STATEWIDE PROVIDER AND HEALTH PLAN CLAIM DISPUTE RESOLUTION PROGRAM

Annual Report
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Pursuant to the provisions of section 408.7057, F.S., the Agency for Health Care Administration (Agency) is required to submit a report to the Governor and the Legislature by February 1 of each year on the status of the Statewide Provider and Health Plan Claim Dispute Resolution Program. Section 408.7057(2) (g) 2., F.S., specifically requires the report to enumerate claims dismissed, defaults issued, and failures to comply with Agency final orders issued under this section.

Program Description

The Statewide Provider and Health Plan Claim Dispute Resolution Program was established by the 2000 Florida Legislature to provide assistance to contracted and noncontracted providers and managed care organizations for resolution of claim disputes that are not resolved by the provider and the managed care organization. The statutes required the Agency to contract with a resolution organization to timely review and consider claim disputes and to submit its recommendation to the Agency. The Agency's responsibility is to issue a final order adopting the recommendation of the resolution organization.

After adopting rules necessary to implement the program (59A-12.030, Florida Administrative Code), the Agency issued a "Request for Proposals", and entered into a contract with Maximus, Inc. to review claim disputes. Maximus has been reviewing claim disputes since March 2001. Because the initial contract terminated January 31, 2005, the Agency issued a Request for Information (RFI) on July 30, 2004, to open the contract to other vendors. Maximus, Inc. was the only vendor interested in entering into a new 2-year contract with the Agency. The new contract allows for two one-year extensions. The essence of the new contract did not change.

Maximus operates a toll free hotline (1-800-356-8151) to provide information and dispute application forms to interested parties. The cost of the program is borne by users of the dispute program. The entity that does not prevail in the Agency's final order must pay the review cost. In cases where both parties prevail in part, the review cost must be shared. The review costs are determined by Maximus and depend largely on the complexity of the cases submitted.

Initially the program was designed to resolve only disputes between providers, health maintenance organizations, prepaid health clinics and exclusive provider organizations. The 2002 Legislature expanded the program to include other insurers offering major

medical expense insurance policies, and preferred provider organizations. The expansion of the program became effective October 2002. The revised law also strengthened the ability of the resolution organization to enforce review timeframes, and timely submission of information requested. The types of claims eligible under this program are further defined in rule consistent with statutory provisions as follows:

Eligible Claims:

The following claim disputes can be submitted by physicians, hospitals, institutions, other licensed health care providers, health maintenance organizations (HMOs), Prepaid Health Plans, Exclusive Provider Organizations (EPOs), major medical expense health insurance policies offered by a group or an individual health insurer, and preferred provider organizations.

- Claim disputes for services rendered after October 1, 2000 (the effective date of the initial legislation).

- Claim disputes related to payment amounts only - provider dispute payment amounts received, or disputed payback amounts. Claim disputes exclusively related to late payment are not eligible but are handled by the Department of Financial Services.

- Hospitals and physicians are required to aggregate claims by type of service to meet certain thresholds:

- Hospital Inpatient Claims (contracted providers)	$25,000
- Hospital Inpatient Claims (noncontracted providers)	$10,000
- Hospital Outpatient Claims (contracted providers)	$10,000
- Hospital Outpatient Claims (noncontracted providers)	$ 3,000
- Physicians	$ 500
- Rural Hospitals	none
- Other Providers	none

Ineligible Claims:

- Claim disputes that are subject to state/federal court action.
- Claim disputes that are subject to an internal binding managed care organization resolution process for contracts entered prior to October 1, 2000.
- Late payment disputes.
- Interest payment disputes.
- Medicare claim disputes.
- Medicaid claim disputes that are subject to fair hearings.
- Other non-state regulated health plans.

Status Report

Total Number of Cases Submitted and Reviewed in 2006*:*

Fifty- nine (59) cases were submitted to Maximus in year 2006 compared to 175 cases in 2005, of these 59 cases:

- 29 cases were returned to the filing entities because the submitted cases did not meet the review criteria;
- two providers submitted incomplete information and the cases were returned;
- six cases were withdrawn by the filing entity prior to the completion of the full review;
- four cases were settled prior to the full review;
- Six cases completed the review process and a final order was issued; and
- 12 cases are still pending

Claim dispute amounts filed ranged from a low of $500 to a high of $97,245. Each claim dispute generally represents several aggregated claims.

Claim disputes were filed against Aetna US Healthcare, AvMed Health Plan, Blue Cross/Blue Shield of Florida, United Healthcare of Florida, and Neighborhood Health Partnership.

Compliance with Florida Statutes

Maximus received review fees due from all parties. Review fees ranged from a low of $145.83 to a high of $418. All insurers, including HMOs, complied with the final orders issued by the Agency, paid the review fee and the amount owed to the filing parties.

Litigation

In June 2003, Maximus completed a review of eight separate claim dispute cases filed by BayCare Health System, Inc. (a hospital group) against Health Options, Inc. (an HMO). Maximus submitted a recommendation to the Agency that largely favored the HMO. Prior to the issuance of a final order by the Agency, the hospital group withdrew all eight cases. Maximus revised its previous recommendations based on the withdrawal of the eight cases by the final party, and recommended that these cases should be withdrawn. The Agency issued a final order dismissing all eight cases.

The HMO Health Options, Inc., timely filed an appeal in the First District Court of Appeals, contending that the Agency was required to issue a final order based on the initial recommendation by Maximus, and that BayCare Health Systems, Inc. (the filing party) had no right to withdraw these cases once Maximus had submitted a final recommendation in these eight cases. In three of the cases, Maximus had not rendered a final recommendation.

On November 17, 2004, the First District Court of Appeals (DCA) released its consolidated decision. In the three cases in which Maximus had not yet issued its recommendation the DCA affirmed that the filing party had the right to withdraw. However, in the five cases in which Maximus had already issued its recommendation to the Agency, the DCA reversed the Agency's determination to allow the provider to withdraw its cases. The DCA determined that the Agency has to issue final orders in each case based on the recommendations by Maximus. Inc.

> The DCA ruled in pertinent part:
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> "We disagree with AHCA's implicit interpretation that the statutorily-created dispute resolution process was, under the circumstances, nonbinding, and instead conclude that once the parties completed fact-finding of the disputed claims [i.e., once Maximus issued its recommendation], the resolution dispute process became binding and BayCare thereafter was not authorized to withdraw its claims in those cases."

In its ruling the court elaborates extensively on the legislative background and intent of the current law. The affected party asked the court to rehear the case, but the request was denied.

BayCare then appealed the Agency's final orders that were issued based on the recommendations by Maximus. BayCare argued not only that the reimbursement formula employed by Maximus was invalid, but that the law creating the Dispute Resolution Program was unconstitutional because the law improperly delegates quasi-judicial power to the review organization without imposing adequate standards, guidelines, or criteria how to exercise that power. In response, the court ruled that the dispute resolution process was voluntary, and because BayCare instituted the process and was not affirmatively misled about the parameters of the process, the final orders issued by the Agency are affirmed. The ruling by the DCA further states that the "process created by section 408.7057, F.S., is not an adequate method to resolve legal issues of first impression that involve payment of millions of dollars. Nevertheless, BayCare selected this process and was entitled to file a lawsuit to resolve this dispute, in which it would have been entitled to certain specific due process protections. Instead, it affirmatively chose a voluntary forum with minimal process." (DCA, Case Nos. 2D05-1691, opinion filed October 27, 2006).

Summary

The number of claim disputes submitted to Maximus, Inc. in 2006, was significantly lower than the number submitted in 2005. No data is available to determine if the number of claim disputes statewide declined, or if providers are going directly to the court system to litigate their disputes.