STORAGE NAME: h0981.hhsa.doc
DATE: March 27, 2001

HOUSE OF REPRESENTATIVES
AS REVISED BY THE COMMITTEE ON
HEALTH AND HUMAN SERVICES APPROPRIATIONS
ANALYSIS

BILL #: HB 981

RELATING TO: Statewide and District Managed Care Ombudsman Committees

SPONSOR(S): Representative Bucher

TIED BILL(S):

ORIGINATING COMMITTEE(S)/COUNCIL(S)/COMMITTEE(S) OF REFERENCE:

(1) HEALTH PROMOTION YEAS 8 NAYS 0
(2) HEALTH AND HUMAN SERVICES APPROPRIATIONS
(3) COUNCIL FOR HEALTHY COMMUNITIES
(4)
(5)

I. SUMMARY:

HB 981 increases the maximum number of members on the district managed care ombudsman committees and modifies the substantive provisions relating to the committees, as follows: requires one member of the committee to be a recipient of managed care services; requires committees to conduct site visits with the Agency for Health Care Administration (AHCA); and requires AHCA to refer certain complaints to the committees. In addition, the bill provides additional duties of the committees relating to assisting and educating consumers and resolving complaints. Requires AHCA to provide for location of the statewide and district committees in the AHCA district offices, and specifies support services to be provided.

HB 981 provides for an annual appropriation of $50,000 from the General Revenue Fund to the Agency for Health Care Administration to fund district ombudsman committee operations, including travel expenses for members.

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

1.	Less Government	Yes []	No []	N/A [x]
2.	Lower Taxes	Yes []	No []	N/A [x]
3.	Individual Freedom	Yes [x]	No []	N/A []
4.	Personal Responsibility	Yes []	No []	N/A [x]
5.	Family Empowerment	Yes [x]	No []	N/A []

For any principle that received a “no” above, please explain:

B. PRESENT SITUATION:

General Background – Managed Care Ombudsman

The following information was obtained from an article published by the Health Law & Policy Institute, published June 29, 1999. [**Note:** The complete article can be found at: http://www.law.uh.edu/healthlawperspectives/Managed/990629Ombuds.html]

Many consumers and policymakers believe ombudsman programs are a promising response to some of the problems associated with managed care. An "ombudsman" (or ombudsperson) has been described as a third party who intervenes to address the concerns of dependent individuals or groups in relation to powerful organizations or bureaucracies. An ombudsman is client-centered but not anti-administration—hence the role is slightly different from that of the advocate who answers only to the client and may adopt a purely adversarial stance vis-a-vis "the system."

Some state agencies have very active consumer assistance programs that perform many of the functions of an ombudsman program without bearing the label, and programs bearing the label have varying degrees of independence. Programs also vary in scope. Many states have an ombudsman program with a narrower focus than health insurance/health care. For example, the Older Americans Act requires that states establish ombudsman programs serving people in long-term care facilities. Also, a number of states have an ombudsman serving participants in Medicaid or Medicaid managed care. At the other end of the spectrum, several states have an ombudsman program with a broader focus, serving consumers with any kind of insurance-related problem.

Existing ombudsman programs with a managed care or health focus tend to fit one of four models:

Model 1: Independent agency funded by state. In Vermont, state law requires the agency that regulates insurance and health care to establish an "office of the health care ombudsman" by contract with a nonprofit organization. Duties of the office include assisting consumers in obtaining coverage, selecting a plan, or understanding their rights and responsibilities; investigating and resolving complaints and assisting consumers in filing and pursuing complaints and appeals (includes administrative and judicial proceedings); and promoting the development of citizen and consumer

organizations. The law requires insurers to give the office access to records of consumers who consent. It also mandates state agency compliance with reasonable requests for information and assistance. The contract, awarded to the state's legal aid office, went into effect on January 1, 1999. As of the end of March 1999, the office had assisted 400 callers and closed 344 cases. Most of the calls were resolved by brief research and a return call or a call to the insurer.

A Florida law [s. 641.65, F.S.] requires the Agency for Health Care Administration to facilitate the development of a network of local managed care ombudsman committees linked to the state's health service planning districts, under the supervision of a statewide managed care ombudsman committee. However, because the program lacks funding and depends on volunteer effort, implementation has been slow.

Model 2: Independent agency funded by private foundations. Three foundations (California Wellness Foundation, Henry J. Kaiser Family Foundation, and Sierra Health Foundation) are funding a four-year pilot program in four California counties. The "Health Rights Hotline" provides assistance to all health care consumers in the region; services include counseling, referrals to resources, direct assistance, and development and distribution of print materials (available via the hotline web site at www.hrh.org). The hotline is sponsored by a nonprofit consumer advocacy organization and a legal aid office. The foundations have hired the Lewin Group to perform an independent evaluation of the program.

The California Endowment, another private foundation, is funding a two-year pilot in six California counties through a $5 million grant. Local legal services programs direct six Health Consumer Centers, supported by two health-focused resource centers. The program has a dual focus on consumer empowerment and direct advocacy. Services are limited to low-income residents experiencing problems with health coverage, access to health care, or health care quality. (More information is available at www.healthconsumer.org/QandA.html.)

Model 3: Office within state agency. A number of states have established an ombudsman program within the state agency charged with regulating managed care organizations (MCOs). The major concerns with the structure include integrating the ombudsman program with existing consumer assistance programs and achieving credibility in the absence of true independence.

In California, the person in the managed care ombudsman position has an oversight or "troubleshooter" role in relation to a large consumer assistance program and carries out public education and agency advisory functions. A Minnesota law required creation of an ombudsman program within the state health agency with broad duties. However, implementation was delayed due to funding issues, and the state has now decided to start over, studying efforts in other states. In Massachusetts, the governor has issued an order creating a managed care consumer advisory board "within, but not subject to the control of," the department of public health. (Exec. Order No. 405 is reproduced at www.state.ma.us/ombud/omcoexec.htm.) The board is empowered to appoint a managed care ombudsman, subject to approval by the governor. Utah and Virginia recently passed laws creating ombudsman programs within state insurance agencies.

Model 4: MCO responsibility. Some states require MCOs to designate an internal ombudsman.

For example, laws in Delaware and New Mexico provide that, upon enrollee request, a MCO must appoint a member of its staff with no direct involvement in the case to assist or represent the enrollee.

Florida's Managed Care Ombudsman Program

In 1996, the Legislature passed CS/HB 119 (ch. 96-391, Laws of Florida), creating the Statewide Managed Care Ombudsman Committee and 11 district managed care ombudsman committees located, for administrative purposes only, within the Agency for Health Care Administration. The committees, with volunteer membership, were authorized to receive complaints regarding the quality of care in managed care plans from the agency, and assist the agency with the investigation and resolution of complaints.

Section 641.65(3), F.S., requires the AHCA Director (Secretary) to appoint the first three members of each district committee, and those three members select the remaining members of the committee, subject to the approval of the AHCA Director. If any of the first three members are not appointed within 60 days after the statewide committee is established and after a request is submitted to the AHCA Director, those members are to be appointed by a majority vote of the statewide committee without further action by the AHCA Director. Members serve for a term of three years and may serve only two consecutive terms. This section also provides for staggered terms for initial appointees, filling of vacancies, and district committee member dismissal.

Under this law, there is one Statewide Managed Care Ombudsman Committee and 11 District Ombudsman Committees, one in each area in which a field office of the Agency for Health Care Administration is located, for a total of 12 committees. The Statewide Managed Care Ombudsman Committee is composed of the 11 chairpersons from the District Managed Care Ombudsman Committees. Presently, there are four fully functional District Managed Care Ombudsman Committees (MCOC) in the state and the chairpersons of these boards serve on the Statewide Managed Care Ombudsman Committee. The MCOCs are located in Areas 8, 9, 10, and 11, which consist of 15 Florida counties: Dade, Monroe, Broward, Palm Beach, Martin, St. Lucie, Indian River, Okeechobee, Charlotte, Collier, DeSoto, Glades, Hendry, Lee and Sarasota. Currently, the chairpersons of the 4 existing local committees constitute the statewide committee.

The remaining 7 district committees have never developed for various reasons, including inability of committee members to obtain reimbursement for travel and out of pocket expenses, lack of interest on the part of citizens in the areas, and inability of the initial appointees to find volunteers with sufficient time and expertise to address these medical and managed care issues. Those committees that have been functioning have done a good job of assisting members of managed care plans to resolve their quality of care related complaints. Since July 1, 2000, the agency has sent these four functional committees 430 subscriber complaints. Of the subscriber complaints sent, 230 have been resolved. Of those resolved, 143, or 62 percent, have been resolved in favor of the subscribers.

Committee members have complained that their out-of-pocket expenses are not reimbursed and that these expenses are sometimes fairly high. In addition, committees have no clerical support from the agency—another source of concern from ombudsman committee members.

The Managed Care Ombudsman Process

The agency receives telephone complaints thorough the agency complaint and information call center. Provided there is a functional Managed Care Ombudsman Committee (MCOC) in the caller's area, call center staff ask if the complainant would like to have the complaint reviewed and addressed by the MCOC. If the complainant agrees, the complaint is sent to the MCOC.

Complaints are sent to the MCOCs as quickly as possible, but always within one week of receipt, by fax or by e–mail.

The MCOC members work with the complainant and the HMO to try to resolve the complaint. In some cases, resolution is a simple matter of getting the HMO grievance coordinator and the complainant together to resolve the problem. In other cases, it requires extensive discussion between the MCOC member and HMO staff, including, in some instances, medical directors. Contact is often done by the MCOC members by phone or letter at the local level. "Working a case" frequently requires multiple contacts between the MCOC members and the HMO staff.

The MCOC does not issue a decision. The members do the work and report their progress and outcomes at the monthly district MCOC meeting. The case is then either resolved in favor of the complainant or in favor of the HMO. There is no enforcement power associated with MCOC resolutions. Generally, the HMO will do what it has agreed to do if the resolution is in favor of the complainant. If the complainant is not satisfied with the recommendation of the MCOC, the complaint is returned to the Statewide Provider and Subscriber Assistance Program for resolution. The one exception is Medicare HMO non-quality of care complaints. These complaints are not within the purview of the Statewide Provider and Subscriber Assistance Program.

C. EFFECT OF PROPOSED CHANGES:

HB 981 revises provisions relating to the statewide and district managed care ombudsman committees, as follows:

- Expands membership of committees;
- Requires certain site reviews by district ombudsman committees;
- Revises provisions relating to referral of complaints to the district ombudsman committees by the Agency for Health Care Administration;
- Provides additional duties of district ombudsman committees;
- Revises facility and administrative support services to be provided by ACHA to the statewide and district ombudsman committees.

In addition, the bill provides for an annual appropriation of $50,000 from the General Revenue Fund to the Agency for Health Care Administration for the operation of the district ombudsman committees, including travel expenses.

D. SECTION-BY-SECTION ANALYSIS:

Section 1. Amends s. 641.65, F.S., relating to district managed care ombudsman committees, as follows:

Subsection (2) is amended to expand the maximum number of members permitted to serve on the committees from 16 to 20. In addition, membership of the committee is expanded to include, if possible, at least one recipient of managed care services. In the appointment of such member, preference shall be given to members of organized consumer or advocacy groups with national or statewide membership.

Subsection (6) is amended to require district ombudsman committees to conduct site visits with the Agency for Health Care Administration. In addition to their current duties, the duties of the district ombudsman committees are expanded, as follows:

- Assist consumers in selecting health care plans appropriate for their needs;

- Train consumers to understand and use the annual consumer guide on plan performance and the marketing information prepared by plans;
- Educate managed care plan enrollees about their rights and responsibilities;
- Identify, investigate, and resolve enrollee complaints about health care services in managed care plans; and
- Assist enrollees with filing formal appeals of managed care plan determinations, including pre-service denials and the termination of services.

Subsection (7) is created to provide AHCA statutory authority to adopt rules to implement the provisions of this section.

Section 2. Amends s. 641.70(2), F.S., regarding agency duties relating to the Statewide Managed Care Ombudsman Committee and the district managed care ombudsman committees, to require the agency to:

- Provide for location of the statewide and district committees in the agency's district offices;
- Require the agency to provide necessary training, equipment, and office supplies, including, at a minimum, clerical and word-processing services, photocopiers, telephone services, record keeping, stationery, and other necessary supplies;
- Delete the general requirement of the agency to provide a meeting place for district committees in agency offices and provision of necessary administrative support.

Section 3. Provides for an annual appropriation from the General Revenue Fund to the agency of $50,000 to be distributed on an equitable basis to each district managed care ombudsman committee, to fund the operation of the committee, including travel expenses for committee members, pursuant to s. 112.061, F.S., relating to state travel reimbursement provisions.

Section 4. Provides an effective date of July 1, 2001.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

N/A

2. Expenditures:

Section 3 provides for an annual appropriation from the General Revenue Fund to the Agency of Health Care Administration of $50,000 to be distributed on an equitable basis to each district managed care ombudsman committee.

The Agency for Health Care Administration has indicated the need for the following amounts for the indicated purposes to fully implement the bill:

- Committee Travel and Telephone Expenses:

  $6,000 per committee X 12 committees = **$72,000**

The $50,000 appropriation does not provide an appropriation for the agency to provide the clerical support, office supplies, telephone service, and record keeping required by the statutory

amendments contained in this bill. These requirements will have a fiscal impact beyond the funding provided. Currently, the agency does not identify resources to provide clerical and record keeping support or telephone services to the ombudsman committees and funding for such services has not been appropriated in the bill.

- Clerical Support:

  OPS ($12/hour X 1,040 hours per year) = $12,480 + social security @7.65% = $13,435 per year X 12 = **$161,220**

At a minimum, the agency estimates that each of the 11 district MCOCs and the statewide committee will require a half-time secretary to provide such clerical support. Based on the agency's past experience with staff obtained through temporary help agencies to take the minutes of committee meetings, such temporary assistance is not a viable option. Career service positions are also not a realistic option as most such positions are full time and full time staff is not needed. The best way to provide such assistance will be through use of OPS funding to allow the committees to hire their own clerical assistants to provide minutes and correspondence. Agency staff estimates that OPS clerical assistants can be hired for approximately $12 per hour plus social security benefits.

- Training:

  7 trips X $550 per trip = **$3,850** (Non Recurring)

In addition, provision of required training would necessitate travel by headquarters staff to each of the 11 district offices to train each new committee as it comes on board. There are currently 4 fully functional committees that have already been trained. Thus, additional travel to train the remaining 7 committees would be required. The agency estimates the cost of these 7 trips would range from $300 to $700 apiece depending upon location, with an average cost of $550.

- Office equipment and meeting space:

  Expense/Position: Recurring = 12 X $3,684= **$44,208**

Although the agency currently provides for meeting space on a monthly basis, there is no office that is occupied by the ombudsman committee in each area location, nor is there an assigned photocopier, telephone, or fax machine. Currently, committee members are free to use agency equipment, including fax, phone, and photocopiers in the area offices. If each committee is to be assigned an office, including a phone, fax, and photocopier, there will be a cost associated with that assignment of space.

Relevant current expenses per person based on the proxy of the Bureau of Consumer Protection are projected at $29,468 for the year. There are four personnel in the bureau office. That translates to $3,684 per year for each half time position.

- Furniture and computer equipment:

  Non-Recurring = 12 X $2,659 = **$31,908**

Equipment required would include furnishings and a computer for each position, irrespective of whether it is a full or half time position. The non-recurring expense would be $2,659 per position X 12 positions = $31,908.

B. FISCAL COMMENTS:

According to the Agency for Health Care Administration, the additional funding necessary to implement this bill would be $263,186 in FY 01-02 and $227,428 in FY 02-03.

C. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

N/A

2. Expenditures:

N/A

D. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Managed care enrollees will potentially have another means available for addressing quality of care concerns.

Managed care entities will be subject to additional oversight and attention from non-members on behalf of plan members.

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not require counties or municipalities to spend funds or to take action requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce the authority that counties or municipalities have to raise revenues in the aggregate.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of state tax shared with counties or municipalities.

V. COMMENTS:

A. CONSTITUTIONAL ISSUES:

N/A

B. RULE-MAKING AUTHORITY:

The bill grants rulemaking authority to the Agency for Health Care Administration to implement s. 641.65, F.S., as amended.

C. OTHER COMMENTS:

The Agency for Health Care Administration analysis of this bill contained the following comment:

The bill requires that ombudsman committees accompany agency staff on site visits. Complaints that come to the Statewide Provider and Subscriber Assistance Program, for which the agency is responsible, are investigated through desk reviews, not site visits. Site visits conducted by the agency are surveys and certification reviews and risk management reviews completed for purposes of accreditation. Staffing of these reviews is limited to agency employees only. The four accrediting organizations (Joint Commission on Accreditation of Healthcare Organizations, National Committee for Quality Assurance, the American Accreditation of Health Care Commission/URA; and Accreditation Association for Ambulatory Health Care) do not permit any consumers to accompany agency staff unless invited to do so by the accrediting organizations themselves. The agency does not conduct individual complaint investigations on site, except in highly unusual circumstances related to complaints that are heard before the Statewide Provider and Subscriber Assistance Program.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

On March 20, 2001, the Committee on Health Promotion approved a technical amendment, page 1, line 31, changing the word “recipients” to “recipient.”

VII. SIGNATURES:

COMMITTEE ON HEALTH PROMOTION:

Prepared by:	Staff Director:
Tonya Sue Chavis, Esq.	Phil E. Williams

AS REVISED BY THE COMMITTEE ON HEALTH AND HUMAN SERVICES APPROPRIATIONS:

Prepared by:	Staff Director:
Cynthia Kelly	Cynthia Kelly