

**Advocating for Improved Consumer
Protections in Managed Long-Term
Services and Supports**

Eric Carlson and Julie Carter

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JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

Justice in Aging is a national non-profit organization that fights senior poverty through law. We secure health and economic security for older adults of limited income and resources by preserving their access to the courts, advocating for laws that protect their rights, and training advocates around the country to serve the growing number of older Americans living in poverty.

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Acknowledgments

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Webinar Logistics

- All attendees are on mute
 - For technical questions, use chat box
 - For substantive questions, use questions box
- E-mail trainings@justiceinaging.org if unable to access webinar
- Slides and recording may be found at justiceinaging.org. An accompanying issue brief also is available on the same website.

Goals of this Webinar

- Provide a brief background on how states have tackled MLTSS implementation
- Focus on issues that give a flavor of the various problems that can confront consumers and their advocates in a managed care environment

Introduction

Justice in Aging has worked with advocates in the following states as they have implemented Medicaid managed care for long-term services and supports (LTSS):

- New Jersey
- Florida
- Kansas

Legal Authority

- Section 1915(c) Waivers (HCBS Waivers)
- Section 1915(b)/(c) Waivers
- Section 1115 Demonstration Waivers

State Summary: Florida

- Statewide program transition August 2013-March 2014
- Non-LTSS Medicaid services for LTSS consumers transferred to managed care May-August, 2014
- Combined § 1915(b)/(c) waiver—brought four waivers under MLTSS
- Still have waitlists
- Six MCOs and one PSN

State Summary: Kansas

- KanCare began in January 2013, included LTSS from the time of the initial implementation
- § 1115 waiver plus six 1915(c) waivers
- HCBS waiver services provided for persons with intellectual or developmental disabilities were not transferred to managed care until February 2014
- Three statewide MCOs

State Summary: New Jersey

- Long history of Medicaid managed care
- As of July 2014, LTSS brought under pre-existing managed care framework and is provided through managed care under § 1115 waiver
- Four existing waivers brought under MLTSS; one waiver exempted from inclusion
- Five MCOs

Advocacy Issues

Issues impacting MLTSS recipients and requiring systemic advocacy:

- Limits on Individual Expenditures
- Ombudsman Programs
- Access to Performance Measure Data
- Continuation of Services Pending Appeal

Limits on Individual Expenditures

CMS Cost Neutrality Requirements

- In New Jersey, Kansas, and Florida, managed care overall program must be budget-neutral—total Medicaid expenses no more than the Medicaid expenses incurred in the absence of the managed care program

Limits on Individual Expenditures

CMS Requirements in New Jersey

- Federal approval requires “cost-effective placement”
- Exceptions to the limits are available in some situations:
 - Member transition from institution to community
 - Short-term change in health condition
 - “Special circumstances” that require an accommodation

Limits on Individual Expenditures

New Jersey's State Implementation

- Problem develops when State has no guidance for the “special circumstances”
- Appeals were made, but state had not enunciated standards.
- Eventually state put appeals on hold and eventually released standards.

Limits on Individual Expenditures

Guidance on Cost Effectiveness

- Examples of change of condition lasting less than six months
 - Acute medical condition
 - Temporary loss of primary caregiver

Limits on Individual Expenditures

Guidance on Cost Effectiveness

- Need for private-duty nursing is special circumstance
 - Ventilator management
 - Tracheostomy with need for deep suctioning, or around-the-clock nebulizer treatments
 - Gastrostomy feedings
 - Seizure disorder marked by frequent seizures
- Private-duty nursing generally limited to 16 hours/day, but that may be exceeded on a temporary basis.

Limits on Individual Expenditures

Advocacy Issues

- New Jersey's "cost threshold" initially looks less flexible
- But can be advantages to explicit limits (if coupled with rational exceptions)
 - Can be appealed
 - Has standards
 - Existence of threshold sets "window" of appropriate authorization
- Systems without explicit limits are still limited, but less transparent

Ombudsman Programs

Federal Guidance

- May 2013, CMS guidance stated that MCO members must have access to independent and conflict-free assistance with any disputes with a state or plan
- Must be provided at no cost to the consumer

Ombudsman Programs

Kansas—Original Requirements

- “independent, conflict-free entity”
- “specific focus and outreach activities ... directed towards ... enrollees utilizing LTSS (institutional, residential and community based).”
- “assist ... enrollees in the resolution of problems and conflicts between the MCOs and participants”
- “help participants understand the fair hearing, grievance, and appeal rights and processes at each MCO and proactively assist them through the process if needed”

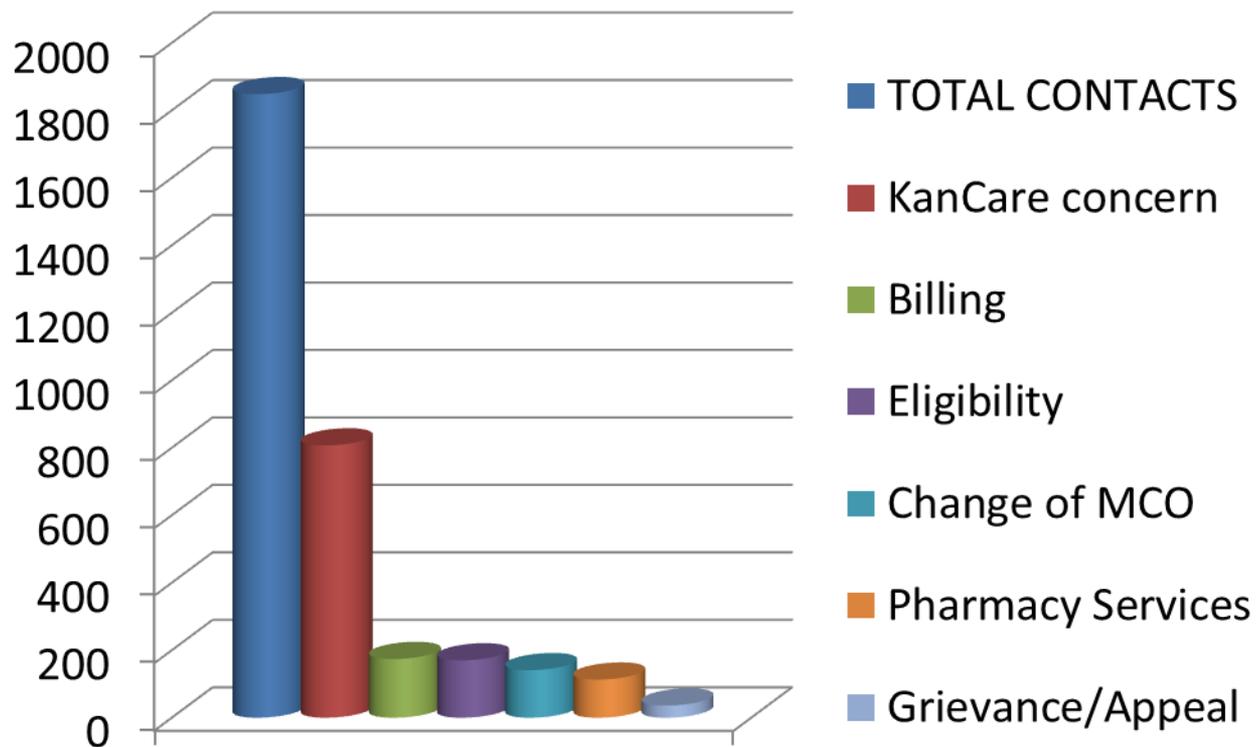
Ombudsman Programs

Kansas—Original Requirements (cont.)

- Advocacy for individual consumers relatively circumscribed
- Not “expected to file or represent the consumer in the grievance or appeal”
- Some provision for systemic advocacy
- Directed to represent state on MCO-convened councils and focus groups, and to provide state with advice on improving consumer protections

Ombudsman Programs

Kansas Performance 2013



Ombudsman Programs

Kansas—2014 Revised Requirements

- CMS revised Standards ombudsman program
- Now more detail regarding minimum job duties:
 - Access point for complaints and concerns about access to services
 - Help members understand and navigate grievance and appeal processes
 - Develop protocol for referring unresolvable issues to state
 - Develop and implement training and outreach with MCOs, providers, and community-based organizations, to facilitate cross-organizational collaboration and improve system capacity
 - Assist members to resolve billings issues and notices of action

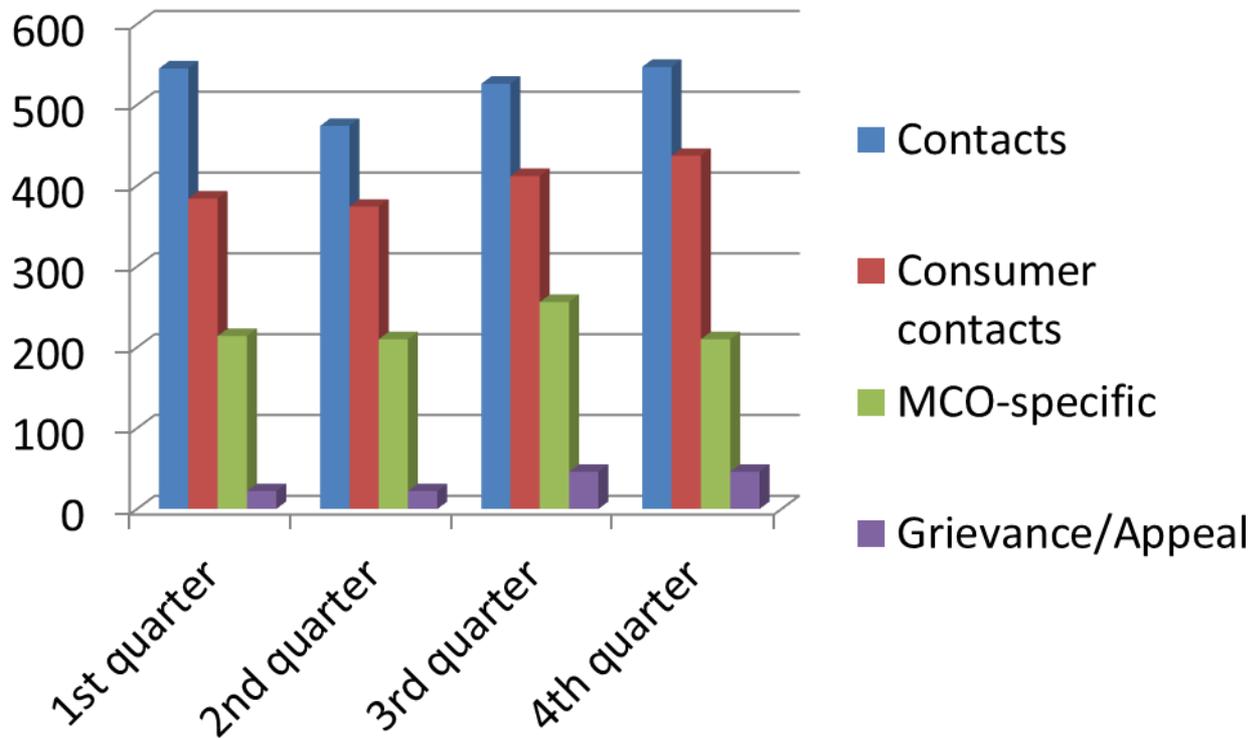
Ombudsman Programs

Kansas—Revised Requirements (cont.)

- Remains focused on advice/referral, not direct assistance
- Revised standards require reporting variety of data:
 - Date, volume, type, issues, and current status of incoming requests, including actions taken
 - Date of any change in status
 - Time required for beneficiaries to receive assistance from Ombudsman, including time from initial request to resolution
 - Health plan(s) and geographic areas involved
- Information not all publicly available yet

Ombudsman Programs

Kansas Performance 2014



Ombudsman Programs

Kansas Currently

- Program staffed by three persons
 - state ombudsman
 - part-time assistant
 - full-time volunteer coordinator who began work in September 2014
- Attempting to develop a training program for volunteers
- Volunteer training is planned to begin by August 2015 and to expand throughout the state in 2016

Ombudsman Programs

New Jersey

- Effective October 2012
- No comparable rules to Kansas
- CMS approval requires self-direct services to have “access to an independent advocate or advocacy system”
- No required system specific to managed care or non-self-direct services

Ombudsman Programs

Florida

- Not required to develop specific managed care program
- CMS approval: “Describe the state's strategy to assist beneficiaries entering the long-term managed care program with enrollment, choice counseling, and complaints. Please describe the state's ability to provide beneficiary assistance through call centers, ADRC assistance, and the independent advocacy/Ombudsman.”
- State cited only to pre-existing programs

Ombudsman Programs

States with Existing Programs

- Requirement of separate MLTSS ombudsman program is well established for programs initiated after May 2013
- But members do not necessarily receive adequate level of assistance
- Ideally, a program can provide direct representative with grievances and appeals without over-reliance on volunteers

Ombudsman Programs

States with Existing Programs (cont.)

Wisconsin's Model

- Covers two Medicaid MLTSS programs
- Program goal of providing at least one advocate for every 2,500 members under age 60
- Services must include:
 - Help obtaining needed services
 - Help pursuing complaints and appeals
 - Negotiation and mediation
 - Help interpreting relevant law
 - Individual advocacy in hearings and court proceedings

Ombudsman Programs

States Without Existing Programs

- These generally are states with managed care programs approved prior to issuance of the CMS MLTSS guidance
- Consumers and their advocates should seek program amendments to add an ombudsman requirement
- Amendment might be easiest as a practical matter when the relevant waiver program is up for renewal
- ***But waivers can be amended at any time***

Access to Performance Measure Data

Performance Measure Requirements

- MCOs typically required to submit large amounts of performance data to the state
- Kansas requires 81 reports from the MCO with various timelines
- Reports cover a wide range of operations, for example:
 - Contacts with member
 - Network adequacy
 - Financial statements and various reports on claims processing

Access to Performance Measure Data

Performance Measure Req. (cont.)

- Information useful for evaluating MCO performance
- Helps better understand where changes to the system may be advisable
- Requests for such reports are generally submitted through the state's public records act

Access to Performance Measure Data

Sample Information

- Kansas advocates obtained copies of LTSS Oversight Report for each MCO
- Variety of information included
 - care coordination staff
 - LTSS enrollment
 - care coordination contacts (for new members, transition members, on-going members, and annual reviews)
 - Money Follows the Person program (which assists in transferring persons from nursing facilities to community-based settings)

Access to Performance Measure Data

Sample Information (cont.)

- Ratio of HCBS to nursing facility services, which ranged from 2.1 to 1.2
- Data suggest which MCOs are better at providing non-institutional options for members
- Average number of members per care coordinator range from 74 to 128
 - MCO with lowest rate of care coordinators was *not* the same MCO with heaviest rate of nursing facility usage
 - Rate of care coordinators did not necessarily correlate with a higher rate of HCBS

Access to Performance Measure Data

Limits on Access to Information

Kansas

- Grievance/appeal data limited by state redaction policies
- Deletions in listings of individual grievances/hearings
- Much of the information has been blacked out for each grievance
- Some deletions are for privacy
- Some could be released without implicating any privacy rights of a member
- Appeal and hearing data are similarly redacted

Access to Performance Measure Data

Limits on Access to Information (cont.)

Florida

- Similar redactions where deletions impact virtually all of the information.
- Each report contains six columns, and the state blacked out the first five: member name, ID, requested service, date of denial, and date of notice of action
- Sixth column — “Reason for Denial” — was blacked out in part, in most cases leaving only the generic description of “Service is not medically necessary”

Access to Performance Measure Data

Advocacy Issues

- Greater availability and usefulness of performance measures
- State/MCO claims about cost savings must be analyzed
- Records with enough specificity to allow for meaningful distinctions
- Deletions limited to genuine privacy interests
- ***Details about the reason for the action, or the rationale for a ruling, do not invade any privacy interests, but are vital to understanding how a system is operating***

Access to Performance Measure Data

Advocacy Issues (cont.)

- Service denials are much better understood if the basics of the denial are accompanied with information about the service involved and the factors that led to a determination that the service was unnecessary
- Difficult to judge MCO actions without this information
- Medicaid regulations require that fair hearing decisions be available to the public

Access to Performance Measure Data

Advocacy Issues (cont.)

- Kansas provides data to outside evaluators
- Wide variation in findings suggests discrepancies in how MCOs classify information
- Performance measures should be provided to the general public without over-aggressive redaction
- Insufficient that some information may ultimately trickle out in reports assembled by evaluator organizations

Services Pending Appeal Decision

CMS Requirements

- Beneficiary entitled to continuation of services while he or she pursues an appeal
- These protections have been less effective in some managed care settings, as some MCOs have limited the continuation of services to the duration of a pre-existing authorization

Services Pending Appeal Decision

State Protections

- Some states explicitly require extended benefits not to be limited by length of an original authorization
- New Jersey: at member request, contract requires continuation of benefits pending appeal with no limitations related to preexisting authorizations
- Kansas: if member asks for appeal or state fair hearing, currently authorized HCBS will continue until a decision—if unfavorable to member, he or she does not have to pay for previously-provided services, “unless fraud has occurred”

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Questions?

ecarlson@justiceinaging.org

jcarter@justiceinaging.org

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