The Florida Senate

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Committee on Health, Aging and Long-Term Care | Senator Burt L. Saunders, Chairman

AN OVERVIEW OF THE LONG-TERM CARE AND MANAGED CARE OMBUDSMAN PROGRAMS

SUMMARY

The Florida Long-Term Care and Managed Care Ombudsman Programs are consumer advocacy organizations for residents of long-term care facilities and subscribers of managed care plans. Ombudsman programs are distinctive in that they are independent, volunteer-based entities that seek to address grievances of health care consumers by means of intervention, advocacy and dispute resolution.

For this project, committee staff conducted surveys and researched federal, state and industry sources with the intent of devising recommended improvements in the programs. The programs are in general well-designed and provide a valuable and unique voice for long-term care residents and managed care subscribers, but they would benefit from specific updates in programming, training and funding. In turn, Florida health care consumers would be the ultimate beneficiaries of such reforms.

The Long-Term Care Ombudsman Program could be improved by: retargeting ombudsman facility inspections and training to the quality of life needs of residents; increasing maximum council size; enhancing training; coordinating ombudsman and related state agency operations; initiating a statewide public awareness campaign; improving data information systems; increasing efforts in assisted living facility quality; and recruiting multilingual ombudsmen.

The Managed Care Ombudsman Program could be improved by: funding necessary operations; updating the database of subscriber identification numbers and managed care plan contacts; initiating a statewide public awareness campaign; creating standardized training packets; improving training of telephone complaint intake personnel; and implementing a recruitment and retention policy.

BACKGROUND

Long-Term Care Ombudsman Program

In response to widespread concerns regarding the quality of life of the aged, the Federal Older Americans Act (OAA), 42 USC section 3001, was enacted in 1965. The OAA established the Administration on Aging within the U. S. Department of Health, Education and Welfare and created the state Units on Aging. That same year Medicare, a health insurance program for the elderly, and Medicaid, a health insurance program for low-income persons, were added to the Social Security Act, Title 42 USC. In 1973 OAA amendments established the Area Agencies on Aging to facilitate the delivery of services for the aged.

The Florida Long-Term Care Ombudsman Program (LTCOP) was initiated in 1975 under chapter 75-233, Laws of Florida. The Legislature's intent was to create a volunteer-based program to discover, investigate and remedy the presence of conditions or individuals which constitute a threat to the rights, health, safety or welfare of residents of long-term care facilities and to conduct investigations to further the enforcement of laws, rules and regulations that safeguard the health, safety and welfare of residents. The statutory authority for the program is found in part I of chapter 400, Florida Statutes.

State long-term care ombudsman programs were made mandatory by amendments to the OAA in 1978 in response to concerns about poor quality in long-term care facilities. The essential functions of the long-term care ombudsman programs as contemplated by the OAA include: identifying, investigating and resolving complaints; protecting the legal rights of residents; advocating for systemic change; providing information and consultation to residents and their families; and publicizing issues important to residents.

Based upon reports by the Federal Institute of Medicine and the General Accounting Office documenting widespread quality of care deficiencies in nursing homes, Congress passed the Omnibus Budget Reconciliation Act of 1987 (OBRA), Pub.L.No. 100-203. OBRA expanded the Medicare requirements of nursing homes and strengthened the rights of residents to be free of physical or mental abuse, and the right to be free from chemical and physical restraints under 42 USC sections 1396a and 1396r. An essential aspect of the appropriations contained in OBRA 1987 was the inception of federal funding for state long-term care ombudsman programs.

Amendments to the OAA in 1992[1] provided that, as a condition of receiving federal funding under OBRA, the state long-term care ombudsman programs were required to:

- Identify, investigate and resolve complaints made by or on behalf of residents of long-term care facilities that relate to the health, safety or welfare of the resident.
- Provide services to assist residents in assuring their health, safety and welfare.
- Inform residents of means of obtaining necessary care from providers and applicable social service agencies.
- Represent the interests of residents before governmental agencies and seek administrative and legal remedies to protect resident health, safety and welfare.
- Monitor, analyze and comment on the development and implementation of federal, state and local laws, and regulations and policies that pertain to resident health, safety and welfare.
- Provide training for ombudsmen.
- Avoid contracting with the state agency responsible for long-term care facility licensing and certification, to preclude conflicts of interest.
- Ensure that all ombudsmen are competent to carry out their responsibilities and are free from personal conflicts of interest.
- Develop policies and procedures to assure resident confidentiality and privacy.
- Ensure ombudsman access to long-term care facilities and records.
- Establish a statewide uniform reporting system to collect and analyze complaints and deficiencies.
- Ensure that adequate legal counsel is available to the ombudsmen and that such counsel is free from representational conflicts of interest.
- Prepare a report of ombudsman activities and complaint resolution data.
- Provide indemnification from liability for ombudsmen acting in good faith under the law.
- Ensure noninterference with the independence of the ombudsman program.

In contrast to other health and residential facility oversight programs, ombudsmen lack enforcement and regulatory oversight authority. As independent advocates, they work solely on behalf of residents and seek to mediate disputes between residents and long-term care facilities on an informal basis. The LTCOP provides residents with the opportunity to develop personal and confidential relationships with the ombudsmen and creates an environment conducive to the candid voicing of resident complaints. As well, the LTCOP is distinct from other agencies in its significant reliance on volunteers.

The National Association of Area Agencies on Aging (NAAAA) states that the most common complaints resolved by long-term care ombudsmen involve: quality of care, financial accounts, food, physical environment, physician services, social activities, facility administration, transfers and discharges, and personal legal problems. The NAAAA describes ombudsman advocacy as:

- Coordinating divergent interests and resources.
- Educating specific groups and elected officials regarding the needs of the elderly.
- Affecting state and local policies.
- Expanding funding options.
- Identifying needs and expanding service areas.
- Promoting co-located services.
- Initiating new programs.
- Protecting and enhancing existing supportive services.
- Encouraging other organizations and individuals to be more responsive to the needs of the elderly.

Forty-two states have placed the ombudsman program within the state Unit on Aging. Other states have located the ombudsman program in another related state agency or maintained it entirely independent of any other entity. In Florida, the Department of Elder Affairs (DOEA) is the designated Unit on Aging and houses the LTCOP under sections 400.0087(3), and 430.101, Florida Statutes.

[1] Pub.L.No. 102-375 section 712, codified at 42 USC sections 3058i and 3058f.

The LTCOP consists of a State Long-Term Care Ombudsman, a State Long-Term Care Ombudsman Council and 14 district councils under sections 400.0063, 400.0067 and 400.0069, Florida Statutes. Each district council is comprised of 15 to 30 members under section 400.0069(4), Florida Statutes. The councils are required to conduct annual inspections of all long-term care facilities in the council's jurisdiction and to undertake complaint investigations as necessary under section 400.0073(4), Florida Statutes. The LTCOP maintains a toll-free complaint telephone line.[2] Local councils meet monthly and the state council meets quarterly. The LTCOP is required to maintain a statewide uniform data collection and analysis system for long-term care statistics and to prepare an annual report incorporating such data under sections 400.0089 and 400.0067(2)(g), Florida Statutes. Comprehensive training must be provided to all ombudsmen under section 400.0091, Florida Statutes.

As part of its administrative oversight over LTCOP, DOEA is required to enact administrative rules regarding: elimination of conflicts of interest, assurance of access to facilities, and establishment of policies and procedures of individual ombudsman councils under sections 400.0065(3), 400.0081(3) and 400.0087(1), Florida Statutes. Such rules regarding conflicts of interest, facility access and policies and procedures are respectively codified at 58L-1, 58L-2 and 58L-3, Florida Administrative Code.

Long-term care facilities in Florida are comprised of nursing homes (744 facilities with 81,918 beds), assisted living facilities or ALFs (2,566 facilities with 84,017 beds), and adult family care homes or AFCHs (351 facilities with 1,454 beds) for a total of 3,661 facilities and 167,389 beds.[3] LTCOP staffing is in constant flux, but typically approximates 260 (17.5 paid FTEs and the remainder volunteers). These ombudsmen accomplished 2,886 routine inspections (78.8 percent of the 3,661 facilities) and 8,040 complaint investigations during the 1999-2000 fiscal year. Based upon preliminary data, volumes for the 2000-2001 year will be comparable to the previous year.

Funding for the LTCOP for fiscal year 1999-2000 was $1.27 million (78.5 percent OAA funds and 21.5 percent general revenue), for 2000-2001 was $1.35 million (74.9 percent OAA and 25.1 percent general revenue), and for 2001-2002 is $2.28 million (47.1 percent OAA and 52.9 percent general revenue).[4]

Managed Care Ombudsman Program

While the LTCOP had as its basis federal statutes and demonstration projects, the Florida Managed Care Ombudsman Program (MCOP) had a decidedly more grassroots background. In approximately 1985, a group of interested health professionals in Broward County formed a group termed "HMO Patient Advocates," whose name was then changed to "Advocates for Patients of Managed Care." This group of approximately 50 to 100 individuals began to unofficially act as advocates for managed care subscribers and became the genesis for the MCOP.

In 1996, the Advocates for Patients of Managed Care became the official MCOP under chapter 96-391, Laws of Florida, to act as a consumer protection and advocacy organization on behalf of all managed care plan subscribers in the state under section 641.60, Florida Statutes, et seq.

At least nine states currently have some type of formal ombudsman or consumer assistance program for managed care subscriber grievance resolution.[5]

The MCOP is authorized to have a Statewide Managed Care Ombudsman Committee and 11 district committees under sections 641.60 and 641.65, Florida Statutes. Currently, only four of the 11 district committees are operational – in Broward, Palm Beach, Dade and Charlotte/Lee/Collier Counties. The district committees consist of a minimum of nine and a maximum of 16 members and are directed to: protect the health, safety and welfare of managed care enrollees; receive complaints regarding quality of care from the Agency for Health Care Administration (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 section 641.65, Florida Statutes.

[2] Volume was 11,390 calls in the 2000-2001 fiscal year, and 7,968 in 1999-2000.

[3] June 30, 2000, data was utilized in order to be comparable to fiscal year 1999-2000 ombudsman inspections and complaint investigations.

[4] The LTCOP was allocated an increase of $948,782 in general revenue for the 2001-2002 year under section 68 of CS/CS/CS/SB 1202 from the 2001 legislative session.

[5] Including California, Connecticut, Massachusetts, New Jersey, New York, Pennsylvania, Texas, Vermont and Virginia.

For administrative purposes, the MCOP is located within AHCA under section 641.60(2), Florida Statutes, 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.[6]

There are 28 managed care organizations in Florida with approximately six million subscribers (4,805,122 commercial, 689,729 Medicare and 524,969 Medicaid),[7] representing health maintenance organizations (HMOs), prepaid health clinics, Medicaid prepaid health plans, Medicaid primary care case management programs, and other similar Medicaid programs.

As a prerequisite to an HMO obtaining a mandatory Health Care Provider Certificate from AHCA and a Certificate of Authority from the Department of Insurance (DOI), the HMO must establish and maintain an internal subscriber grievance procedure under sections 641.21(1)(e), 641.22(9) and 641.495(9), Florida Statutes. 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 section 408.7056(2), Florida Statutes.

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, discussing terms of coverage and the like.

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, and no funds are allocated for any travel expenses incurred by the volunteers. Senate Bill 1454 and House Bill 981 for the 2001 legislative session both proposed annual funding for the MCOP of $50,000, but neither SB 1454 nor HB 981 was passed into law.

METHODOLOGY

To evaluate the efficacy of the ombudsman programs, committee staff surveyed AHCA, DOEA, DOI, the chairs of the ombudsman councils, and industry associations representing long-term care and managed care entities. As well, federal and state studies, national industry association data, the OAA, the LTCOP annual reports, administrative rules, and federal and state case law were reviewed. Committee staff attended a long-term care ombudsman site survey and received data from the Long-Term Care Ombudsman and AHCA officials.

FINDINGS

Long-Term Care Ombudsman Program

In a March 1999 comparative evaluation of ten state long-term care ombudsman programs, the Office of the Inspector General (OIG) of the Department of Health and Human Services found that while the programs are well designed, inadequate resources limit their capability. The specific recommendations proposed by the OIG to remedy these perceived problems include:

- Develop guidelines for minimum levels of ombudsman program visibility, including criteria for frequency and length of regular visits and staffing ratios.
- Formulate strategies for recruiting, training and supervising more ombudsman volunteers.
- Create guidelines for ombudsman complaint response and resolution times.
- Refine and improve the ombudsman data reporting system.
- Establish methods to enhance coordination between the state agency responsible for survey and certification and the ombudsman program.

Committee staff conducted a survey of LTCOP council chairs, DOEA and several long-term care industry associations regarding the LTCOP and received the following feedback:

- Industry representatives report that ombudsman investigations and training are inappropriately targeted to clinical and physical plant evaluation, which results in a duplication of AHCA oversight and a neglect of residents' unresolved

[6] While managed care organizations are dually regulated by AHCA and DOI under chapter 641, Florida Statutes, DOI reported that it had no contact with the MCOP.

[7] As of March 31, 2001.

interpersonal, psychological, emotional and spiritual needs.
- Ombudsmen consistently cite as chronic long-term care facility quality deficiencies: inappropriate treatment of dementia and Alzheimer's residents; inconsistent medication administration (particularly as to psychotropics); resident rights and notice abuses regarding discharge (particularly in ALFs); insufficient staffing (particularly in ALFs); insufficient protection of frail elders from younger mental health residents; and inappropriate commingling of resident funds with facility business operating accounts.
- Ombudsmen consistently encounter programmatic difficulties involving: interrelationships and communications among the LTCOP and AHCA, DOEA and the Department of Children and Families (DCF); public awareness of the LTCOP; interpretation of legal guardianships and powers of attorney; and limited or unpredictable ombudsman staffing.
- ALFs provide 50.2 percent of all long-term care beds in Florida, but ombudsmen spend only 29.7 percent of their total time on ALF matters.
- Ombudsman training appears lacking in cultural sensitivity and diversity matters, and too few ombudsmen are multilingual.

The LTCOP has proven itself to be a successful and meaningful long-term care resident rights advocate. With program updates and augmented training, the LTCOP can maximize its effectiveness.

The primary focus of the program should be to champion the quality of life, dignity and personal needs of residents. The LTCOP should emphasize problem solving and dispute resolution rather than the reporting of deficiencies. That is not to say that ombudsmen should not report substandard care when observed, only that the investigation and remedy of violations of minimum standards under parts II, III and VII of chapter 400, Florida Statutes, should remain within the purview of AHCA. In order to optimize the efficacy of the LTCOP, the program needs to adhere to the initial legislative intent – long-term care facility resident advocacy as expressed in section 400.0061, Florida Statutes.

Managed Care Ombudsman Program

Committee staff conducted a survey of MCOP committee chairs, AHCA, DOI and an industry association regarding the MCOP and received the following responses:

- Funding for the MCOP is nonexistent.
- Ombudsmen and industry representatives report that some subscribers become aware of MCOP services so late in the internal managed care grievance process that conflicts are resolved prior to initial ombudsman intervention.
- Ombudsmen consistently state that subscriber plan identification numbers and managed care plan contact information is commonly erroneous, incomplete or out-of-date.
- Ombudsman training appears inconsistent.
- Ombudsmen relate that AHCA telephone complaint intake personnel lack training in rudimentary clinical terminology sufficient to create meaningful referrals to the MCOP.
- Ombudsmen cite lack of recognition of current volunteers and insufficient identification of potential new volunteers as barriers to ombudsman recruitment and retention.

The MCOP has handled the complaints it has been referred with expediency and expertise. However, the exceptionally limited geographical coverage of the program has greatly restricted its effectiveness. This is most likely a reflection of the lack of funding for the program.

Key to the long-term success of the MCOP is proper alignment of the program with AHCA, managed care organizations' internal grievance processes, and the Statewide Provider and Subscriber Assistance Panel. All these entities, while necessarily integrated and complementary, must not conflict or be duplicative. The MCOP should seek to refine its operations to accomplish its unique mission in accordance with original legislative intent, to "act as a consumer protection and advocacy organization on behalf of all health care consumers receiving services through managed care programs in the state" under section 641.60(2), Florida Statutes.

RECOMMENDATIONS

Staff recommends the following as to the LTCOP:

- Retargeting of ombudsman investigations and training to emphasize the quality of life of residents and reduce the emphasis on facility inspections that duplicate AHCA surveys. Ombudsmen are in a unique position to ensure the dignity and quality of life of long-term care residents in a culturally appropriate manner and

should make these concerns a primary objective of the program. Such updates should ensure that the ombudsmen remain advocates instead of regulators.

- Expansion of the statutory maximum council size from 30 to 40 ombudsmen to enhance coverage of the state's larger districts under section 400.0069(4), Florida Statutes. Such increase would permit improved coverage of ALFs, particularly in the larger districts.
- Training of ombudsman as to: guardianships and powers of attorney; medication administration; care and medication of dementia and Alzheimer's residents; accounting for resident funds; discharge rights and responsibilities; and cultural sensitivity and diversity under section 400.0091, Florida Statutes. A continuing training program could be instituted in order to keep ombudsmen informed of new developments. Joint training sessions with ombudsmen and facility staff might be helpful.
- Convening workshops between the LTCOP and officials from AHCA, DOEA and DCF to better coordinate communication and operations. The work product of all these entities should be better coordinated to maximize effectiveness and efficiency.
- Initiation of a statewide public information campaign to increase LTCOP visibility and bolster public awareness. This should encourage more residents and residents' families to access appropriate ombudsman services.
- Improvement of the LTCOP's management and data information systems capability under section 400.0089, Florida Statutes. Enhanced data will likely aid in further refinements to the program. Perhaps the use of quarterly reporting instead of the current annual report would offer additional flexibility and improve accountability.
- Reassignment of ombudsmen to a more representative proportion of ALF grievances. This reallocation of ombudsman resources should assist in addressing unmet ALF quality of life complaints.
- Recruitment of additional multilingual ombudsmen. This will assist in the more meaningful delivery of ombudsman services in a culturally appropriate manner.

Staff recommends the following as to the MCOP:

- 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.

Other issues that may warrant further discussion include:

- Expansion of the LTCOP from just residential care to community-based care funded under Medicaid waiver programs. Because non-residential long-term care is becoming an increasingly attractive option for some elders and some communities, perhaps the need for ombudsman services will present itself for these alternative-care settings.
- Consolidation of all ombudsman activities in a single office.[8] Such centralization could offer efficiencies and minimize duplication of efforts.[9] As well, specialty ombudsman functions might be more readily offered under a single office. After recent court decisions interpreting the Americans with Disabilities Act,[10] there may be a need for

[8] Consolidation was proposed in SB 438 which died in committee in the 2001 session.

[9] Such as the MCOP housed in AHCA, and SHINE (Serving Health Insurance Needs of Elders) of DOEA which provides volunteer-based health insurance information, counseling and advocacy services for elders, families and caregivers under chapter 430, Florida Statutes.

[10] For example, *Olmstead v. L.C.*, 119 S.Ct. 2176, 527 U.S. 581, 144 L.Ed.2d 540 (1999) (State could not keep disabled persons institutionalized if clinically appropriate, albeit more costly, community-based services are available as an alternative).

disability ombudsmen. Given Florida's significant population of HIV/AIDS patients, an appropriate ombudsman program may be useful, such as that implemented by Puerto Rico. There may also be unmet need for workers' compensation ombudsman services.