STORAGE NAME: h0693a.hp.doc
DATE: February 7, 2002

HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH PROMOTION
ANALYSIS

BILL #: HB 693

RELATING TO: Managed Care Ombudsman Committee

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:

THIS DOCUMENT IS NOT INTENDED TO BE USED FOR THE PURPOSE OF CONSTRUING STATUTES, OR TO BE CONSTRUED AS AFFECTING, DEFINING, LIMITING, CONTROLLING, SPECIFYING, CLARIFYING, OR MODIFYING ANY LEGISLATION OR STATUTE.

HB 693 relates to managed care ombudsman committees. The bill increases the maximum number of members on a district managed care ombudsman committee from 16 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.

The bill's effective date is July 1, 2002.

On February 7, 2002, the Committee on Health Promotion adopted one amendment, with title amendment, which inserted language to refer to the Provider and Subscriber Assistance Panel by its current title.

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

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

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

Less Government: The bill requires the Agency for Health Care Administration to conduct a background screening of committee members, to review all appointments for compliance with the law, to conduct a public awareness campaign, and to provide committee members 8 hours of initial training and 8 hours of continuing education annually. The bill also provides for additional responsibilities for committees, which are quasi-governmental entities.

B. 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 chapter 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 of initial appointment, not to exceed two consecutive terms.

Currently, only four of the 11 district committees are operational. These are located in AHCA Areas 8, 9, 10 and 11, which take in the following 15 counties: Broward, Palm Beach, Dade, Monroe, Martin, St. Lucie, Indian River, Okeechobee, Charlotte, Lee, Collier, Desoto, Glades, Hendry, and Sarasota 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 24 health maintenance organizations in Florida with nearly five million subscribers. As of September 30, 2001, there were 3,269,172 commercial subscribers, 665,760 Medicare subscribers, 552,715 Medicaid subscribers, and 192,873 Healthy Kids 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 758 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.

To access the Senate Interim Report, go to:
http://www.leg.state.fl.us/data/Publications/2002/Senate/reports/interim_reports/pdf/2002-137hc.pdf

C. EFFECT OF PROPOSED CHANGES:

This bill makes changes to the Managed Care Ombudsman Program that would strengthen the role of local ombudsman committees and focus the committees' work on quality-of-care issues. The bill repeals s. 641.60, F.S., relating to the Statewide Managed Care Ombudsman Committee. 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., and modifies provisions relating to this program.

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's effective date is July 1, 2002.

D. SECTION-BY-SECTION ANALYSIS:

Section 1. Creates s. 641.64, F.S., to provide definitions for the following terms: "agency", "covered medical service", "district", "district committee", "enrollee", "managed care program", and "physician." It should be noted that these definitions are the same as those currently included in s. 641.60, F.S., which is repealed by section 5 of the bill.

Section 2. Amends s. 641.65, F.S., to require the formation of a managed care ombudsman committee in each health services planning district of the agency. Removes the existing provision that requires such committees only in areas where AHCA staff is assigned to regulate managed programs.

Allows for up to 20 members, instead of a maximum of 16 members, in each committee. Clarifies that when possible, members should be chosen from among the originally required professions, but states that those professionals are no longer mandatory in order for the committee to form. States that at least one member must be a recipient of managed care program services.

Requires the agency to conduct and pay for Level I background screening of committee members.

States that the agency shall review all appointments for compliance with this section and can disqualify appointments that do not comply. Removes the provision of automatic approval of a replacement member if the agency Secretary fails to approve or disapprove a replacement member within 30 days after the nomination.

Clarifies that all committee members serve in a voluntary capacity. Clarifies that committee assistance must be requested by the managed care enrollees before complaints may be sent to the committees, and that once such assistance is requested, complaints must be sent to the appropriate committee. Permits the district managed care ombudsman committees and their members to take complaints directly from complainants provided that such complaints are reported to the agency. Requires the managed care ombudsman committees to assist the enrollees with their appeals to the Subscriber Assistance Panel under s. 408.7056, F.S., if requested to do so. Requires the committees to educate enrollees about their rights and responsibilities in managed care programs. Requires the committees to teach consumers to understand and use the consumer guide on plan performance (HMO report card) to help them select appropriate health care plans. Requires committees to help enrollees file formal appeals of managed care program determinations. Requires committees to submit an annual report to the agency, and removes reference to the Statewide Managed Care Ombudsman Committee. Requires the committees to conduct meetings as required at the call of the committee chairpersons.

Prohibits members or employees of committees from having direct involvement in the licensing, certification, or accreditation of a managed care program, or from having an ownership or investment interest in a managed care program. Prohibits members or employees of committee members from being employed by or participating in the management of a managed care program. Prohibits members or employees of committees from receiving any kind of remuneration, directly or indirectly, under a compensation agreement with a managed care program. Prohibits members from gaining financially through an action or potential action brought on behalf of individuals the ombudsman serves.

Section 3. Amends s. 641.70, F.S., to eliminate references to the Statewide Managed Care Ombudsman Committee. Requires the agency to adopt additional rules that specify procedures to identify and eliminate conflicts of interest as described in s. 641.65, F.S. Allows, rather than requires, the agency to incorporate recommendations made by committees into its policies and procedures.

Retains the requirement for the agency to provide a meeting place and the necessary administrative support for the committees. Requires the agency to conduct a statewide public information campaign to increase the public's awareness of the services provided by the district committees. Requires the agency to establish standardized training for committee members, including 8 hours of training upon appointment and 8 hours of continuing education annually thereafter. Allows the agency to assist the committees in recruiting and retaining managed care ombudsmen.

Section 4. Amends s. 641.75, F.S., relating to ombudsman immunity from liability and limitation on testimony, to remove references to the Statewide Managed Care Ombudsman Committee.

Section 5. Repeals s. 641.60, F.S., which created the Statewide Managed Care Ombudsman Committee.

Section 6. Appropriates $300,000 from the General Revenue Fund to the agency, and authorizes one position for purposes of implementing this act during the 2002-2003 fiscal year.

Section 7. Provides that the bill take effect July 1, 2002.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

N/A

2. Expenditures:

The bill appropriates $300,000 from the General Revenue Fund to the Agency for Health Care Administration, and authorizes 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 a total of 220 members, the cost for background checks would be $3,300 during the first year and $1,100 for the second year (assuming a turn-over rate of 1/3 of the members).

AHCA estimates the following non-recurring expenditures:	
Public Awareness Campaign –printed materials	$50,000
Training video (initial) production ($300 x 16 hours for training tape) ($500 x 32 hours for editing)	$20,800
11 OPS support staff at $2,076 per position	$22,836
1 Professional staff (PG 24) @ $2,659 per FTE	$2,659
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	**$112,963**

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—Level I Background Screening (First year $15 x 220 members) (Following years est. to one-third member turnover =74 members)	$3,300	$1,110
DMS Videoconference center expense	$5,400	$5,400
Training Video updated annually (1/4 production cost)	$0	$5,200
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
Committee-member travel to annual videoconference training sessions ($71 x 80 members) + (.20/mile x 50 miles x 220 members) + ($50 per diem for one day x 80 members)	$12,980	$12,980
1 Professional staff travel expense, above standard allowance, to resolve committee problems ($550 per trip x 7 committees).	$3,850	$3,850
Total Recurring Expenditures	**$314,045**	**$383,125**
Sub-Total Non-Recurring Expenditures	$112,963	$0
Sub-Total Recurring Expenditures	$314,045	$383,125
Total Expenditures	**$427,008**	**$383,125**

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

N/A

2. Expenditures:

N/A

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Managed care consumers will benefit from having another avenue for resolution of their grievances.

There will be an unknown fiscal impact on the managed care organizations for provision of information and documents to the managed care ombudsman committees.

D. FISCAL COMMENTS:

Since AHCA's fiscal review of the bill indicates a need for more resources than appropriated by the bill, it must be anticipated that the provisions of the bill may not be fully implemented.

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

A. APPLICABILITY OF THE MANDATES PROVISION:

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

B. REDUCTION OF REVENUE RAISING AUTHORITY:

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

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

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

V. COMMENTS:

A. CONSTITUTIONAL ISSUES:

None.

B. RULE-MAKING AUTHORITY:

The bill provides additional rulemaking authority to the agency for this program.

C. OTHER COMMENTS:

On page 6, lines 7-8, and in the title on page 1, line 18, the bill refers to the Subscriber Assistance Panel under s. 408.7056, F.S. While there are pending legislative proposals (CS/SB 256 and a forthcoming House companion) to refer to the panel by this name, the current title for the panel is the Provider and Subscriber Assistance Panel.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

On February 7, 2002, the Committee on Health Promotion adopted one amendment (page 6, line 7), which inserted language to refer to the Provider and Subscriber Assistance Panel by its current title. The title was also amended (page 1, line 18).

VII. SIGNATURES:

COMMITTEE ON HEALTH PROMOTION:

Prepared by:	Staff Director:
Sarah Graham	Phil E. Williams