with the adverse determination.

(c) An organization shall establish written procedures for a review of an adverse determination. Review procedures shall be available to the subscriber and to a provider acting on behalf of a subscriber.

(d) In any case when the review process does not resolve a difference of opinion between the organization and the subscriber or the provider acting on behalf of the subscriber, the subscriber or the provider acting on behalf of the subscriber may submit a written grievance to the Statewide Provider and Subscriber Assistance Program.

(5) Except as provided in subsection (6), the organization shall resolve a grievance within 60 days after receipt of the grievance, or within a maximum of 90 days if the grievance involves the collection of information outside the service area. These time limitations are tolled if the organization has notified the subscriber, in writing, that additional information is required for proper review of the grievance and that such time limitations are tolled until such information is provided. After the organization receives the requested information, the time allowed for completion of the grievance process resumes.

(6)(a) An organization shall establish written procedures for the expedited review of an urgent grievance. A request for an expedited review may be submitted orally or in writing and shall be subject to the review procedures of this section, if it meets the criteria of this section. Unless it is submitted in writing, for purposes of the grievance reporting requirements in subsection (1), the request shall be considered an appeal of a utilization review decision and not a grievance. Expedited review procedures shall be available to a subscriber and to the provider acting on behalf of a subscriber. For purposes of this subsection, "subscriber" includes the legal representative of a subscriber.

(b) Expedited reviews shall be evaluated by an appropriate clinical peer or peers. The clinical peer or peers shall not have been involved in the initial adverse determination.

(c) In an expedited review, all necessary information, including the organization's decision, shall be transmitted between the organization and the subscriber, or the provider acting on behalf of the subscriber, by telephone, facsimile, or the most expeditious method available.

(d) In an expedited review, an organization shall make a decision and notify the subscriber, or the provider acting on behalf of the subscriber, as expeditiously as the subscriber's medical condition requires, but in no event more than 72 hours after receipt of the request for review. If the expedited review is a concurrent review determination, the service shall be continued without liability to the subscriber until the subscriber has been notified of the determination.

(e) An organization shall provide written confirmation of its decision concerning an expedited review within 2 working days after providing notification of that decision, if the initial notification was not in writing.

(f) An organization shall provide reasonable access, not to exceed 24 hours after receiving a request for an expedited review, to a clinical peer who can perform the expedited review.

(g) In any case when the expedited review process does not resolve a difference of opinion between the organization and the subscriber or the provider acting on behalf of the subscriber, the subscriber or the provider acting on behalf of the subscriber may submit a written grievance to the Statewide Provider and Subscriber Assistance Program.

(h) An organization shall not provide an expedited retrospective review of an adverse determination.

(7)~~(2)~~ Each ~~health maintenance~~ organization shall send to the agency ~~department~~ a copy of its annual and quarterly grievance reports submitted to the Department of Insurance pursuant to s. 408.7056(2).

(8)~~(3)~~ The agency ~~department~~ shall investigate all reports of unresolved quality of care grievances received from:

(a) Annual and quarterly grievance reports submitted by the ~~health maintenance~~ organization to the Department of Insurance.

(b) Review requests ~~Appeals~~ of subscribers whose grievances remain unresolved after the subscriber has followed the full grievance procedure of the organization.

(9)(a)~~(4)~~ The agency ~~department~~ shall advise subscribers with grievances to follow their organization's ~~the health maintenance organization~~ formal grievance process for resolution prior to review by the Statewide Provider and Subscriber Assistance Program ~~department~~. The subscriber may, however, submit a copy of the grievance to the agency at any time during the process.

(b) Requiring completion of the organization's grievance process before the Statewide Provider and Subscriber Assistance Program panel's review does ~~However, this shall~~ not preclude the agency ~~department~~ from investigating any complaint or grievance before the organization makes its final determination ~~prior to completion of the health maintenance organization's formal grievance process~~.

(10)~~(5)~~ Each organization must notify the subscriber in a final decision letter that the subscriber may request review of the organization's decision concerning the grievance by the Statewide Provider and Subscriber Assistance Program, as provided in s. 408.7056, if the grievance is not resolved to the satisfaction of the subscriber. The final decision letter must inform the subscriber that the request for review must be made within 365 days after receipt of the final decision letter, must explain how to initiate such a review, and must include the addresses and toll-free telephone numbers of the agency and the Statewide Provider and Subscriber Assistance Program. ~~A quality of care grievance which remains unresolved after a subscriber has followed the full grievance procedure of the organization, after review by the department, may be presented to the Statewide Subscriber Assistance Program Panel as set forth in s. 408.7056.~~

(11) The agency may impose administrative sanction, in accordance with s. 641.52, against an organization for noncompliance with this section.

Section 9. Subsections (3), (4), and (5) are added to section 641.54, Florida Statutes, to read:

641.54 ~~Hospital and physician~~ Information disclosure.—

(3) The organization shall make available to subscribers, upon request, a detailed description of the authorization and referral process for health care services. Any changes in the organization's authorization and referral process shall be reported to the agency immediately.

(4) The organization shall make available to subscribers, upon request, a detailed description of the process used to determine whether health care services are "medically necessary." Any change in the organization's definition of "medically necessary" or the process used to determine medical necessity shall be reported to the agency immediately.

(5) Each organization shall provide to subscribers, upon request, the following:

(a) A description of the organization's quality assurance program.

(b) Policies and procedures relating to the organization's prescription drug benefits, including the disclosure, upon request of a subscriber or potential subscriber, of whether the organization uses a formulary. A subscriber or potential subscriber may also request information as to whether a specific drug is covered by the organization.

(c) Policies and procedures relating to the confidentiality and disclosure of the subscriber's medical records.

(d) The decisionmaking process used for approving or denying experimental or investigational medical treatments.

(e) Policies and procedures for addressing the needs of non-English-speaking subscribers.

(f) A detailed description of the process used to examine qualifications of and the credentialing of all providers under contract with or employed by the organization.

Section 10. Except as otherwise provided herein, this act shall take effect July 1, 1997.

Approved by the Governor May 29, 1997.

Filed in Office Secretary of State May 29, 1997.