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BILL ANALYSIS

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Senate Bill 809 (as enacted) **PUBLIC ACT 198 of 2016**
Sponsor: Senator Peter MacGregor
Senate Committee: Veterans, Military Affairs and Homeland Security
House Committee: Appropriations

Date Completed: 11-15-16

CONTENT

The bill enacted a new statute to create the Office of the Michigan Veterans' Facility Ombudsman in the Legislative Council, and do the following:

- **Require the Council to appoint a Michigan Veterans' Facility Ombudsman, as the principal executive officer of the Office.**
- **Authorize the Ombudsman to investigate complaints about an administrative act, medical treatment of a resident veteran, or a condition at a Michigan veterans' facility that poses a significant health or safety issue for which there is no effective administrative remedy or allegedly is contrary to law or policy.**
- **Permit the Ombudsman to investigate on his or her own initiative or upon receiving a complaint from a complainant (a resident veteran of a Michigan veterans' facility, a family member of a resident veteran, a legal guardian or individual with power of attorney for a resident veteran, or a legislator).**
- **Require the Ombudsman to be given access to residents' health records and other records in the possession of the Department of Military and Veterans Affairs (DMVA) or a veterans' facility.**
- **Require the Ombudsman to be granted access to inspect a facility at any time.**
- **Authorize the Ombudsman to interview employees or contractors of the DMVA or of a private contractor that operates a veterans' facility.**
- **Authorize the Ombudsman to hold informal hearings and request a person to appear and testify or give evidence.**
- **Permit the Legislative Council to hold a hearing upon the Ombudsman's request, subpoena witnesses, and examine records of the DMVA or a veterans' facility.**
- **Provide that the Ombudsman is not required to conduct an investigation or hold a hearing on a complaint.**
- **Provide for confidentiality of communications between the Ombudsman and complainants.**
- **Require the Ombudsman to submit a report and make recommendations to the Council within 10 business days if he or she makes certain findings after an investigation.**
- **Require the Ombudsman, when publishing an opinion adverse to a person or facility or the DMVA, to include a statement made by that person or facility or the Department in defense or mitigation of the Ombudsman's finding.**
- **Provide that a facility resident may not be penalized for filing a complaint, communicating a complaint to a legislator, or cooperating in an investigation.**
- **Require the Ombudsman to submit to the Council, the board of managers, and the Legislature a semiannual report on the conduct of the Office.**

(The Legislative Council is a body created by the Michigan Constitution and statute, and consists of six members of the Senate appointed by the Senate Majority Leader and six members of the House appointed by the Speaker of the House. At least two members appointed by each leader must be members of the minority party. The Council must appoint an administrator who is the chief executive officer of all Council agencies.)

The bill took effect on September 20, 2016.

Creation of the Office; Appointment of Ombudsman

The Office of the Michigan Veterans' Facility Ombudsman is created within the Legislative Council. The principal executive officer of the Office is the Michigan Veterans' Facility Ombudsman, who must be appointed by and serve at the pleasure of the Council. The Council must establish procedures for approval of the Office's budget, expenditure of funds of the Office, and the employment of personnel for the Office.

Subject to approval of the Legislative Council, the Ombudsman must establish procedures for receiving and processing complaints, conducting investigations, holding hearings, and reporting the findings from the investigations.

Investigation of Complaints; Hearings

The Ombudsman may begin investigation upon his or her own initiative or upon receiving a complaint from a complainant concerning an administrative act, medical treatment of a resident veteran, or a condition existing at a Michigan veterans' facility that poses a significant health or safety issue for which there is no effective administrative remedy or that is alleged to be contrary to law or departmental policy.

The Ombudsman may interview any of the following individuals whom he or she considers necessary in an investigation:

-- A person employed by or retained under contract by the DMVA.
-- A person employed by or retained under contract by a private contractor that operates a facility housing resident veterans.

Subject to the Council's approval, the Ombudsman must establish procedures for receiving and processing complaints, conducting investigations, holding hearings, and reporting the findings resulting from the investigations.

Upon request and without the requirement of any release, a facility must provide access to all information, and the Ombudsman must be given access to all information, records, and documents in the possession of the DMVA or a Michigan veterans' facility that the Ombudsman considers necessary in an investigation. These items include medical health records, mental health records, and mortality and morbidity records of resident veterans (veterans residing in a Michigan veterans' facility).

Upon request and without notice, the Ombudsman must be granted access to inspect a Michigan veterans' facility at any time.

The Ombudsman may hold informal hearings and request any person to appear before the Ombudsman or at a hearing and give testimony or produce documentary or other evidence that he or she considers relevant to an investigation.

The Ombudsman must advise a complainant to pursue all administrative remedies available to him or her. The Ombudsman may request and must receive from the DMVA or from a facility a progress report concerning the administrative processing of a complaint. After administrative action on a complaint, the Ombudsman may conduct further investigation on his or her own initiative or on the request of a complainant.

Upon receiving a complaint and deciding to investigate it, within 10 business days the Ombudsman must notify the complainant, the resident veteran or resident veterans affected, and the Department. If he or she declines to investigate, the Ombudsman must notify the complainant within 10 business days in writing, and inform the resident veteran or veterans affected of the reasons for that decision.

Upon the Ombudsman's request, the Legislative Council may hold a hearing. The Council may administer oaths, subpoena witnesses, and examine the books and records of the DMVA or of a facility in a matter that is a proper subject of investigation by the Ombudsman.

Confidentiality

Correspondence between the Ombudsman and a complainant is confidential and is privileged communication.

All records, reports, and communications relied upon, referred to, or prepared are subject to the privacy provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA) and regulations promulgated under that Act.

Report of Investigation

The Ombudsman must prepare and submit a report of the findings of an investigation and make recommendations to the Legislative Council within 10 business days after completing the investigation, if he or she finds any of the following:

-- A matter that should be considered by the Department.
-- An administrative act that should be modified or canceled.
-- A statute or rule that should be altered.
-- Administrative acts for which justification is necessary.
-- Significant resident veteran health and safety issues.
-- Any other significant concerns.

The report and recommendations are exempt from disclosure under the Freedom of Information Act. Subject to the following provisions, the Council must forward the report to the DMVA, the resident veteran or resident veterans affected, and the complainant who requested the report.

Before announcing a report with a conclusion or recommendation that expressly or by implication criticizes a person or facility or the DMVA, the Ombudsman must consult with that person or facility or the Department. When publishing an opinion adverse to a person or facility or the DMVA, the Ombudsman must include in that publication a statement of reasonable length made to him or her by that person or facility or the Department in defense or mitigation of the finding, if that statement is provided within a reasonable period of time as determined by the Council.

The Ombudsman may request to be notified by the person or facility or the DMVA, within a specified time, of any action taken on any recommendation presented. The Ombudsman must notify the complainant of the actions taken by the person or facility or the DMVA.

Prohibitions

A resident veteran may not be penalized in any way by a person or facility or the Department as a result of filing a complaint, communicating a complaint to a legislator, or cooperating with the Ombudsman in investigating a complaint.
A person or facility or the DMVA is prohibited from hindering the lawful actions of the Ombudsman or employees of the Office, or willfully refusing to comply with any lawful demand of the Office.

Ombudsman's Authority

The authority granted to the Ombudsman under the statute is in addition to the authority granted under any other act or rule under which a remedy or right of appeal or objection is provided for a complainant, or any procedure provided for the inquiry into or investigation of any matter concerning a facility.

The authority granted to the Ombudsman may not be construed to limit or affect any other remedy or right of appeal or objection and may not be deemed to be exclusionary.

Semiannual Report

The Ombudsman must submit a semiannual report on the conduct of the Office to the Council, the board of managers, and the Legislature. The report must include all of the following information for each Michigan veterans' facility during the preceding six months, at a minimum:

-- The number of complaints received.
-- The number of complaints concerning each of the following categories: the modification or cancelation of, or justification for, an administrative act; a statute or rule; significant veteran health issues; and significant veteran safety issues.
-- The number of complaints resulting in the initiation of an investigation.
-- The number of investigations initiated by the Ombudsman.
-- The number of hearings.
-- The number of reports of findings issued.

MCL 4.771-4.784

BACKGROUND

In February 2016, the Office of Auditor General (OAG) released a performance audit of the Grand Rapids Home for Veterans that assessed the sufficiency of the Home's provision of member care services to be "not sufficient". The audit included nine findings that resulted in either a "material condition" or a "reportable condition".

(According to the audit report's Glossary of Abbreviations and Terms, a "material condition" is a matter that is more severe than a reportable condition and could impair the ability of management to operate a program in an effective and efficient manner and/or could adversely affect the judgment of an interested person concerning the effectiveness and efficiency of the program. A "reportable condition" is a matter that is less severe than a material condition and falls within any of the following categories:

-- An opportunity for improvement within the context of the audit objectives.
-- A deficiency in internal control that is significant within the context of audit objectives.
-- All instances of fraud.
-- Illegal acts unless they are inconsequential within the context of the audit objectives.
-- Significant violations of provisions of contracts or grant agreements.
-- Significant abuse that has occurred or is likely to have occurred.)

The audit report found need for improvement in the following:

-- Completing and properly documenting member accountability and safety checks.
-- Contractor staffing levels.
-- Administering pharmaceuticals as prescribed.
-- Developing, executing, and monitoring member comprehensive care plans.
-- Controls over nonnarcotic pharmaceuticals.
-- Prescription billing practices.
-- The Home's member complaint process.

-- Controls over disbursement of deceased or discharged members' funds.
-- The process to resolve past due member assessments.

The audit revealed all of the following:

-- Caregivers at the Grand Rapids Home did not conduct 43% of the necessary member location checks and did not conduct 33% of the necessary fall alarm checks, but produced documentation indicating that they had completed those checks.
-- The Home's caregiving services contractor did not meet the required staffing needs 81% of the time during four sampled months, ranging up to 22 staff per day.
-- 39% of nonnarcotic prescriptions were refilled late or more than five days early.
-- 25% of comprehensive care plans were not completed in a timely manner and 59% of the plans were not completed sufficiently.
-- There was no inventory system to account for an estimated $2.7 million of nonnarcotic pharmaceuticals dispensed annually.
-- $425,500 of rejected prescription billing claims were not followed up on, and $458,200 of dispensed pharmaceuticals were not billed to members' insurance companies.
-- All complaints were forwarded to the manager of the department against whom the complaints were filed, and nine complaints alleging abuse or neglect were not investigated by the Home's director of nursing.
-- The Home did not provide the balance and disposition of members' funds to the responsible parties in four of 10 instances, and the Home took up to seven months to provide the balance and disposition of members' funds.
-- There were no collection efforts documented for 83% of past due member assessments and 94% of past due assessments were not fully resolved.

Legislative Analyst: Patrick Affholter

FISCAL IMPACT

The bill will have an indeterminate fiscal impact on the State budget. As the bill does not appropriate funding for the implementation of its provisions, the fiscal impact will depend upon the extent to which, the Legislature chooses to appropriate funding for the new requirements. For FY 2016-17, House Bill 5294, (Public Act 268 of 2016), appropriates $150,000 GF/GP for the Veterans' Facility Ombudsman.

The Legislature also funds the Office of Legislative Corrections Ombudsman, within the Legislative Council. For fiscal year 2016-17, House Bill 5294 appropriates $729,200 GF/GP for the Office. The Office has a staff of seven, consisting of the Ombudsman, a chief analyst, a senior analyst, three analysts, and an administrative secretary. The Office's responsibilities span more than 30 correctional facilities in the State. It is likely that the cost of providing ombudsman services will be significantly less for veterans' facilities than for correctional facilities since the scope of the new Ombudsman's responsibilities will cover only two facilities -- the Grand Rapids Home for Veterans and the D.J. Jacobetti Home for Veterans. It also is possible that the cost of an Office of the Michigan Veterans' Facility Ombudsman will be mitigated through the potential synergy of the two Offices working together and sharing resources to the extent feasible.

Fiscal Analyst: Bruce Baker