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National Senior Citizens Law Center

Disability Rights Education & Defense Fund DREDF

Long–Term Services and Supports in a Managed Care Environment: Advocacy Strategies for Increasing Independence

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DREDF

Disability Rights Education & Defense Fund

Founded in 1979, by people with disabilities and parents of children with disabilities, the Disability Rights Education and Defense Fund (DREDF) is a national law and policy center, based in Berkeley, CA, dedicated to protecting and advancing the civil rights of people with disabilities. www.dredf.org.

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NSCLC

The National Senior Citizens Law Center is a non-profit organization whose principal mission is to protect the rights on low-income older adults. Through advocacy, litigation and the education and counseling of local advocates, we seek to ensure the health and economic security and preserve access to the courts for those elders with limited income and resources.

LTSS: Beneficiary Protections in a Managed Care Environment

- Increasing reliance on managed care to deliver LTSS in Medicaid and as part of integrated Medicaid/Medicare delivery systems.
- Tool kit jointly developed by NSCLC and DREDF
- 15 areas of consumer protections
- Drill down with specific recommendations applicable to LTSS

Consumer Protection Categories

- Managed Care Plan Infrastructure
- HCBS Benefit Packages
- Provider Choice and Access
- Care Continuity
- Person Centered Care Planning
- Self direction
- Assessments
- Care Transitions
- Appeals and Grievances
- Ombudsman
- Stakeholder Involvement
- Civil Rights
- Financing
- Oversight/Monitoring
- Quality Measurements

Managed Care Context

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- Overview
  - State contracts with MCOs
  - Capitated payment
  - Few LTSS in provider benefit packages
- Trends
  - More Medicaid seniors/PWDs in MCOs
  - States expanding MCO role to include LTSS (full or partial)
- Snapshot of the state-of-the-states
- Concerns, risks, and potential opportunities

Managed Care Context

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- Snapshot of state-of-the-states
  - 29 states – PACE program with 200,000 enrollees
  - As of May 2012 16 states have MMLTSS programs;
    - 16 target seniors
    - 11 target PWDs; 8 of these for people with IDD and 8 serve children
    - Enrollment from 200 – 400,000 (Texas)
    - # of MMC contractors from 1 to 18 (Michigan)
    - 10 states have voluntary enrollment; 9 are mandatory
    - 10 programs offer self direction
  - 26 states posted draft proposals; 11 official proposals

Managed Care Context

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- Concerns
  - MCOs unfamiliar/uncomfortable with LTSS—steep learning curve ahead
  - Can MCOs demonstrate LTSS competency?
  - Can core principles—independent living, HCBS, consumer control be preserved?
  - Will LTSS in MCOs advance rebalancing?
  - Defining “community” in HCBS—group homes?

Managed Care Context

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- Risks
  - Disruption in continuity of Care (COC)
  - HCBs and Personal Assistance Services (PAS) will require medical justification
  - MCOs will deny service; underserve
  - MCOs will reduce provider rates
  - State reduction of Medicaid LTSS funding
  - Quality—longstanding concerns w/ MMC, LTSS

Managed Care Context

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- Potential Opportunities
  - Integration: improving/coordinating/integrating LTSS & healthcare
  - Rebalancing: shift focus from institutional care to HCBS
  - Prevention: reduce nursing home placements
    - Cover cost effective alternatives to covered services

Benefit Packages

Opportunity to Rebalance State's LTSS System

- MCO liable for costs, & thus with incentive to choose HCBS over facility-based care
- MCO responsible for coordinating care
    - Opportunity for state to set coordination standards

No Arbitrary Limit on HCBS Enrollment

- No wait lists!!!!!!!!!
- States are leery due to feared financial impact
  - Need to argue that HCBS is cost-effective overall
    - *See, e.g.*, Kaye, *Gradual Rebalancing of Medicaid LTSS Saves Money and Serves More People*, 31 Health Affairs 1195 (2012)

Beware Cagey Language in Proposals

- E.g., Michigan dual-eligible proposal
  - "… as the cap on the current [HCBS] waiver is lifted …." (p. 26)
  - BUT proposal also says demonstration has "potential for addressing the significant wait, depending on how the waiver and the demonstration relate." (p. 32)

Florida Proposes to Retain Waiting Lists

- Combined Section 1915(b),(c) proposal
  - Medicaid only

- Proposes to retain enrollment cap of 45,000 throughout five years of waiver

Services Must Be Adequate

- At a minimum, MCO must provide services required by underlying program (Medicaid and/or Medicaid)
  - At least same amount, duration and scope

Ideally, Additional Services

- E.g., Virginia dual-eligible proposal adds "person-centered care coordination and case management"
  - Including "care transition programs" in hospitals and nursing facilities (pp. 17-20)

Other Optional Services

- E.g., Virginia (pp. 20-21)
  - Vision
  - Dental
  - Assistive technology
  - Environmental modifications

Service Array Under Community First Choice Option

- Required
  - Assistance with ADLs, IADLs, etc.
- Optional: Transition Costs
  - Rent
  - Deposits
  - Bedding
  - Basic kitchen supplies
    - 42 C.F.R. §441.520(b)(1)

Provider Choice

Are Provider Networks Adequate?

- Do research at the beginning
  - E.g. Oregon dual-eligible proposal
    - MCOs taking “proactive approach to network development via a required community needs assessment” (pp. 20-21)
      - Updated annually
      - Info on community health needs, health disparities, barriers to care, & utilization patterns

Retain Small Providers

- Providers should not be excluded for lack of administrative/billing capacity
  - MCO should be required to provide necessary support

Care Transitions

Multiple Factors

- Benefit packages (already discussed)
- Assessment and care planning (to be discussed subsequently)
- Targeted programs
  - E.g., Nursing home diversion programs, Money Follows the Person
- Appropriate financial incentives to MCOs
- Ability to retain previous residence

Making Financial Incentives Work

- No carve-out of nursing facility expenses
  - E.g., Arizona, Hawaii, Minnesota, Tennessee

Varying Rates a Possibility

- Blended rate
  - E.g., in AZ, if higher HCBS usage, state splits saving with MCO
- Relatively higher rates for HCBS, compared to nursing facilities
    - *See* Leslie Hendrickson & Laurel Mildred, Flexible Accounting for Long-Term Care Services: State Budgeting Practices that Increase Access to Home- and Community-Based Services (Scan Foundation Jan. 2012)

What if HCBS Is the High-Cost Option?

- Potentially, risk pools for high-cost HCBS, in order to spread risk
  - E.g., recent Mass. announcement re: dual-eligible proposal

Keeping Providers: Retainer Payments

- "Retainer payments" allow for retention of LTSS provider during stay in hospital or nursing facility
  - Authorized by CMS's *Olmstead* Update No. 3 (July 25, 2001)

Keeping Residence

- Program should offer income allocation or benefit to allow retention of home, if nursing facility resident to return within 6 months
  - *See* Medicaid income allocations at 42 C.F.R. §435.725(d), 435.733(d), 435.832(d).

Retention of Assisted Living Rooms

- Require room holds, or comparable right under state's landlord/tenant law

Assessments

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- States must develop a uniform assessment tool (clinical and services) and processes
  - MCOs use assessments to determine eligibility for LTSS and to plan for needed services
  - Must include services that are currently available and those needed but not currently available
  - Must include all info. relevant to living in community-based settings
  - No conflict of interest
  - Conducted when significant change or at least once/12 months

Person-Centered Care Planning

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- ACA requires person-centered LTTS
- Person receiving services is primary expert (or they can designate a trusted family member or friend)
- Core values:
  - Independence/choice
  - Control
  - Autonomy
- Person defines who is included in planning
- Person defines goals and desired outcomes

Person-Centered Care Planning

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- Written person-centered plan
  - Supports self-directed services
  - Documents service scope and goals
  - Names/signatures of responsible persons/agencies
  - Option to opt out of general requirements when appropriate (e.g., care provider training)
  - Conflict resolution mechanisms
  - States and MCOs create procedures

Person-Centered Care Planning

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- States and CMS establish requirements for the plan. For example:
  - Integrates all elements of clinical and community living supports
  - Understandable person-first language
  - Set goals and scope of services and supports to achieve them
  - MCO monitoring/feedback process
  - CMS, States, MCO mission/vision = person centered
  - Monitoring part of quality improvement

Person-Centered Care Planning

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- CMS, States, MCO obligations
  - Adequate person-centered planning considered in setting reimbursement rates
  - Incorporate person-centered principles in policies, mission/vision statements and operational documents
  - Leadership training on principles of person-centered planning

Self Direction

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- Beneficiaries control services and supports
  (with help if desired)
- Services and supports based on preferences and needs
- Goals:
  - Maximize independence
  - Most integrated community-based settings
- LTSS managed care MUST preserve and enhance self-direction (hiring, firing, training PAS)

Self Direction

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- Self direction optional for most Medicaid programs now
- MCOs integrating LTSS required to preserve and enhance self direction if it is already in place
  - Preserve employer and budget authority
  - Hiring, firing, supervision of PAS workers
  - Purchasing goods and services (technology, home modifications, etc.)
  - Taking risks

Civil Rights

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- Equally effective services regardless of disability per Americans with Disabilities Act
  - Also age, sexual orientation, gender identity, linguistic, cultural, racial background
- Reasonable accommodation
- Policy and Procedural modifications

Civil Rights

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- Methods
  - Survey provider networks for physical, programmatic accessibility:
    - Accessible exam tables, weight scales
    - Available extended appointment times
    - Sign Language Interpreters
    - Alternative print formats
  - Beneficiaries have access to info. about access of provider sites
  - MCOs develop language access plans for Limited English Proficiency (LEP) individuals

Care Continuity

Preventing disruptions when joining a managed care system. Ensuring smooth transition

- Transition period of up to 12 months: plan pays existing providers. At least previous rate.
- State pays if provider will not accept plan payment
- No forced moves from existing residence
- Training, billing, etc. requirements should not be barriers to continuity.

Appeals/Ombudsman

Easy to navigate system, full Medicaid rights

- Aid paid pending until final resolution. No restrictions to current authorization period.
- Non-medical goals must be taken into account
- Publicly shared data on denial rates, reversal rates.
- Ombudsman: Assists beneficiary in appeal
- Indentifies systemic problems
- Independent, knowledgeable re LTSS, funded.

Meaningful Systemic Stakeholder Involvement

Consumers, especially LTSS consumers, and advocates must have established channels to participate in planning, execution and monitoring

- State stakeholder advisory board—planning and execution.
- MCO-consumer advisory committee, member meetings, all accessible
- Transparency required for meaningful participation

State and Federal Oversight and Monitoring

- Structures must be in place to ensure that plans are performing contracted duties and delivering high quality services. Both longer term and short term
- Multiple state agencies, CMS. Clear responsibilities
- Secret shopper to test network adequacy
- Dashboard to track home care delivery.

Resources

- Tool kit: http://dualsdemoadvocacy.org/resources/ltss
- DREDF website: www.DREDF.org
- NSCLC website: www.NSCLC.org
- NSCLC duals website: www.dualsdemoadvocacy.org

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