SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

BILL: SB 412

SPONSOR: Health, Aging and Long-Term Care Committee

SUBJECT: Managed Care Ombudsman Committees

DATE: March 8, 2002 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Harkey	Wilson	HC	Favorable
2.	Peters	Belcher	AHS	Favorable
3.			AP	
4.				
5.				
6.				

I. Summary:

SB 412 increases the maximum number of members on a district managed care ombudsman committee to 20 members. The Agency for Health Care Administration (AHCA or agency) must require a background screening of committee members and must review all appointments for compliance with the law. The bill prohibits conflicts of interest for committee members and describes the nature of such conflicts. The agency must provide committee members 8 hours of initial training and 8 hours of continuing education annually.

The bill repeals the statewide managed care ombudsman committee and provides instead for the district committees to assist enrollees with appeals to the Subscriber Assistance Panel under s. 408.7056, F.S. The district committees would assist with an appeal only at the enrollee's request.

The bill appropriates $300,000 from the General Revenue Fund to the Agency for Health Care Administration, and authorizes one position, for the purpose of implementing the act during the 2002-2003 fiscal year.

This bill amends sections 641.65, 641.70 and 641.75; creates s. 641.64; and repeals s. 641.60, F.S.

II. Present Situation:

Chapter 96-391, Laws of Florida, created the district managed care ombudsman committees under s. 641.65, F.S. A district managed care ombudsman committee is provided for each of the 11 AHCA districts that has staff assigned for regulation of managed care programs. Each district committee is subject to direction and supervision of the Statewide Managed Care Ombudsman

Committee under s. 641.60, F.S. Each district committee must have between 9 and 16 members, including at a minimum: 4 physicians, 1 each licensed under chapters 458, 459, 460, and 461, F.S.; 1 psychologist; 1 registered nurse; 1 clinical social worker; 1 attorney; and 1 consumer, preferably a member of an organized national or statewide consumer or advocacy group. No member may be employed by or affiliated with a managed care program.

The Secretary of AHCA appoints the first three members of each district committee and those three select the remaining members, subject to approval of the Secretary. Each committee selects a chair, for a term of one year, not to exceed two consecutive terms. Members serve three-year terms, with staggered terms after initial appointment, not to exceed two consecutive terms.

Currently, only four of the 11 district committees are operational – in Broward, Palm Beach, Dade and Charlotte/Lee/Collier Counties. The district committees are directed to: protect the health, safety and welfare of managed care enrollees; receive complaints regarding quality of care from AHCA and assist AHCA with resolutions; conduct site visits with AHCA if appropriate; and submit an annual report to the statewide committee detailing activities, recommendations and complaints reviewed under s. 641.65, F.S.

For administrative purposes, the Managed Care Ombudsman Program (MCOP) is located within AHCA under section 641.60(2), F.S., and AHCA is charged with the responsibility of providing administrative support for the program. AHCA assists in training for the district committees, provides complaint referrals, and maintains a database of referrals and case outcomes.

There are 28 managed care organizations in Florida with approximately six million subscribers. As of March 1, 2001, there were 4,805,122 commercial subscribers, 689,729 Medicare subscribers and 524,969 Medicaid subscribers.

As a prerequisite to a health maintenance organization (HMO) obtaining a mandatory Health Care Provider Certificate from AHCA and a Certificate of Authority from the Department of Insurance, the HMO must establish and maintain an internal subscriber grievance procedure under sections 641.21(1)(e), 641.22(9) and 641.495(9), F.S. Upon exhaustion of subscriber rights under the internal grievance procedure, the subscriber may have his or her grievance heard by AHCA's Statewide Provider and Subscriber Assistance Panel under s. 408.7056(2), F.S.

The MCOP often assists subscribers by guiding them through the managed care organization's internal grievance process, including: advising subscribers on filling out forms, contacting the organization's staff, and discussing terms of coverage. The MCOP receives referrals from AHCA that originate with the AHCA telephone complaint center. For fiscal year 2000-2001 the MCOP handled 636 disputes, the vast majority of which related to HMOs.

While the MCOP has been in existence since 1996, it has never received funding. MCOP volunteers are free to utilize AHCA district offices' equipment and supplies, but there is not an AHCA office in each of the 11 districts. No funds are allocated for any travel expenses incurred by the volunteers.

Senate Interim Project 2002-137 reviewed the operation of the managed care ombudsman program and made the following recommendations:

- Funding of essential ombudsman expenses. The current lack of travel reimbursement is clearly an impediment to the effectiveness of the program.
- Institution of a continuously updated database of subscriber identification numbers and managed care plan contacts. This effort will expedite intervention and communication.
- Initiation of a statewide public information campaign to increase MCOP visibility and heighten public awareness. This should expedite initial ombudsman contact and offer subscribers improved grievance resolution.
- Creation of standardized training packets for ombudsmen. Such standardization should assure at least minimum levels of training.
- Training of AHCA complaint intake personnel in basics of medical terminology. Current personnel can be trained in how to obtain essential clinical criteria from complainants, in order to expedite meaningful referrals to the ombudsmen.
- Development of an ombudsman recruitment and appreciation policy. This will aid in identification of prospective new ombudsmen and augment retention of current volunteers.

III. Effect of Proposed Changes:

This bill makes changes to the Managed Care Ombudsman Program that would strengthen the role of local ombudsmen committees and focus the committees' work on quality-of-care issues. The bill repeals s. 641.60, F.S., and the Statewide Managed Care Ombudsman Committee governed by that section. The bill creates s. 641.64, F.S., to provide definitions for the managed care ombudsman program in ss. 641.64–641.75, F.S. The bill defines:

- *Agency*, as the Agency for Health Care Administration;
- *Covered Medical Service*, as a service contracted for under the managed care program agreement;
- *District*, as one of the health service planning districts under s. 408.032, F.S.;
- *District Committee*, as a district managed care ombudsman committee;
- *Enrollee*, as an individual who has contracted with a managed care program for health care;
- *Managed care program*, as a health care delivery system that emphasizes primary care and integrates the financing and delivery of services to enrolled individuals through arrangements with selected providers; and
- *Physician*, as a person licensed under chapters 458, 459, 460, or 461, F.S.

These definitions are the same as those currently included in s. 641.60, F.S.

The bill amends s. 641.65, F.S., to increase the maximum number of members on a district managed care ombudsman committee to 20 members. If possible, the membership must include: four physicians, one each licensed under chapters 458, 459, 460 and 461, F.S.; one psychologist; one registered nurse; one clinical social worker; one attorney; and at least one recipient of managed care services, preferably a member of an organized national or statewide consumer

group. The agency must require each ombudsman to undergo a Level I background screening, under s. 453.03, F.S., and must pay the cost of the screening. The Secretary will appoint the first three members of each district committee and those members will select the remaining members. The agency will review all appointments for compliance with the statute and may disqualify an applicant for failure to meet the requirements of the law.

Each committee member serves in a voluntary capacity. When an enrollee requests the ombudsman's assistance, the committee must receive the enrollee's complaint, and may assist in the resolution of the complaint. If a complainant requests that his or her complaint be referred to the committee, the agency must refer the complaint, if it concerns a question as to whether a managed care program may have inappropriately denied the enrollee a covered medical service; may be inappropriately delaying the provision of a covered medical service; or is providing substandard medical service. If the district committee, or a member of the committee, receives such a complaint directly from an enrollee, the committee must assist the enrollee with resolution of the complaint and report the complaint to the agency. At the request of an enrollee, a district managed care ombudsman committee must assist the enrollee in any appeal of an unresolved grievance to the Subscriber Assistance Panel under s. 408.7056, F.S.

District committees must educate enrollees about their rights and responsibilities in managed care programs and must train consumers to use the annual consumer guide and the marketing information prepared by managed care programs. Committees may assist consumers in selecting health care plans. Committees must assist enrollees with filing formal appeals of managed care program determinations, including preservice denials and the termination of services. Each district committee must submit an annual report to AHCA concerning activities and complaints reviewed by the committee during the year.

The bill clarifies the extent to which the committees must be independent of the managed care industry. A member or employee of a district committee may not have a direct involvement in the licensing, certification, or accreditation of a managed care program; have ownership or investment interest in a managed care program; be employed by, or participate in the management of, a managed care program; receive, or have a right to receive, directly or indirectly, remuneration, in cash or in kind, under a compensation agreement with a managed care program; or gain, or stand to gain, financially through an action or potential action brought on behalf of individuals the ombudsman serves.

The bill amends s. 641.70, F.S., to require AHCA to adopt rules that specify:

- Procedures by which managed care programs will make enrollee information available to members of the district committees.
- Procedures by which recommendations made by the committee may be incorporated into policies and procedures of the agency.
- In consultation with district committees, procedures to identify and eliminate conflicts of interest under s. 641.65, F.S.
- Procedures by which committee members will be reimbursed for expenditures.
- Any other procedures necessary to administer ss. 641.64-641.75, F.S.

The agency must provide a meeting place for the committee in agency offices and must provide necessary administrative support, within available resources. The agency must conduct a

statewide public awareness campaign to increase public knowledge of the committees' services and establish standardized training of committee members. The agency may assist committees in recruiting and retaining managed care ombudsmen.

All volunteers serving on district committees must receive a minimum of 8 hours of initial training and 8 hours of continuing education annually. The agency must provide standardized training for all committee members.

The bill amends s. 641.75, F.S., to delete references to the statewide committee, which is repealed by the bill. The bill repeals s. 641.60, F.S., which governs the statewide committee.

The bill appropriates $300,000 from the General Revenue Fund to the Agency for Health Care Administration, and authorizes one position, for the purpose of implementing the act during the 2002-2003 fiscal year.

The bill will take effect July 1, 2002.

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 Art. VII, s. 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 Art. I, s. 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 Art. III, s. 19(f) of the Florida Constitution.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The bill appropriates $300,000 from the General Revenue Fund to the Agency for Health Care Administration, and one position, for implementation of the program in the 2002-2003 fiscal year. Expenses to be covered by the appropriation include: Background

screening of appointees; training ombudsmen; a public awareness campaign; clerical support for 11 committees; salary for one agency staff position; and travel by ombudsmen and by the agency staff person.

The agency estimates that the position of the person overseeing the program would be a Medical Health Care Program Analyst, Pay Grade 24. As the individual hired would have to be familiar with the laws and regulations affecting managed care organizations in order to provide appropriate training, the agency anticipates the need to hire at minimum plus 10%. Salary for Medical Health Care Program Analyst @($37,645 x 1.10) = $41,410 x 1.275 = $52,798 (Recurring).

The agency's cost for Level I background screening is $15.00 per person. Estimating an average of 15 members per committee, the cost for background checks would be $3,375 during the first year and an indeterminate amount in subsequent years for new members.

AHCA estimates the following non-recurring expenditures:	
Public Awareness Campaign –printed materials	$50,000
11 OPS support staff at $2,076 per position	$22,836
1 Professional staff (PG 24) @ $2,659 per FTE	$2,659
1 Prof. staff (PG 24) additional travel expense for training ($550 per trip x 7 committees)	$3,850
OCO (11 OPS support staff x $1,389 per person)	$15,279
(1 Professional staff (PG 24) @ $1,389 per FTE)	$1,389
Total Non-Recurring Expenditures	**$96,013**

AHCA estimates the following recurring expenditures:	**Amount Year 1 (FY 02-03)**	**Amount Year 2 (FY 03-04)**
Salaries—1 Prof. Staff PG 24@ Minimum +10% (Anticipate hiring 7/1/02)	$52,798	$52,798
OPS (11 clerical assts. @ $12/hr + 7.65% (Soc. Security) (anticipate hiring 4 on 7/1/02, 4 on 10/1/02 and 3 on 1/1/03)	$114,198	$147,785
Expense--Committee travel & telephone expenses ($6,000 per committee x 11 committees) (Anticipate presence of 4 committees for the full year at $24,000, 4 committees for 75% of the year at $18,000 and 3 committees for 50% of the year at $9,000)	$51,000	$66,000
11 OPS support staff @ $6,995 per position with 4 to be hired as of 7/1/02, 4 to be hired as of 10/1/02 and 3 to be hired as of 1/1/03)	$59,462	$76,945
1 Professional staff @ $11,057 per FTE	$11,057	$11,057
Total Recurring Expenditures	**$288,515**	**$354,585**

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

None.