FLORIDA HEALTH JUSTICE PROJECT

Medicaid Long-Term Care Managed Care Enrollees
The Right to Continuous Care

Frail and elderly Floridians whose disabilities require a nursing home level of care and who receive home and community-based services (HCBS) through a Medicaid Managed Care Long-Term (LTC) plan have certain "rights" to continuous services. This *Know Your Rights* Q&A provides some examples of those rights and how to get help.

Q. My Medicaid LTC plan calls for 8 hours of personal care 7 days a week. I need help with many activities of daily living, including bathing, dressing, and eating. However, my home health aide sometimes does not come, arrives late, or leaves early. Is this supposed to happen?

A. NO. Medicaid managed care organizations (also called "MCOs" or "Plans") must have a process for "*immediately reporting any unplanned gaps in service delivery*." As part of this process, the Plan must prepare a "Service Gap Contingency and Back-Up Plan" for enrollees who receive services in their home. A "gap" is the difference between the number of hours required by the care plan and the number of hours actually provided. For example, if you are approved for 8 hours/day of personal care and the caregiver only shows up for 1 hour, that's a gap of 7 hours. The MCO must ensure that gap services are provided within a three-hour time frame.

Q. What should be in the gap plan?

A. The contingency plan must inform the enrollee (or authorized representative) of resources available, including on-call back-up service providers and the "enrollee's informal support system" in the event of an unforeseeable gap, such as a service provider illness or transportation failure.

Q. When I learned of my "right" to a gap plan and asked my case manager for one, she said it is up to me to write it, and it should rely on my family. Is this right?

A. NO. That is not correct. The plan is required to prepare a written "Service Gap Contingency and Back-Up Plan." It is also important to know that the "informal support system" should not be the "primary source" for addressing a gap, unless that is the

enrollee's choice. The MCO must discuss the gap/contingency plan with the enrollee and ensure it is updated quarterly.

Q. What can I do if I do not get a "gap" plan or it does not work?

A. First, you may try filing a complaint or grievance directly with your Plan. Steps for doing so should be included in your Plan's member handbook. If this does not resolve the issue, you can file a complaint through the AHCA complaint portal.

Q. I live alone and have MS, which is getting worse. I am now paralyzed and need help with everything. I am currently receiving 6 hours of home health services per day. However, about a week ago, I received a notice in the mail that my managed care plan would be cutting my home services to 3 hours per day. I am afraid that I will not be able to safely stay at home and out of a nursing home without at least 6 hours. What can I do?

A. If you appeal within 10 days of the date of the notice, your home health service hours cannot be reduced while the appeal is pending. For more information on the right to appeal and how to do so, read this publication on grievances, appeals, and fair hearings.

Q. How do I get more information or help regarding these rights?
A. This "Know Your Rights" publication is based on information in the *Advocate's Guide to the Florida Long-Term Care Waiver* and in the consumer video for navigating the Florida Medicaid LTC Waiver HCBS Program, prepared by the Florida Health Justice Project (FHJP).

Because of our limited capacity, FHJP provides legal services or direct assistance to only a limited number of individuals. You can complete our online intake form. We also offer technical assistance to local legal services staff. You can find the contact information for your local legal services office here.

If you are having difficulty getting needed HCBS services and want to share your story, you can contact the FHJP *STORIES* project.