§ 131E-287. PSO Reporting.

(a) The PSO shall file with the Division financial information relating to PSO solvency standards described in this Article, according to the following schedule:

(1) On a quarterly basis until breakeven; and

(2) On an annual basis after breakeven, if the PSO has a net operating surplus; or

(3) On a quarterly or monthly basis, as specified by the Division, after breakeven, if the PSO does not have a net operating surplus.

(b) To the extent not preempted by federal law or otherwise mandated by the Medicare program, the PSO shall annually, on or before the first day of March of each year, file with the Division the following information for the previous calendar year:

(1) The number of and reasons for grievances and complaints received from Medicare beneficiaries enrolled with the PSO under the PSO's Medicare contract regarding medical treatment. The report shall include the number of covered lives, total number of grievances categorized by reason for the grievance, the number of grievances referred to the second level grievance review, the number of grievances resolved at each level and their resolution, and a description of the actions that are being taken to correct the problems that have been identified through grievances received. Every PSO shall file with the Division, as part of its annual grievance report, a certificate of compliance stating that the PSO has established and follows, for its Medicare contract, grievance procedures that comply with this Article.

(2) The number of Medicare beneficiaries enrolled with the PSO under the PSO's Medicare contract who terminated their enrollment with the PSO for any reason.

(3) The number of provider contracts between the PSO and network providers for the provision of covered services to Medicare beneficiaries that were terminated and reasons for termination. This information shall include the number of providers leaving the PSO network and the number of new providers in the network. The report shall show voluntary and involuntary terminations separately.

(4) Data relating to the utilization, quality, availability, and accessibility of service. The report shall include the following:

a. Information on the PSO's program to determine the level of network availability, as measured by the numbers and types of network providers, required to provide covered services to covered persons. This information shall include the PSO's methodology under its Medicare+Choice program for:

1. Establishing performance targets for the numbers and types of providers by specialty, area of practice, or facility type, for each of the following categories: primary care physicians, specialty care physicians, nonphysician health care providers, hospitals, and nonhospital health care facilities.

2. Determining when changes in PSO Medicare+Choice program enrollees will necessitate changes in the provider network.

The report shall also include: the availability performance targets for the previous and current years; the numbers and types of providers currently
participating in the PSO’s provider network; and an evaluation of actual plan performance against performance targets.
b. The PSO’s method for arranging or providing health care services from nonnetwork providers, both within and outside of its service area, when network providers are not available to provide covered services.
c. Information on the PSO’s program under its Medicare+Choice program to determine the level of provider network accessibility necessary to serve its Medicare enrollees. This information shall include the PSO’s methodology for establishing performance targets for member access to covered services from primary care physicians, specialty care physicians, nonphysician health care providers, hospitals, and nonhospital health care facilities. The methodology shall establish targets for:

1. The proximity of network providers to members, as measured by member driving distance, to access primary care, specialty care, hospital-based services, and services of nonhospital facilities.
2. Expected waiting time for appointments for urgent care, acute care, specialty care, and routine services for prevention and wellness.

The report shall also include: the accessibility performance targets for the previous and current years; data on actual overall accessibility as measured by driving distance and average appointment waiting time; and an evaluation of actual Medicare+Choice plan performance against performance targets. Measures of actual accessibility may be developed using scientifically valid random sample techniques.
d. A statement of the PSO’s methods and standards for determining whether in-network services are reasonably available and accessible to a Medicare enrollee for the purpose of determining whether such enrollee should receive the in-network level of coverage for services received from a nonnetwork provider.
e. A description of the PSO’s program to monitor the adequacy of its network availability and accessibility methodologies and performance targets, Medicare+Choice plan performance, and network provider performance.
f. A summary of the PSO’s utilization review program activities for the previous calendar year under its Medicare+Choice program. The report shall include the number of: each type of utilization review performed, noncertifications for each type of review, each type of review appealed, and appeals settled in favor of Medicare enrollees. The report shall be accompanied by a certification from the carrier that it has established and follows procedures that comply with this Article.

(5) Aggregate financial compensation data, including the percentage of providers paid under a capitation arrangement, discounted fee-for-service or salary, the services included in the capitation payment, and the range of compensation paid by withhold or incentive payments. This information shall be submitted on a form prescribed by the Division.
The name, or group or institutional name, of an individual provider may not be disclosed pursuant to this subsection. No civil liability shall arise from compliance with the provisions of this subsection, provided that the acts or omissions are made in good faith and do not constitute gross negligence, willful or wanton misconduct, or intentional wrongdoing.

(c) Disclosure Requirements. – To the extent not otherwise prohibited by federal law or under the terms of the PSO's Medicare contract, each PSO shall provide the following applicable information to Medicare beneficiaries enrolled with the PSO under the PSO's Medicare contract and bona fide prospective enrollees upon request:

1. The evidence of coverage under the Medicare+Choice plan provided by the PSO to Medicare beneficiaries under the terms of the PSO's Medicare contract;

2. An explanation of the utilization review criteria and treatment protocol under which treatments are provided for conditions specified by the prospective enrollee. This explanation shall be in writing if so requested;

3. If denied a recommended treatment, written reasons for the denial and an explanation of the utilization review criteria or treatment protocol upon which the denial was based;

4. The plan's restrictive formularies or prior approval requirements for obtaining prescription drugs, whether a particular drug or therapeutic class of drugs is excluded from its formulary, and the circumstances under which a nonformulary drug may be covered; and

5. The procedures and medically based criteria under the PSO's Medicare contract for determining whether a specified procedure, test, or treatment is experimental.

(d) Effective January 1, 1999, PSOs shall make the reports that are required under subsection (b) of this section and that have been filed with the Division available on their business premises and shall provide any Medicare beneficiary enrolled with the PSO access to them upon request, unless otherwise prohibited by federal law or under the terms of the PSO's Medicare contract.

(e) Every PSO licensed under this Article shall annually on or before the first day of March of each year, file with the Division a sworn statement verified by at least two of the principal officers of the PSO showing its condition on the thirty-first day of December, then next preceding; which shall be in such form as the Division shall prescribe. In case the PSO fails to file the annual statement as herein required, the Division is authorized to suspend the license issued to the PSO until the statement shall be properly filed.

(f) A PSO shall report to the Division the efforts it has undertaken to foster measurable improvements in the health status of the community's Medicare population, increase access to health care for noncovered benefits, and address critical health care needs of the community's Medicare population. (1998-227, s. 1.)