Coalition to Protect the Rights of New York's Dual-Eligibles

Testimony of the Coalition to Protect the Rights of New York's Dual-Eligibles

on

Medicaid Transition to Care Management for Long-Term Care

PART I – CONCERNS ABOUT IMPLEMENTATION OF MLTC

Submitted to:

The Assembly Committee on Health
and
The Assembly Committee on Oversight, Analysis And Investigation

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On Behalf of the Coalition

December 7, 2012

Part II of Coalition testimony – presented by Douglas Coggin-Callahan, Medicare Rights Center, on concerns re expansion of MLTC to **Fully Integrated Dual Advantage (FIDA**)

Part III of Coalition Testimony – presented by Nora Chaves, Community Health Advocates, on Need for **Ombudsprogram** for MLTC

The **Coalition to Protect the Rights of New York's Dual Eligibles** is a coalition of disability rights and seniors rights advocates, consumers, community advocacy organizations, and lawyers representing people with disabilities and older New Yorkers. We provide this testimony to express concerns about the implementation of the 1115 waiver in New York State to include mandatory enrollment of Dual Eligibles who receive Medicaid personal care and other community-based long-term services in Managed Long Term Care ("MLTC") plans.

The MLTC plans, providers, and consumers all want a system that achieves the common goal of providing adequate and necessary services to enable people to live in the community, in furtherance of the goals of the ADA and *Olmstead*. However, the State is rushing into implementing a monumental change in how at least 85,000 individuals now receive Medicaid community-based services in New York City, to be followed later statewide, without sufficient safeguards to ensure that enrollees will receive the services they need in the community to avoid institutionalization. We are particularly troubled by anticipated problems with capacity, enrollment, gaps and interruptions in coverage, as well as with the program's lack of proper incentives, due process protections, oversight, and ability to absorb special programs currently providing critically important services. Our concerns and our recommendations are set forth in detail below.

1. Timing and Capacity -- Mandatory enrollment should be slowed down until systemic concerns described below are addressed, and then solely with new applicants -- over 1,000 persons per month in NYC alone, which would provide an opportunity to work out and test the new systems. Auto-assignment and mandatory enrollment **of current personal care recipients should be suspended for at least six months**, to allow the State, in consultation with stakeholders, to monitor the impact of mandatory enrollment upon new applicants and adjust the capitation rates and other systems as necessary.

Even with less than 1000 people auto-assigned – the first in November 2012 -- enrollment in MLTC plans in NYC has skyrocketed, due to marketing by plans and in response to Maximus' letters sent to over 10,000 current recipients explaining that enrollment is now or will shortly be mandatory.

Total MLTC Enrollment NYC – MLTC only, without PACE or MAP[1]

Dec-10	Dec-11	Feb-12	Jun-12	Sep-12	Oct-12	Nov-12
32,264	39,487	42,684	45,634	50,760	54,947	59,102

The rushed enrollment challenges not only the plans' capacity to absorb large numbers of enrollees, but also their ability to serve enrollees with more extensive needs for home care and other services. We question the State's claim that the current voluntary MLTC plans are equipped to serve the influx of new members because they already serve members with a "high level of impairment." The State admits that the population historically served by MLTC as a voluntary program "…is less impaired than the nursing home population," yet it fails to

[1] http://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/

compare the MLTC population to the Medicaid personal care population now being enrolled *en masse*. According to the United Hospital Fund, "…two-thirds of New York City's personal care beneficiaries had comparable levels of need [to nursing home residents] on key indicators, such as functional and cognitive status, as indicated by resource utilization group ("RUG") scores…."[2] Moreover, in the last six years of voluntary MLTC enrollment, many of the MLTC plans have "cherry-picked" a lower need population, leaving a higher-acuity population in the personal care program.

1.a. Auto-assignment algorithms must be intelligent, based on consumer's preferred providers, and based on plan experience and quality. We are concerned that five of the 15 MLTC plans in NYC are brand new with no track record or experience with MLTC. What is the Department's standard for determining that a plan is ready for auto-assignment? What are the quality criteria used for this algorithm? Plans should be assigned based in part on their including the consumer's existing providers to minimize disruption. DOH must closely monitor auto-assignment and suspend auto-assignment when it exceeds a specified percentage of enrollments, since all agree that consumer choice is critical.

2. Consumers Need Better Information to Make Informed Choices in Enrollment, and the Network of Community Partners Must be Educated About the Sweeping Changes.

MLTC represents a sea-change in a forty-year old system for accessing Medicaid home care, shifting from the community-based CASA offices that were a one-stop center for both Medicaid and home care applications. Consumers and staff of community-based organizations are confused and anxious about changes they do not understand. Consumers must not only select one of three different types of plans -- MLTC, PACE, or Medicaid Advantage Plus -- but must select from over 25 individual plans, with new plans added every month. New York State DOH and/ or Maximus/New York Medicaid Choice should be conducting community and professional education programs to inform consumers, their families and advocates about their choices. It is also important that the information is provided in a linguistically and culturally competent manner.

Unlike the "PlanFinder" for Medicare Part D, there is no single website where consumers can compare the over 25 plans now available in NYC – to see which plans' networks include their preferred providers. When they call Maximus for phone counseling, the only information available is which providers are in the plans' networks. There is no objective factual information about the track record of each plan in authorizing services. Consumers need to

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[2] Alene Hokenstad et al., *An Overview of Medicaid Long-Term Care Programs in New York* (United Hospital Fund 2009), posted at http://www.uhfnyc.org/publications/880507; *see also* S. Samis & M. Birnbaum, *Medicaid Personal Care in New York City: Service Use and Spending Patterns* (United Hospital Fund 2010), posted at http://www.uhfnyc.org/publications/880720 (Over 70 percent of New York City personal care recipients in a 2003 cohort had at least one chronic disease, and over half had multiple chronic diseases, with one in four recipients having a mental health diagnosis.)

know the extent to which particular plans authorize 24-hour care or other service plans, and the number of a plan's members placed in a nursing home rather than provide home care. This is all information which the plans report to the State quarterly, and which should be made available publicly. [3] The new consumer guide issued by DOH does not include this type of data – and instead relies on subjective information based on self-reporting by the plans. See http://www.health.ny.gov/health_care/managed_care/mltc/consumer_guides/index

Consumer advocacy organizations should be funded to provide training to the myriad grassroots neighborhood-based organizations that provide services to the aging and disabled.

3. An Independent Entity Should Make Conflict-Free Determinations of Eligibility for MLTC Enrollment

The initial determination of whether an individual is eligible for community-based long-term care services must be made by an entity that has no conflict of interest in making this decision. Assigning the MLTC plan the role of determining whether an individual is eligible for services allows the plans to "cherry pick" potential enrollees. An MLTC plan may deny enrollment to an individual who is said to be "not safe" in the community, or who lacks a so-called "backup" person to fill in when the aide does not come. In our experience, the individuals denied enrollment have extensive needs and would need high hours of care – as much as 24 hours/day. Since this care is costly, the MLTC plan has a financial interest in refusing enrollment to these individuals.

With no single outside entity designated to determine eligibility for MLTC services, the consumer's right to appeal is eviscerated. In the situations we've seen, the MLTC plan did not provide a written notice of its decision to reject enrollment. The consumer did not know their appeal rights or the basis of the decision. Moreover, if several other plans denied enrollment – for the same reasons – the consumer must appeal each plan's decision separately. A fair hearing decision finding one plan's denial was improper would not necessarily be binding on another plan. The specter of multiple appeals for the same consumer is raised, burdening the State's hearing system as well as the plan's resources and the consumer.

While not perfect, the past system at least affords an unbiased initial determination of eligibility. The local Medicaid office (HRA CASA in NYC) was responsible for determining eligibility for personal care services. Denials by HRA were stated in a written notice, which the consumer could appeal at a fair hearing. When the State reversed HRA's denial after a fair hearing, that decision was binding on HRA and all its contracting home care provider agencies. Thus the issue of eligibility was finally resolved (at least until the individual's medical condition changed).

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[3] These "cost reports" filed with the State for 2010 show data such as Home Health Care and Personal Care Services Hours Provided by MLTC and PACE Plans in NYS (2010) posted at http://wnylc.com/health/afile/169/324/; and Percentage of members who were in a nursing home for the entire quarter (2010) posted at http://wnylc.com/health/afile/169/325/

A new entity would determine whether an individual could continue to live in the community with a combination of the various community-based services in the MLTC benefit package. Factors would include whether the individual had someone to "direct" their care if the individual was not self-directing because of dementia or other condition. Given the wide variety of services available, few people should be denied.

4. Increased Consumer Protections & State Oversight Are Needed to Ensure Compliance with *Olmstead*.

A. To incentive providing community-based rather than institutional care, MLTC plans should be required to contract with all nursing homes that meet specified quality measures. Otherwise, plans may dis-enroll high-need members whom they determine require nursing home placement. The fact that nursing home care is part of the benefit package for MLTC is potentially an incentive for plans to provide services to keep members at home. Since nursing home care is usually more costly than community-based care, the plan has an incentive to avoid those high costs. But for some people with the most severe disabilities, the cost of care at home can be as expensive or even more costly than nursing home care. Now, plans can avoid the costs of providing ANY care to these high-need individuals. Here's how it works. The plan determines that the person's needs can only be met in a nursing home, and informs the consumer of which nursing homes are in its network. The consumer does not like the choices of nursing homes. In order to go to her preferred nursing home, she can disenroll from the plan and obtain FFS Medicaid for the nursing home of her choice. The Plan has thus avoided providing care to a high-need individual, creating an incentive to place higher-cost members into nursing homes rather than to provide adequate community-based services to prevent institutionalization.

B. Plans must be given uniform standards for determining medical necessity that are consistent with established policy and precedent. Mandatory enrollment must be slowed down at least until the State has tested, revised, solicited input from consumers and other stakeholders, and conducted the necessary training for a new **Uniform Assessment Tool** that will be used by MLTC plans. The State must ensure that plans provide personal care and other services in the same amount, duration, and scope as is available under the State plan. Instead, plans have discretion to make up their own standards of medical necessity.

Unlike much of the primary and acute medical care authorized under traditional managed care plans, the authorization of long-term care, particularly home care services, must take into account myriad factors that are not solely medical – e.g. the individual's available social network of informal caregivers, his or her housing situation, the logistics needed for basic housekeeping, shopping, and other tasks. **Mandatory enrollment must be postponed at least until the State has finished testing, revising, and soliciting consumers' and other stakeholders' input about, a new Uniform**

Assessment Tool that will be used by MLTC plans.[4] The lack of a uniform tool results in inconsistent and arbitrary determinations, including outright denials of services.

In addition to a uniform assessment tool, the standards used to assess the amount of services necessary must comply with standards set by regulation, litigation and administrative precedent in New York State over decades. For example, state regulations restrict the use of "task-based assessment" for people determined to have 24-hour a day needs (18 NYCRR 505.14(b)(5)(v)), and a State directive prohibits the denial of personal care services needed to assist a consumer to safely perform basic activities of daily living –a policy that is vital to protect people who have dementia.[5]

C. **An Ombudsprogram Should be Created to Investigate Consumer Complaints, Monitor Systemic Problems and Proposals by an MLTC Plan to Place a Consumer in a Nursing Home.** We endorse the DOH proposal for the Fully Integrated Dual Advantage (FIDA) program for establishment of an Ombudsprogram. This should be created now to provide vital oversight and consumer assistance in the implementation of MLTC. One critical role of an Ombudsprogram would be to receive notice of any proposed action by an MLTC plan to discontinue community-based services and place the member in a nursing home. The Ombudsprogram would ascertain whether the member voluntarily agrees to placement based on an informed choice, and whether community-based services could be provided as an alternative.

There are insufficient procedural and oversight mechanisms to prevent MLTC plans from utilizing excessive nursing home services instead of community-based care. Even now, with a lower-acuity voluntary enrollment population, cost reports filed with the State indicate that some MLTC plans spend as much as 11.4% of their capitation on nursing home care. The MLTC model contract gives MLTC plans total discretion in determining when to utilize nursing home services that are included in the capitation rate. An ombudsprogram would be one crucial safeguard to ensure access to community-based care.

D. **Improvements of Risk Adjustment of Capitation Rates are Needed to Ensure that Plans have the Resources and Incentive to provide Community-Based Care to High-Need Individuals.** While rates are risk-adjusted to some extent for MLTC plans, the adjustment is not sufficient to take into account the influx of higher-need individuals transitioning from the CASA personal care population now, and are not sufficient for plans to provide the care needed for the most vulnerable consumers. See our recommendations in *Incentives for Community-Based Services and Supports in Medicaid Managed Long Term Care: Consumer Advocate Recommendations for New York State (March 2012), posted at* .http://wnylc.com/health/download/304/.

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[4] The State also must conduct training in order to effectively implement such a uniform assessment tool.

[5] *See* NYS Dep't of Health GIS 03 MA/003, http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/03ma003.pdf.

E. **State DOH needs increased staffing and technological resources to conduct the robust state oversight that is critically needed, including expansion of Quality Assurance Reporting Requirements (QARR)** to include metrics applicable to members who need long-term care. With thousands of vulnerable people at risk of losing stable long-term Medicaid home care services in this transition, the State must do more pro-active monitoring than simply obtaining reports from MLTC plans on the numbers of grievances or hearings filed, or conducting consumer satisfaction surveys. The vast majority of consumers, who by definition are elderly and/or disabled, many with mental illness, will not utilize the grievance and hearing systems. CMS has wisely required in the Special Terms & Conditions:

> … For initial implementation of the auto-assigned population, the plans must submit data for state review on a monthly basis reporting instances when the plan has issued a notice of action that involves a reduction of split shift or live-in services or when the plan is reducing hours by 25 percent or more.[6]

As of November 14, 2012, the State had not yet designed a system or provided instructions to plans to report this data – let alone assembled staff and resources to monitor and respond to the data as it is received in real time. True oversight of plan decisions to reduce hours must be done immediately, with follow-up -- in order to prevent potential harm. The data required by CMS should be shared in real time with an oversight panel that includes stakeholder representatives including consumer advocates and the ombudsprogram.

Additionally, the State must randomly sample approvals and denials for other services – i.e. motorized wheelchairs and other durable medical equipment, transportation for medical care, dental care and eye care, and other services covered in the package. Oversight is also needed to ensure timely authorizations for services.

Quality Assurance Reporting Requirements ("QARR") reporting data must be expanded to include additional metrics that are applicable to members who need long-term care (e.g. ability to perform activities of daily living, prevalence of decubitus conditions, usage of incontinence pads as opposed to assisting with toileting, incidence of falls and other accidents, temporary and permanent nursing home placement.)

DOH has indicated that it lacks staffing to make "secret shopper" calls to plans to test the accessibility of their Member Services hotlines, and to test capacity and availability of their provider networks. Such monitoring is critical to ensure access.

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[6] CMS Special Terms & Conditions, Partnership Plan, amended August 2012, posted at http://www.health.ny.gov/health_care/medicaid/redesign/docs/2012-08_partnership_amendment_stc.pdf (¶ 28.d. p. 17)

F. Three Changes are Recommended to Strengthen Due Process Rights

Any reduction by MLTC plans in the personal care services that were previously determined to be medically necessary is potentially life-threatening. Over 40 percent of personal care recipients have been receiving personal care services for at least seven years due to long-term chronic conditions.[7] Therefore, consumers must have full due process protections to challenge any reduction by MLTC plans of their personal care services. Three State policies threaten these fundamental protections.

1. "**Exhaustion" of internal appeals within the plan is being required by the State -- for the first time ever in Medicaid managed care – and without legislative authority -- before one may request a fair hearing.** This requirement threatens to bar access to appeals for thousands of vulnerable people used to the old long-time system of requesting a fair hearing immediately. We have already seen a consumer request a hearing when an MLTC plan denied an increase in home care hours, only to have her hearing dismissed months later because she had not requested an internal appeal. By that time, it was too late to request an internal appeal.

   The legislature should clarify that exhaustion is not required before requesting a hearing. Yet we understand that efficiencies can be achieved if plans review their own determinations before a hearing. To that end, any fair hearing request could be deemed to be a request for an internal appeal, and the State Office of Administrative Hearings could notify the MLTC plan of any fair hearing requests. While the hearing is being scheduled, the plan could conduct the internal appeal. If the issue is resolved, the hearing would not be necessary.

2. **The State must ensure that an MLTC member has the due process right to continue receiving services unchanged, as "aid continuing" pending an internal appeal and/or fair hearing**, before an MLTC plan reduces or terminates services that were previously authorized by the local Medicaid program prior to MLTC enrollment, or by the plan. We understand that CMS may be revising its waiver approval to require "aid continuing" rights if a plan reduces services at the initial transition from the Medicaid home care program as previously run. This is an encouraging start, but needs to be broadened so that all MLTC plans may not arbitrarily reduce services at any time, without the consumer having the right to seek review with services continue unchanged pending that review. This is a fundamental due process right guaranteed by the Due Process clause of the Fourteenth Amendment to the Constitution, since the Supreme Court decision in *Goldberg v. Kelly*, 397 U.S. 254 (1970).

3. **Lack of Model Notices** – DOH has indicated that Plans have not been given model notice formats with standardized, tested language. This is very concerning, as the message is complicated, readability and literacy issues, in addition to ADA issues are critical. Just as DOH has prescribed notices for all the local DSS, the same is

[7] S. Samis & M. Birnbaum, *Medicaid Personal Care in New York City: Service Use and Spending Patterns* (United Hospital Fund 2010), *supra*, at pp. iii-iv, 6-8.

necessary for the many MLTC plans to ensure they include the minimum information in a clear way.

G. DOH must create, in partnership with consumers and their advocates, an Americans with Disabilities Act Compliance Appendix to the contract, and monitor its implementation as a step towards disability literacy.

With its emphasis on interdisciplinary care coordination and avoidance of inappropriate reliance on institutional settings, MLTC presents some opportunities to improve the care of people with disabilities. However, MLTC will only achieve this promise if it attends to the disability literacy of MLTC plans. Disability literacy for MLTC plans may be defined as the capacity to understand, communicate, and partner with people with disabilities with demonstrated understanding of their perspectives and beliefs concerning health behavior. An example would be recognition of the preference for self-direction and informed choice. Lack of training on disability literacy issues and problem-solving to remove barriers for health plan administrators, staff and care practitioners creates a very significant barrier to effective health care.

Disability literacy is critical to the success of the MLTC program. New York State recently has observed that people with disabilities requiring significant assistance have a lower health quality of life, engage in behaviors such as smoking that present health risks and engage in fewer health promoting activities such as exercise. They experience chronic conditions at a higher rate than people without disabilities.[8] They also experience health disparities and face significant problems accessing health services. For example, adults who are deaf report poor health with greater frequency than people who are not deaf, lack interpreters in health settings and fail to receive health information and instructions from practitioners. Adults with developmental disabilities are at higher risk of obesity, cardiovascular disease and hypertension than people without developmental disabilities. They encounter problems working with providers who do not give them enough time to undress, communicate or understand instructions.[9]

Managed long-term care can fulfill its promise of coordinating care and avoiding expensive and overly restrictive institutional placement, only if it addresses disability literacy issues.

One of the Coalition members, the Center for Independence of Disabled of NY, reviewed the ADA compliance plans (Appendix J to the model contract) of 16 NYC MLTC plans obtained through a 2012 Freedom of Information Act request. While all the plans submitted showed serious deficiencies, it appeared that no State evaluation of the Appendix J plans had occurred or that corrective action had been taken.

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[8] New York State Department of Health, Disability and Health Program, "Chartbook on Disability in New York State, 2007, Results from the Behavioral Risk Factor Surveillance System." 2008.

[9] National Council on Disabilities, "The Current State of Health Care for People with Disabilities," 2009.

What kinds of deficiencies in the ADA plans were evident in the MLTC contracts?

- ✓ One in three plans does not provide evidence that they identify people with disabilities;
- ✓ None of the 18 plans provides has a procedure for identifying and recording requests for accommodations for people with disabilities or the disposition of those requests;
- ✓ Only two of the 18 plans provide notice to enrollees of the right to reasonable accommodations—it is limited to hearing and vision-related disabilities.
- ✓ Not one plan provides detailed guidance on how to request a reasonable accommodation, how and when the request will be addressed and by whom.
- ✓ No plans provide accommodations for people with psychiatric disabilities, or mention learning disabilities or intellectual disabilities.
- ✓ Plans list a very narrow spectrum of accommodations and do not indicate that the accommodations listed are nonexclusive.
- ✓ Not one of the managed long-term care plans trains its employees on the policies and specific procedures for ADA compliance of the managed long-term care plan.
- ✓ No plan gives notice of the right to complain to the U.S. Department of Health and Human Services Office of Civil Rights.

An *Americans with Disabilities Act Compliance Appendix* to the contract would make provision for eradication of physical, communications-related, programmatic and attitudinal barriers. For example, MLTC Plans must be required to have and/or develop an experience and knowledge base to serve people with significant disabilities. Among issues to be considered are:

A. the physical accessibility of administrative and provider facilities;
B. willingness and capacity to provide written materials in alternate, accessible formats;
C. expertise in assessing needs for adaptive equipment and environmental modifications, including wheelchair fitting and seating and home modifications, with policies and practices for approval of durable medical equipment and transportation that are consistent with applicable laws and promote independent living;
D. understanding of, and the capacity to address, the housing and social service needs of participants;
E. a proven and documented commitment to maintaining people in the most integrated setting;
F. policies that facilitate the provision of reasonable accommodations to people with disabilities; and
G. provision of opportunities for plan participants to participate, in a significant manner, in the development of plan policies and practices.

5. Consumer Directed Personal Assistance Program ("CDPAP") Services Must be Protected

Effective November 1, 2012, all MLTC plans are required to offer CDPAP services, consistent with State law that requiring MLTC plans to offer this option. This provision holds the promise that consumers will continue to have the guaranteed option to self-manage their services through the CDPAP, as required by state law. However, we have concerns about how this requirement will be implemented. There is an inherent conflict in the notion of having a nurse manage a care plan for a consumer who is directing his or her own care. The recent release of CDPAP regulations[10] recognizes the unique self-management attributes of the model which is contradictory to nurse management and supervision of the consumer's care needs as delivered by consumer employed and trained Personal Assistants.

We are concerned about the delegation of the duty of determining whether the consumer is eligible for CDPAP to the MLTC plan.[11] The MLTC plan may have a conflict of interest in being the decision maker on this issue. Consumers must receive notice of and the opportunity to appeal denial of eligibility for CDPAP services at a fair hearing, as they do now.

We are pleased that DOH has required MLTC plans to contract with existing CDPAP providers/fiscal intermediaries at the current Fee for Service rate, at least until October 2013. See FN 13.

6. A NEW POINT OF ENTRY THAT IS ACCESSIBLE FOR NYC RESIDENTS WITH DISABILITIES SEEKING COMMUNITY-BASED LONG-TERM CARE SERVICES TO APPLY FOR AND RENEW MEDICAID IS NOT YET DEVELOPED, TESTED OR PUBLICIZED, THREATENING TO DISRUPT CARE AND DENY ACCESS.

Mandatory MLTC fundamentally alters the 30-year old system and entry point for 1,170 NYC residents to file Medicaid applications each month and 50,000 recipients to process annual Medicaid renewals. For over 30 years, New York City's Human Resources Administration (HRA) has maintained between one and three "one-stop" offices in each borough called "CASA offices," (also known as "CASAs") at which frail homebound seniors and people with disabilities can both apply for Medicaid and initiate a request for personal care services, and then annually renew eligibility for Medicaid.

These CASAs accommodate the disabilities of many applicants by having a caseworker visit the applicant at home to complete the applications for both Medicaid and home care. By simultaneously processing the dual applications for Medicaid and for personal care services, the CASA system is efficient

[10] NYCRR Title 18 Section 505.28 (g)(1).

[11] See NYS DOH CDPAP MLTC Policy (10/1/2012) http://www.health.ny.gov/health_care/medicaid/redesign/docs/final_transitional_care_policy_cdpap.pdf

and can approve Medicaid and home care within 45 -60 days. We are told that the CASA program will still accept and process the Medicaid applications through a new central intake location that is not yet well publicized or tested. Otherwise, applications will have to be filed through the other Medicaid offices that serve all ages and populations. These offices do not have a reliable system for promptly accommodating the needs of people whose disabilities make travel difficult. Applicants are required to wait until Medicaid is approved—a period of at least 45 days—before they can apply to an MLTC plan, delaying delivery of services significantly.

Systems are not developed or ready to ensure continuity of home care when inevitable bureaucratic glitches occur in routine renewals for Medicaid after April 1, 2012. Until now, NYC HRA CASAs handled the routine Medicaid renewals for personal care recipients to demonstrate continuing financial eligibility for Medicaid, accommodating their disabilities by assisting them with collecting documents via home visits. Given the huge volume of Medicaid renewals in NYC, errors commonly happen, with vulnerable clients experiencing lapses in Medicaid coverage due to renewal paperwork that was lost in the mail or was never processed. *The current NYC HRA policy ensures that vital personal care services are not disrupted during any temporary lapse in Medicaid due to such renewal errors.* HRA has exercised its contractual authority with personal care providers to direct them to continue providing services while the problem is being corrected. Under managed care, however, if the managed care plan does not receive their monthly capitation payment because Medicaid eligibility erroneously has lapsed due to a bureaucratic error, plans may and have been known to discontinue home care services, leaving vulnerable seniors and people with disabilities at risk of severe harm.

RECOMMENDATION: It is critical that procedures be established to ensure that no vital Medicaid home care will be discontinued during temporary lapses in Medicaid pending resolution of renewal/ recertification errors, and to ensure that Medicaid applications and requests for home care services are expeditiously processed in ways that reasonably accommodate the disabilities of the applicants.

7. ALLOW INDIVIDUALS RECEIVING HOSPICE CARE TO ENROLL OR REMAIN IN MLTC. The current state statute excludes hospice recipients from MLTC. Many hospice recipients need the extra home care and other supports offered by MLTC to supplement the hospice services. Now, they are banned from enrolling in MLTC, or must disenroll once they begin receiving hospice. A simple legislative amendment could lift this barrier.

8. STAKEHOLDER PARTICIPATION – The most critical aspects of implementation of MLTC have lacked meaningful consumer engagement – from development and testing of the Uniform Assessment Tool to drafting terms of plan model contracts with the plans, and development of rate methodologies. In the so-called "stakeholder conference calls" include several hundred participants, news is disseminated, but they are not a true opportunity for dialogue or opportunity for stakeholder input on policy. No workgroups have been convened in the implementation phase.

CMS' waiver approval documents require input of recipients and their recipients. Within 90 days of the waiver approval, "The state must obtain the input of recipients and other stakeholders in the development of its revised comprehensive Quality Strategy and make the Strategy available for public comment." [12] Though this deadline would have passed December 1, 2012, nothing has been communicated on this.

Additionally, the CMS approval further provides[13]:

> 44. **Advisory Committee as required in 42 CFR 438.** The state must maintain for the duration of the Demonstration a managed care advisory group comprised of individuals and interested parties appointed pursuant to state law by the Legislature and Governor. To the extent possible, the state will attempt to appoint individuals qualified to speak on behalf of seniors and persons with disabilities who are impacted by the Demonstration‟ use of managed care, regarding the impact and effective implementation of these changes on individuals receiving LTSS.

[12] CMS Special Terms & Conditions, Partnership Plan, amended August 2012, posted at http://www.health.ny.gov/health_care/medicaid/redesign/docs/2012-08_partnership_amendment_stc.pdf (¶ 39. p. 24)

[13] CMS Special Terms & Conditions, supra, at p 25

LEGISLATIVE RECOMMENDATIONS:

1. **Require intelligent assignment** of consumers to plans for auto-assignment, based on maintaining existing provider relationships, quality and other factors, and require plans to ensure continuity of care with existing providers.
2. **Establish external entity to make conflict-free determinations** of eligibility for community-based long term care, including CDPAP, that are binding on MLTC plans so that they may not decline enrollment to eligible persons
3. **Increase DOH budget for the staffing and technological support required for meaningful monitoring and oversight of the program, to include funding for:**
    a. an **Ombudsprogram** as an external oversight entity to receive and investigate consumer complaints, real time copies of the plans' monthly reports of reductions in 24-hour/day personal care services and other significant service reductions, and notice of all proposed institutional placement of plan members, with the authority to investigate and intervene;
    b. **educational outreach** to consumers and their advocates to be conducted by community-based organizations
    c. individual plan compliance investigations to be conducted by DOH or its contractor, to include **"secret shopper" surveys** thattest plan capacity and responsiveness of plan Member Services hotlines
    d. development of a "**PlanFinder"** website similar to that available for Medicare Part D, for comparing provider networks and other characteristics of plans.
    e. Creation of a **centralized notices committee** that utilizes expert literacy and accessibility consultants and, with consumer input, formulates standardized notices and other consumer communications for DOH and MLTC plans.
    f. Expanded **stakeholder participation** in formulation of policy and monitoring, including support for an expanded and invigorated MMCARP.
4. **Remove exclusion of individuals receiving hospice services from MLTC.**
5. **Strengthen due process protections by:**
    a. **Clarifying that exhaustion of internal appeals is not required prior to requesting a fair hearing.** Alternatively, a request for a fair hearing shall be deemed to be a request for an internal appeal, which the plan would process while the fair hearing request is pending.
    b. **And require State to ensure that consumers continue receiving services unchanged while** they appeal a proposed reduction or termination of services, and that State develop, with consultation with stakeholders, **model notices** of service changes to be used by MLTC plans.

Steering Committee of Coalition
Center for Disability Rights
Center for Independence of the Disabled NY
Community Service Society of NY
Empire Justice Center
Legal Aid Society
Medicare Rights Center
New York Association on Independent Living

Other Members of the Coalition (list in formation)
Alzheimer's Association, NYC Chapter
Autistic Self Advocacy Network
Cardozo Bet Tzdek Legal Services
Bronx Jewish Community Council, Inc.
Brooklyn Center for Independence of the Disabled
Federation of Protestant Welfare Agencies
Institute for the Puerto Rican/Hispanic Elderly, Inc.
Lenox Hill Neighborhood House
Medicaid Matters NY
MFY Legal Services
Morningside Retirement and Health Services (MRHS)
New York Lawyers for the Public Interest
Not Dead Yet
Staten Island Center for Independent Living
United Spinal Association
Wheels of Progress
Women's City Club of New York
Westchester Disabled On the Move Inc.

ATTACHMENT -- Center for Independence of the Disabled NY -- ADA Compliance Report on MLTC, Nov. 2012

See also

Home Health Care and Personal Care Services Hours Provided by MLTC and PACE Plans in NYS (2010) posted at http://wnylc.com/health/afile/169/324/

Percentage of members who were in a nursing home for the entire quarter (2010) posted at http://wnylc.com/health/afile/169/325/

Incentives for Community-Based Services and Supports in Medicaid Managed Long Term Care: Consumer Advocate Recommendations for New York State (March 2012), posted at .http://wnylc.com/health/download/304/.

ATTACHMENT

Center for Independence of the Disabled NY

ADA Compliance Report on MLTC, Nov. 2012 (supporting data available upon request sdooha@cidny.org)

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Center for Independence of the Disabled, NY

October 5, 2012

Mr. Mark Kissinger
New York State Department of Health
Empire State Plaza, Corning Tower, 14th Floor
Albany, New York 12237

By Email: mlk15health.state.ny.us

Re: ADA Compliance by Managed Long-term Care Plans in New York State

Dear Mark:

People with disabilities cannot derive a full and equal benefit from publicly funded health insurance unless health plans comply with federal civil rights law. Health disparities are an inevitable result of failure to ensure programmatic accessibility. The State has the responsibility to ensure that Medicaid health plans identify barriers to care and provide reasonable accommodations and full programmatic accessibility.

To facilitate greater State and health plan compliance, some fifteen years ago, the disability community worked with New York City and New York State to develop ADA Compliance Guidelines for health plans serving Medicaid beneficiaries. These guidelines are included as Appendix J in the New York State Department of Health contract with managed long-term care plans. Appendix J educates managed long-term care plans regarding their obligations pursuant to the Americans with Disabilities Act, Title II and Title III and Section 504 of the Rehabilitation Act of 1973. It provides guidance for the development of a plan to assure compliance and standards for review of managed long-term care plan compliance.

What are some things managed long-term care plans are required to do?

- ✓ Identify enrollees with disabilities *in order to* provide reasonable accommodations that are necessary to avoid discrimination.
- ✓ Give notice of how disability is defined with examples of disabilities that include functional limitations (e.g. trouble standing, ongoing sadness, difficulty with reading).
- ✓ Let people know what kinds of accommodations are available (providing examples that are nonexclusive).
- ✓ Ensure that personnel are trained to provide accommodations.
- ✓ Include a network of providers with accessible practices.
- ✓ Ensure that people with disabilities know that they may file ADA compliance-related complaints with the HHS Office of Civil Rights.

What is the "state-of-the state" of managed long-term care compliance?

Unfortunately, as mandatory enrollment in managed long-term care unfolds and as preparation for mandatory enrollment of dual eligible proceeds, a review of managed long-term care ADA Compliance Plans shows a pervasive lack of compliance. This lack of compliance will impede efforts to achieve State health policy goals related to eradication of disparities and will place the State and its managed long-term care plans at risk of litigation. Our intention in bringing these concerns to the attention of State and Federal regulators is to encourage remediation.

In 2012, a Freedom of Information Act request to the New York State Department of Health seeking release of ADA compliance plans and any related documents revealed that 16 of 18 managed long-term care plans had submitted an Appendix J plan. While all the plans submitted showed serious deficiencies, no documents were transmitted in response to the FOIL that showed that evaluation of the Appendix J plans had occurred or that corrective action had been taken.

What kinds of managed long-term care plan deficiencies are evident?

- ✓ One in three plans does not provide evidence that they identify people with disabilities;
- ✓ None of the 18 plans provides has a procedure for identifying and recording requests for accommodations for people with disabilities or the disposition of those requests;
- ✓ Only two of the 18 plans provide notice to enrollees of the right to reasonable accommodations—it is limited to hearing and vision-related disabilities.
- ✓ Not one plan provides detailed guidance on how to request a reasonable accommodation, how and when the request will be addressed and by whom.
- ✓ No plans provide accommodations for people with psychiatric disabilities, or mention learning disabilities or intellectual disabilities.
- ✓ Plans list a very narrow spectrum of accommodations and do not indicate that the accommodations listed are nonexclusive.
- ✓ Not one of the managed long-term care plans trains its employees on the policies and specific procedures for ADA compliance of the managed long-term care plan.
- ✓ No plan gives notice of the right to complain to the U.S. Department of Health and Human Services Office of Civil Rights.

Are there things that the managed long-term care plans and the State could do to improve?

- ✓ Assign responsibility for compliance activities within the Department of Health (DOH), including regularly updating ADA compliance guidelines that contain clear and detailed guidance on baselines for compliance, model compliance plan and member handbook language, and educate DOH personnel regarding federal civil rights law compliance.
- ✓ Work with the disability community to write model ADA compliance plan that guides managed long-term care plans—as does the model member handbook.
- ✓ DOH must provide or require plans to obtain training for grievance and appeal personnel, member services personnel, case managers and other relevant personnel to receive training on the ADA, compliance plan requirements and disability literacy.
- ✓ DOH must have adequate personnel to review ADA compliance plans, issue statements of deficiency and review and approve plans of correction with clear timelines for compliance, provide or arrange for technical assistance, and test compliance with ADA compliance plan provisions.
- ✓ OTDA must provide training on a regular basis on ADA compliance or arrange for it to be provided to Administrative Law Judges, health plan grievance and appeal personnel.
- ✓ The Department of Health must report to the public on progress towards ADA compliance in the managed long-term care program;
- ✓ Train plans on ADA compliance planning and implementation in relation to their staff training, quality assurance activities, provider compliance, network adequacy activities, etc.
- ✓ Develop a brochure for enrollees regarding ADA rights in managed care that is distributed upon enrollment.

In conclusion, CIDNY and other advocates are willing to work with the State and the managed long-term care plans to achieve improvements in Americans with Disabilities Act compliance.

Best regards,

Susan M. Dooha, J.D.
Executive Director

On behalf of:

Cardozo Bet Tzedek Legal Services

Catskill Center for Independence

Center for Disability Rights, Inc.

Coalition of the Institutionalized Aged and Disabled

Commission on the Public's Health System

Directions in Independent Living, Inc.

Disability and Aging Rights, MFY Legal Services

Empire Justice Center

Independent Living, Inc.

Independent Living Center of the Hudson Valley, Inc.

The Long Term Care Community Coalition

New York Association on Independent Living

New York Association of Psychiatric Rehabilitation Services, Inc.

Options for Independence, Inc.

Southern Tier Independence Center

Taconic Resources for Independence, Inc.

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