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Consumer Protection in MLTSS: Good (and Not-So-Good) Enrollment and Disenrollment Practices

Introduction to An Advocate's Library

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The National Senior Citizens Law Center is a non-profit organization whose principal mission is to protect the rights of low-income older adults. Through advocacy, litigation, and the education and counseling of local advocates, we seek to ensure the health and economic security of those with limited income and resources, and access to the courts for all. For more information, visit our Web site at www.NSCLC.org.

Webinar Series on "An Advocate's Library"

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Contracts Performing Regulatory Function

- Contracts with states and managed care organizations (MCOs) are important …
- But difficult to find or use
  - Typically 300 to 600 pages long

Developing "An Advocate's Library"

- Review of State/MCO Contracts in most states offering MLTSS
  - Collecting and categorizing important provisions
  - Allows user to
    - See what states are doing
    - Obtain exact contractual language

Using “An Advocate’s Library”

Benefits of "An Advocate's Library"

- Individual advocacy
- Systems advocacy
  - Get in front of issues!

Enrollment

Broad Parameters Set by Federal Regulations

- Must have choice of at least two MCOs
  - Exception for "rural," (i.e., non-urban) areas
    - 42 C.F.R. § 438.52

Regulations Also Address Default Enrollment

- Enrollment process must seek to preserve:
  - Existing provider-consumer relationships
  - Relationships with providers that traditionally have served Medicaid beneficiaries
    - 42 C.F.R. § 438.50 (technically applying only to state-plan managed care, but generally extended to waiver-authorized managed care as well)

Also, CMS Guidance on Auto-Assignment

- "Intelligent assignment" that takes LTSS providers into account
  - CMS, Guidance to States Using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs (May 2013), at 10

Default Rules Generally Commonsense

- Arizona
  - "Decision tree" based on consumer's place of residence or current care provider
    - Relevant provider is LTC facility; second relevant provider is primary care physician
  - Otherwise, use of "algorithm," which is less sophisticated than term would suggest
    - Two MCOs – 50% each
    - Three MCOs – 33% each
      - Ariz. Contract, p. 17

Again, Focus on Whether Plan Includes Facility or PCP

- Hawaii
  - Determined by participation by LTC facility or PCP, if determinative
  - Otherwise, enrollment alternatively between MCOs
    - Hawaii Contract, pp. 50-51

Retroactive Coverage

- Medicaid law requires retroactive coverage of up to three months prior to month of application
  - 42 U.S.C. § 1396a(a)(34)

MCO Providing Retroactive Coverage

- *See* Kansas RFP, p. 95
  - MCO responsible for retroactive coverage if consumers determined eligible by State
  - Up to 3 months prior to month of application
  - MCO's claim-filing timelines are disregarded

Initiating HCBS Waiver Services

- Reimbursement effective only after plan of care has been developed
  - Provisional plan of care adequate, to ensure that HCBS waiver recipients are not penalized in comparison to nursing facility residents
    - Olmstead Letter No. 3, Atch. 3-a (July 25, 2000)

Medicaid Pending

- Florida provides for HCBS services while financial eligibility is being determined
  - MCO provides services during eligibility determination process
  - If consumer ultimately found ineligible, MCO can seek reimbursement for services from consumer
    - Fla. Contract, Atch. II, Exh. 3, p. 8

Disenrollment: At Consumer's Choice

- Change of MCO allowed without cause
  - Within initial 90 days
    - e.g., Fla. Contract, Atch. II, p. 36
    - Hawaii Contract, pp. 53-54
  - Every 12 months thereafter
  - After automatic reenrollment, following temporary Medicaid ineligibility
  - Terms of intermediate sanction
    - 42 C.F.R. § 438.56(c)(2)

With Cause

- Consumer moves out of service area
- Consumer needs services that MCO does not cover due to moral or religious reasons
- Consumer needs services to be performed together, but MCO cannot provide all services
  - 42 C.F.R. § 438.56(d)(2)

With Cause (cont.)

- Poor quality of care
- Lack of access to covered services
- Lack of access to providers experienced in dealing with consumer's health care needs
  - 42 C.F.R. § 438.56(d)(2)

For Cause – Florida

- Relationship with provider
  - Consumer has active relationship with provider not with MCO, but with other MCO
    - "Active relationship" means services within previous 6 months

Florida's "Other Reasons"

- Inappropriate changes of primary care MD
- Unreasonable delay or denial of service
- Service access impairments due to significant changes in geographic location of services
- Consumer not allowed to participate in development of service plan
  - Fla. Contract, Atch II, pp. 44-45

Disenroll to Stay in Facility

- Disenrollment allowed if consumer's residential care facility is not in MCO's network, but is in network of another MCO
  - Hawaii RFP, p. 57

Disenrollment Procedures

- Request submitted to
  - State, or
  - MCO (if State allows MCOs to process disenrollment requests)
    - 42 C.F.R. § 438.56(d)(1)

State Generally Deciding on Disenrollments

- State of Florida decides; consumer can appeal via fair hearing
  - Fla. Contract, Atch. II, p. 37
- Hawaii DHS "solely responsible" for making disenrollment decisions
  - Hawaii RFP, p. 183

Involuntary Disenrollment

When can’t consumers be disenrolled?

When can they be?

Who can disenroll?

What notice is required?

What happens after?

When can’t consumers be disenrolled involuntarily?

Prohibited Reasons for Disenrollment by MCO

Federal Disenrollment Limitations

- "[MCO] may not request disenrollment because of an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, [or] diminished mental capacity . . ."
    - 42 CFR § 438.56(b)(2)

Federal Disenrollment Limitations

- "[MCO] may not request disenrollment because of . . . uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the [MCO], seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees)
  - 42 CFR § 438.56(b)(2)

Standard Disruptive Behavior Language

- "The enrollee's behavior is disruptive, unruly, abusive or uncooperative to the extent that enrollment in the Managed Care Plan seriously impairs the organization's ability to furnish services to either the enrollee or other enrollees."
  - Fla. Contract, Atch. II, p. 45

Disruptive Behavior by Friends or Family

- "An Enrollee or an Enrollee's family member or other person in the home engages in conduct or behavior that seriously impairs the Contractor's ability to furnish services to either that particular Enrollee or other enrollees"
  - N.Y. Partnership Contract, p. 20

Disruptive Behavior Limitations

- "This section does not apply to enrollees with medical or mental health diagnoses if the enrollee's behavior is attributable to the diagnoses."
  - Fla. Contract, Atch. II, p. 46

Addressing Disruptive Behavior

- Give at least one oral and written warning;
- Attempt to educate regarding rights and responsibilities;
- Offer assistance through care coordination or case management;
- Ensure behavior not related to medical or mental health condition.
  - Fla. Contract, Atch. II, p. 46

Resolving Disruptive Behavior

- "serious effort to resolve the problems presented by the individual, including providing reasonable accommodations . . . [and] must inform the individual of the right to use the organization's grievance procedures. The beneficiary has a right to submit any information or explanation"
  - 42 CFR § 422.74(d)(2)

Prohibited Disenrollment – Capitation Rate

- "Disenrollment by the Contractor may not be based in whole or in part on . . . the capitation rate payable to the Contractor"
  - N.Y. Partnership Contract, p. 17

Prohibited Disenrollment – Grievance

- "The Managed Care Plan shall not request disenrollment of an enrollee due to . . . [a]ttempt to exercise rights under the Managed Care Plan's grievance system"
  - Fla. Contract, Atch. II, p. 46

Prohibited Disenrollment – Missed Appointments

- The health plan shall not request disenrollment of a member for discriminating reasons, including . . . Missed Appointments"
  - Haw. RFP, p. 184

Prohibited Disenrollment – High Cost of Bills

- TENNCARE shall not disenroll members for any of the following reasons . . . High cost medical or behavioral health bills"
  - Tenn. Contract, p. 39

Prohibited Disenrollment – Failure to Pay

- "Failure or refusal to pay applicable cost sharing responsibilities," except when this results in loss of eligibility for Medicaid managed care
  - Tenn. Contract, p. 39

When can consumers be disenrolled?

Federal Disenrollment Requirements

- All MCO contracts must "[s]pecify the reasons for which the MCO . . . may request disenrollment of an enrollee"
  - 42 CFR 438.569(B)(1)

Refusal to Comply with Restrictions

- "Member steadfastly refuses to comply with managed care restrictions (e.g., repeatedly using emergency room in combination with refusing to allow MCO to treat the underlying medical condition)."
  - Tex. Contract, p. 24

Refusal to Relocate

- "The enrollee will not relocate from an assisted living facility or adult family care home that does not, and will not, conform to HCB requirements contained in . . . this Contract"
  - Fla. Contract, Atch. 11, Exh. 3, p. 9

Fraud


GUESS YOUR WEIGHT, HEIGHT, DATE OF BIRTH, E-MAIL ADDRESS, AND SOCIAL SECURITY NUMBER
Hafeez

False Information

- An Enrollee provides the Contractor with false information, otherwise deceives the Contractor, or engages in fraudulent conduct with respect to any substantive aspect of his/her plan membership.
  - N.Y. Partnership Contract, p. 20

Membership Card Fraud

- "Member misuses or loans Member's MCO membership card to another person to obtain services."
  - Tex. Contract, p. 24
- "The Enrollee . . . permits abuse of his or her enrollment card."
  - Minn. Contract, p. 42

Enrollment Forms and Releases

- "The Enrollee provided fraudulent information on his or her enrollment form"
  - Minn. Contract, p. 42
- "An Enrollee knowingly fails to complete and submit any necessary consent or release."
  - N.Y. Partnership Contract, p. 20

Who can disenroll consumers against their wishes?

Who Approves Disenrollment

- State will make final determinations about granting disenrollment requests
  - Fla. Contract, Atch. II, p. 37
- CMS must review and approve disenrollment for disruptive behavior
  - Minn. Contract, p. 42

Disenrollment Only by State

- 'The CONTRACTOR shall not request disenrollment of an enrollee for any reason."
  - Tenn. Contract, p. 38

What notice and documentation is required for involuntary disenrollment?

Procedure for Involuntary Disenrollment

Written Documentation

- "With proper written documentation, the following are acceptable reasons for which the Managed Care Plan may submit involuntary disenrollment requests"
  - Fla. Contract, Atch. II, p. 45

Notice of Disenrollment

- When MCO requests an involuntary disenrollment, it must notify consumer in writing including the reason for the request, and an explanation that MCO is requesting the consumer be disenrolled in the next contract month, or sooner if necessary
  - Fla. Contract, Atch. II, p. 46-47

Notice of Disenrollment

- MCO must give prior verbal and written notice to member, with a copy to state, of its intent to request disenrollment
  - N.Y. Medicaid Advantage Plus Contract, App. 8, p. 14

What happens after the disenrollment?

Appeal Rights

- If member disagrees with decision, state must notify member of complaint procedure and fair hearing process
  - Tex. Contract, p. 24
- MCO must notify members who receive an adverse appeal resolution of their right to a fair hearing
  - N.Y. Partnership Contract, p. 20

Appeal Rights

- Right to file an appeal "except for the following reasons: (1) Moving out of the region; (2) Loss of Medicaid eligibility; (3) Determination that an enrollee is in an excluded population"
  - Fla. Contract, Atch. II, p. 43

Re-enrollment After Disenrollment

- If disenrollment due to disruptive conduct, MCO "may not reject the individual's enrollment without first substantiating and maintaining written documentation that the circumstances which resulted in the disenrollment have not been remedied"
  - N.Y. Medicaid Advantage Plus, Sect. 8, p. 4

Questions?

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