Advocating for Clients in Medicaid Long-Term Care and HCBS Appeals

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Session Overview and Goals

- **Road Map**
  - Use of IOTA Funds under the Restrictions
  - Understanding the Medicaid Long-Term Care Waiver and HCBS Framework
  - Identifying and Developing Strong Appeal Cases
  - Federal Litigation
  - Client Education and Outreach Strategies
  - Q&A
- **Goals**
  - Equip advocates with practical tools for LTC/HCBS appeals
  - Strengthen advocacy at every stage: intake, evidence development, hearing preparation, and client education

Overview of Florida's Medicaid Long-term Care Waiver Program

Medicaid Waiver Programs for Home and Community Based Services (HCBS)

- States can craft their own HCBS programs with differing eligibility categories
- BUT programs are subject to the federal Medicaid Act and regulations
- States submit a hefty waiver application for federal CMS approval
- Jointly federal-state funded

Federal Waiver Authority

- **42 USC 1396, et seq,** (Medicaid Act, aka Section 1915 C of the Social Security Act)
- **42 USC 1396n(c),** HCBS Waivers
- **42 CFR 440.180,** HCBS Waiver services
- **42 CFR Part 438,** Regulations on Medicaid Managed Care, including requirements for the grievance and appeal system
- **42 CFR Part 431, Subpart E:** Regulations that apply to all Medicaid fair hearings

Florida LTC Waiver Authority

- **Fla. Stat. Chapter 409**
- **SMMC LTC Program Coverage Policy, Fla. Admin Code R. 59G-4.192:**

  Includes goal of program, service definitions, assessment and care planning requirements
- **Other Policies:**

  Medicaid Definitions, Rule 59G-1.010

  Service Specific Policies (as long as not more stringent than LTC Waiver Policy), including e.g., Private Duty Nursing, Rule 59G-4.261; Personal Care, Rule 59G-4.215
- **AHCA-Managed Care Plan Contracts:**

  Attachment II- Core Contract

  Exhibit II-B Long-Term Care Managed Care Program

What an HCBS Waiver can waive

States can waive Medicaid's requirements for:

- **Comparability** (having to give medically necessary services to everyone regardless of diagnosis)
- **Statewidedness** (having to provide the same services throughout the state)
- **No caps on enrollment**
- **Freedom of provider choice** (which allows for administration by managed care)

NOT A STEPPING STONE

- All HCBS enrollees must meet an **institutional level of care** per federal law
- But HCBS Waivers are NOT A STEPPING STONE to institutional care; they are a SUBSTITUTE
- Almost all HCBS direct care services have no cap except for medical necessity
- ***Olmstead v. LC***, 527 U.S. 582 (1999), Supreme Court decision that unnecessary institutionalization is a violation of Title II of the Americans with Disabilities Act of 1990. States must provide benefits in the "most integrated setting."

Managed Care Organizations & HCBS

- Managed care is now the predominant payment model for Medicaid. Florida uses MCOs for standard Medicaid and the Long-Term Care Waiver.
- MCOs act as "gatekeepers" for service authorization and delivery.
- MCOs are paid the same amount for each enrollee ("capitated rate") based on the historical average amount for everyone on the Waiver.
- MCOs create their own network of providers through negotiated contracts.
- MCOs must offer the same benefits, using the same federal and state requirements for authorization.

Florida Statewide Medicaid Managed Care (SMMC)

SMMC LTC includes both nursing homes and HCBS. LTC Waiver Program covers the HCSB.

- Meets Medicaid financial eligibility (Dep't of Children & Families determines)
- Age 65; or 18+ and eligible for Medicaid due to a disability
- Meets Nursing Home Level of Care, or hospital level if cystic fibrosis (Dep't of Elder Affairs determines medical eligibility and level of care)
- Oversight by AHCA but administered by contract with MCOs
- Fair hearings through AHCA Office of Fair Hearings

Medical Necessity

- Services are only approved if they are medically necessary, which is defined in Fla. Admin. Code R. 59G-1.010(155) and LTC Coverage Policy 1.3.14
- Services must be:
  - individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of the patient's needs.

  AND/OR

  - furnished in a manner not primarily intended for convenience of the recipient, caretaker, or provider.
- Medical necessity is the only cap on services for the LTC Waiver.

If services are denied or reduced

Ask for:

- The parts of the medical necessity definition used to make the decision
- Any other legal authority relied upon by the MCO or agency
- Any internal review criteria of guidelines
- The individualized facts relied upon to make the decision

Not in Excess of Need

- Services are needed to enable the enrollee to maintain or regain functional capacity, or
- Services are needed to enable the enrollee to access the benefits of community living, achieve person-centered goals, and live in the setting of their choice. *LTC Coverage Policy* 1.3.14(b)
- The MCO is "required to provide an array of HCBS that enable enrollees to live in the community and to avoid institutionalization." *LTC Coverage Policy* 1.1

Not for Convenience of Caretaker

- Natural supports are defined as unpaid and voluntary provided in lieu of HCBS. *LTC Coverage Policy* 1.3.16
- Using LTC Supplemental Assessment, *LTC Coverage Policy* 6.2.1, MCOs are required to evaluate:
  - amount of time an enrollee can safely be left alone
  - ability of "natural supports" to assist in the enrollee's needs, including work and other responsibilities, stress, medical limitations, and willingness to participate in care. The assessment is the.
- MCOs agree in their contract with AHCA to not deny services because of cost or solely because a caregiver must work or can't participate in care due to medical or cognitive impairments.

Service Definitions

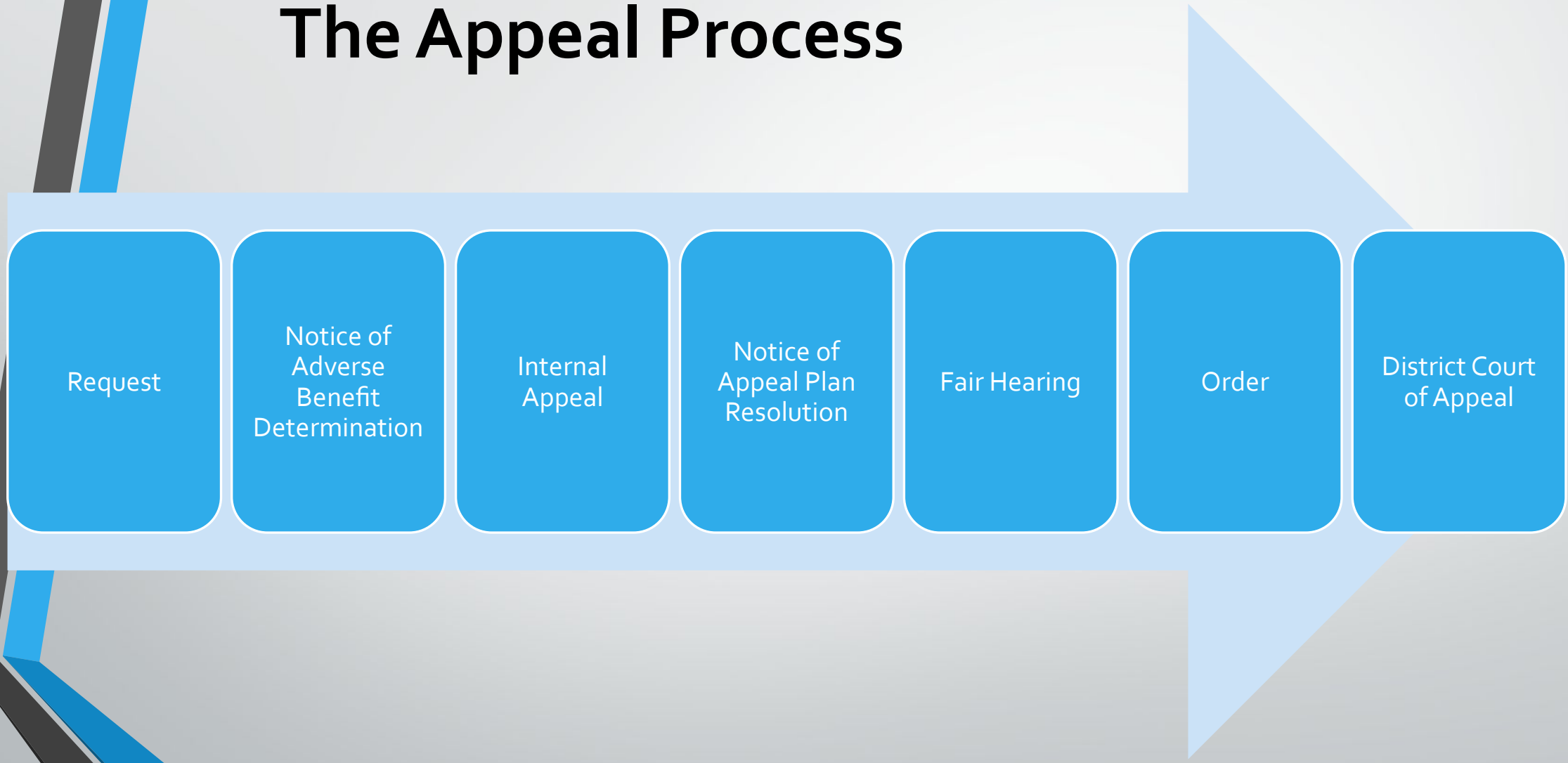
- Defined in both the LTC Coverage Policy and the LTC Waiver Application approved by CMS:
  - Personal Care: To provide assistance with ADLs and IADLs, including meal prep and housekeeping essential to health and welfare.
  - Adult Companion: To provide non-medical care, supervision when necessary to protect health, safety and well-being, or social enrichment. Can include meal prep, laundry, and incidental light housekeeping.
  - Some other services include skilled nursing, respite, and homemaker
- Personal care is the only "hands-on" non-medical direct care.
- While the goal of LTC is an adequate "array" of services, MCOs often deny a service based on restrictive definitions without suggesting that a different service would be approved.

LEGAL ELEMENTS TO PROVE

MEDICAL NECESSITY	SERVICE DESCRIPTIONS
Not in excess of need: Services are needed to live at home Can't safely be left alone Array of services need to avoid institutionalization	**Personal Care:** Hands-on care is required for ADLs and IADLs
Not for caretaker convenience: Unpaid, voluntary natural supports Caregivers must work Caregivers are responsible for minor child Caregivers have physical limitations	**Companion:** Supervision & non-medical care required for health & safety

Identifying and Developing Strong Appeal Cases

The Appeal Process



Requests for Services

Significant Additional Need Request (SAN)

A formal request made by a managed care plan or case manager on behalf of a member to increase services beyond the current care plan authorization, based on a documented change in the member's condition or circumstances.

Service Types

- Member Handbooks
- AHCA Coverage Policies

Submitted to plan via case manager

Notice of Adverse Benefit Determination (NOABD)

SAN Request

- Sixty (60) days to request appeal (internal appeal)
- Acknowledgment w/in five (5) days
- Thirty (30) days to issue resolution
- Option for expedited appeal – threat to life, health, ability to maintain function
  - Forty-eight (48) hour resolution

Termination or Reduction

- Continuation of Services
  - Appeal ten within (10) days or before the 1st day that services will be terminated or suspended (whichever is later) and
  - Must request that services continue
- Sixty (60) days to request appeal (internal appeal)
- Acknowledgment w/in five (5) days
- Thirty (30) days to issue resolution
- Option for expedited appeal – threat to life, health, ability to maintain function
- Forty-eight (48) hour resolution

Internal Appeal

- Submitted to directly to the plan (phone, email, fax)
- Request complete copy of file, including medical records, a copy of the plan review criteria and guidelines, contract provisions, other documents, records, and other information relevant to the adverse benefit determination.
- Plan of care, 701B Assessment, LTC Supplemental Assessment
- Authorized Representative Form
- Supporting Documentation
- Type of Service

Notice of Appeal Resolution (NOAR)

SAN Request

- One hundred twenty (120) days to request fair hearing
- Acknowledgment from AHCA
- Notice of Appearance
- Designated Representative Form

Termination or Reduction

- Continuation of Services
  - Appeal ten within (10) days or before the 1st day that services will be terminated or suspended (whichever is later) and
  - Must request that services continue
- One hundred twenty (120) days to request fair hearing
- Acknowledgment from AHCA
- Notice of Appearance

Fair Hearing

- Submitted to directly to AHCA (phone, email, fax)
- Notice of Appearance
- Authorized Representative Form
- Acknowledgment of Third-Party Medicaid Hearing Request

HCBS Fair Hearing Authority

- US Constitutional due process requirements, *Goldberg v Kelly*, 397 US 254 (1970)
- Medicaid Act fair hearing requirements (42 CFR 431.200, et seq; 42 CFR 438.400, et seq for MCO grievances and appeals and continuation of services)
- Fla. Stat. Chapter 120 (Fla. Administrative Procedures Act)
- Fla. Admin. Code R. 59G-1.100 (AHCA Fair Hearing procedures)
- Fla. Admin. Code Chapter 28-106 (Uniform Rules of Procedure)
- Discovery under Fla. R. Civ. P. and evidence using Fla. Stat. Chapter 90

Final Order/Appeal to DCA

- Issued post hearing
- Thirty (30) days to file Notice of Appeal
- Attach Final Order
- Motion for Leave to Proceed in Forma Pauperis
- Basis for Appeal
  - Error of Law
  - Lack of competent, Substantial Evidence
  - Procedural Due Process Violation

Grievances

- A formal complaint that a member (or their representative) files with the managed care plan when they are dissatisfied with any aspect of the plan's operations, staff, or services — other than the denial, reduction, termination, or suspension of a service or benefit (which is handled through an appeal, not a grievance).
- A member can file a grievance if they are unhappy with:
  - The quality of care or services provided (e.g., rude or unprofessional behavior by a care coordinator or provider).
  - Delays in getting services that have already been approved.
  - Difficulty communicating with the plan (e.g., unreturned calls, missed appointments).
  - Failure to respect member rights (e.g., confidentiality breaches, discrimination, or lack of dignity/respect).
  - Issues with the care plan that do not involve a denial or reduction (e.g., disagreement over how care coordination is handled).
  - Transportation problems, missed home visits, or poor service from vendors.

Complaints

- **AHCA Medicaid Complaint**
  - Online at https://ahca.myflorida.com/medicaid/florida-medicaid-complaints
  - Phone 877-254-1055
- **Long-Term Care Ombudsman** (for complaints about care in facilities, including ALFs and Adult Family-Care Homes): 888-831-0404 or ltcopinformer@elderaffairs.org
- **DOH Medical Quality Assurances** (for complaints against healthcare practitioners): 888-419-3456

Federal Litigation on LTC Policies and Practices

Long et al. v. Benson et al. (N.D. Fla., J. Hinkle, filed 2008)

- 2008 WL 4571903 (granting preliminary injunction),
  2008 WL 4571904 (certifying class) (N.D. Fla., J. Hinkle 2008),
  383 Fed. Appx. 930 (11th Cir. 2010) (affirming preliminary injunction)
- Statewide class action on behalf of about 8,500 people with disabilities in nursing homes who wanted to live in the community with appropriate services. But there were no available slots in the LTC Waiver. Claim under the Americans With Disabilities Act and Section 504 of the Rehabilitation Act, which require states to provide services in the most integrated setting appropriate for the individual. Nursing homes are not. A mediated settlement established a new statewide program instead of expanding the LTC Waiver. The Medicaid Nursing Home Transition Program provides funding for people in nursing homes for at least 90 days to receive services in the community. The Legislature authorized $27 million for the transition program in 2009-10, which later was permanently appropriated using the savings from funding the more expensive nursing homes.
- Counsel: Southern Legal Counsel, Steve Gold, AARP Foundation Litigation, National Health Law Program

Parrales et al. v. Dudek (N.D. Fla., J. Hinkle, filed 2015)

- 2015 WL 13373978
- Five individuals with disabilities challenged the State's implementation of the LTC Waiver program by private managed care organizations, which were arbitrarily denying needed services in the community. AHCA had no rules to guide the private manages care in its coverage decisions.
- In a mediated settlement, the State agreed to:
  - 1) adopt rules setting out requirements for coverage of long-term care services;
  - 2) adopt a new assessment procedure that takes into account availability, willingness and ability of voluntary caregivers;
  - 3) change health plan member handbooks to clarify enrollee rights and how to file consumer complaints;
  - 4) train health plans, hearing officers, state staff and others on the new requirements; and
  - 5) implement new monitoring and evaluation to assure quality and sufficiency of services to ensure people can remain safely in the community.
- This impacted more than 94,000 enrollees in all six health plans providing Florida Medicaid services through the Long-Term Care Program.

Counsel: Nancy E. Wright, Southern Legal Counsel, Disability Rights Florida.

Alexander, et al. v. Mayhew et al. (N.D. Fla., J. Hinkle, filed 2018)

- Seniors and people with disabilities were on the state's wait list for LTC Waiver services. Class action filed under the Americans With Disabilities Act alleging that the failure to provide services put them at risk of unnecessary and unwanted institutionalization. In August 2018, there were over 50,000 people on the wait list including anyone who applied and may basic eligibility requirements. After excluding people who applied but who have lower levels of disability, there is now 54,000 people on the wait list. The court declined certification of a class concluding they were not entitled to an injunction requiring the defendants to obtain an increase in or to exceed the cap on the state's Medicaid long-term waiver program. However, in settlement, we obtained full services for the four plaintiffs who were on the wait list, and an agreement that the State would build a website that provides information about long-term care services in one place, as it was extremely difficult to get any online information.
- Counsel: Justice in Aging, Southern Legal Counsel, Disability Rights Florida, Nancy Wright, Cozen O'Connor.

Grant, et al. v. Harris (N.D. Fla., J. Hinkle, filed 2024)

- AHCA promulgated rules, but the managed care plans were not implementing them appropriately and LTC recipients are being denied needed services. We represented individuals with substantial disabilities who are recipients of the LTC Waiver. In determining what services to approve, managed care plans consider the services available to the recipient from other sources—from family members, for example. These are known as "natural supports." The Court found that the plaintiffs did not allege facts showing they suffered any injury from any deficiency in the current natural-support policies and rules or that the requested injunction would make any difference in the future treatment of the plaintiffs.

  Counsel: Nancy Wright, Southern Legal Counsel, Legal Services of Greater Miami

Client Education and Outreach

Client Education

- Educating Clients and Caregivers
  - Right to appeal service denials or reductions, to choose providers and participate in care planning.
  - Right to receive person-centered services that meet assessed needs and the difference among services.

Outreach Strategies

Partner with case managers and community health workers to reinforce education

- Local Ombudsman's office
- Elected Officials
- Medical Providers

Questions?