

Managed Long-Term Services and Supports (LTSS) and Service Authorizations

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Justice in Aging

Justice in Aging is a national organization that uses the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources. Since 1972, we have focused our efforts on populations that have traditionally lacked legal protection such as women, people of color, LGBT individuals, and people with limited English proficiency.

Key Lessons

1. When states transition to a Medicaid managed care system, they should include beneficiary protections like adequate notices and post enrollment health risk assessments.
2. Advocates should be on the lookout for assessments and plans that require family members and friends to provide services and push back on plan protocols and criteria.
3. Delays in service authorizations may push back the date of eligibility, but the issue could be ripe for advocacy.
4. Members can appeal adverse determinations.
5. Under certain circumstances, beneficiaries may be able to access additional HCBS without incurring additional cost by using their patient pay amount.

Introduction

More and more state Medicaid agencies are using managed care as the primary delivery system for Medicaid services, including long-term services and supports (LTSS). In 2012, 16 states had managed LTSS (MLTSS) programs, which grew to 24 states in 2017.¹ In total, these plans provide MLTSS for 1.8 million Medicaid beneficiaries. Over half of states require MLTSS, while others make it voluntary, and it is no surprise that the most common population that MLTSS programs serve is older adults. The prevalence of MLTSS programs across the country presents complexities but also opportunities for advocates.

Transitions to Medicaid Managed Care Must Include Certain Beneficiary Protections

Beneficiaries in Medicaid fee-for-service transitioning to Medicaid managed care are entitled to a number of beneficiary protections that allow them to successfully transition from one delivery system to another.

As an initial matter, beneficiaries are entitled to informational notice informing them of the transition. The notice must clearly explain the transition, its timing, what it means to be enrolled in a managed care plan, the services covered, and, in a voluntary managed care program, the choice that beneficiaries are expected to make. In a mandatory managed care program, the notice must provide information about consequences of inaction and default enrollment, as well as other types of information.²

In addition, if states automatically assign beneficiaries to a Medicaid plan, the state is required to take into account pre-existing relationships with Medicaid providers in making the plan assignment. This requirement applies to providers who have experience serving Medicaid beneficiaries and is established through state or encounter data from the past year, or upon contact with the beneficiary.³ This helps ensure that beneficiaries can enjoy continuity with providers during the transition to the greatest extent possible.

States are given considerable latitude in shaping their informational notices, so advocates should work with their state Medicaid agencies in developing consumer-friendly, simple notices.

EXAMPLE

In California's recent transition to Medicaid managed care for dual eligibles, despite three separate mailings and the inclusion of contact information for a consumer ombudsman on the notices, beneficiaries found the notices confusing and did not understand what the transition meant for their Medicaid benefits. The state committed to undergoing beneficiary testing and redrafting so the notices were more accessible for consumers. Advocates should work with their state Medicaid agencies to ensure consumer testing of notices as a way to develop consumer-friendly communications.

After Enrollment, the Beneficiary is Entitled to a Health Risk Assessment and Assessments for LTSS When Appropriate

Federal regulations require that Medicaid plans administer a health risk assessment (HRA) within 90 days of enrollment into the plan.⁴ Regulations further require plans to assess for unmet LTSS needs among members who benefit from LTSS, and to create a treatment plan from the results of that assessment, to be reviewed annually.⁵

Although there is not a standard HRA form that all Medicaid plans are expected to use, HRAs are a mechanism that allow the health plan the opportunity to get to know its new member. It is not intended to be an exhaustive survey of all the member's health needs, but it is supposed to alert the plan to any major issues. Many health risk assessments will ask about medical needs but also include questions about the supports and services that older adults may need to stay in their communities, like transportation, durable medical equipment, and oral health needs.

In asking about these needs, the plan can also have a better sense of what potential continuity of care needs the member may have when transitioning into the plan.

PRACTICE TIP

Before enrollment, state Medicaid agencies will share prospective member information, including contact information and prior Medicaid utilization data, with the Medicaid plan. Sometimes this information is dated or incomplete. Health plans may find it hard to reach all their new members within the 90-day timeframe. Work with plans in your community to suggest innovative ways of reaching their members, like sending plan staff to health facilities that are high-touch points for members, including pharmacies. Plans are better able to engage in care coordination when they can reach members to conduct a timely HRA.

PRACTICE TIP

Some services in particular prove to be potentially tricky to access in managed care. Advocates have reported that beneficiaries encounter barriers working with Medicaid plans to access Medicaid-covered medical transportation and incontinence supplies. Sometimes beneficiaries are simply not used to accessing

these services in a managed care network, but other times plans may create cumbersome processes to authorizing services. Advocates should work to get clear answers from plans about their networks and authorization processes. Many plans have LTSS-specific liaisons who work with advocates and others.

Service Assessments Must Not Force Family Members and Friends to Provide Services

Since March 2014, federal regulations have set standards for service planning in Medicaid HCBS.⁶ One regulation applies to services provided through HCBS waivers, and an almost identical regulation applies to services provided through the HCBS state-plan option.⁷ In other Medicaid HCBS funding mechanisms — most notably, Section 1115 demonstration waivers — CMS is likely to require similar standards, even in the absence of a regulation.

The service planning regulations govern the planning *process* as well as the *plan* resulting from that process. Both the process and the plan are described as “person-centered.” The consumer leads the planning process whenever possible, and is assisted by persons of his or her choice.⁸

The regulations address assistance from family members through defining “natural supports.” Within the discussion of service plans, “natural supports” are described as “unpaid supports that are provided *voluntarily* to the individual in lieu of” Medicaid HCBS.⁹

In the service planning process, the rubber meets the road when Medicaid programs and health plans decide whether and to what extent to authorize HCBS. In too many occasions, personal care hours are denied or reduced based on an assumption that necessary services should be provided by a family member or friend. Sometimes these assumptions are based upon state policies purporting to deny Medicaid services for “caregiver convenience.”¹⁰ In other occasions, the assumption is not tied explicitly to a state law or policy.¹¹

The advocacy message to Medicaid beneficiaries (and their representatives) is that the voluntariness requirement is far from self-enforcing. They should emphasize the voluntariness requirements whenever the possible assistance of family and friends comes into play: during assessments and service planning meetings, for example, and during any appeals following an inadequate authorization of services.

Delays in Service Authorization Often Delay Effective Date of Eligibility, But Advocacy May Bear Fruit

In general, Medicaid programs must grant eligibility for up to three months prior to the month of application for all months in which the applicant met eligibility standards.¹² Consider, for example, a nursing facility resident who spent down her savings to Medicaid eligibility levels in October 2018, but confused Medicaid with Medicare, and did not apply for Medicaid until December 12, 2018. The Medicaid program will grant her eligibility beginning in October, since she first met eligibility standards for that month.

Now assume that this same woman lived in an assisted living facility rather than a nursing facility, and the assisted living facility is certified to be paid through the state’s HCBS program. Also assume that a Medicaid service plan was finalized for her on January 15, 2019. In most states, her eligibility will not start until January 15, based on the description in the HCBS waiver statute of HCBS being “provided pursuant to a written plan of care,” and the assumption that this written plan of care requirement takes precedence over the Medicaid requirement that eligibility be recognized up to three months prior to the month of application.¹³

Justice in Aging recently participated in litigation asserting that the prompt coverage requirement (up to three months prior to the application month) can be harmonized with the written plan of care requirement, by authorizing payment for services provided prior to application if they are consistent with a subsequently approved service plan. This argument prevailed in the district court, but the Ohio Medicaid program appealed

and the Sixth Circuit reversed.¹⁴ The Sixth Circuit opinion did not address a core argument: that the HCBS requirement of a written plan of care is essentially identical to the requirement that nursing facility care be provided “in accordance with a written plan of care” — and all state Medicaid programs allow for coverage of nursing facility care up to three months prior to the application month.¹⁵ Advocates interested in this issue should contact NCLER for more in-depth discussion.

Alternatively, administrative advocacy might be successful in convincing a state government (or managed care plan) to make an extra effort to authorize coverage that at least becomes effective on the application date. In Olmstead Letter No. 3, Attachment 3-a (July 25, 2000), the federal government explained the HCBS requirement of a written plan of care, but in an effort to encourage more prompt coverage of HCBS, authorized *provisional* written plans of care to initiate coverage for up to the first 60 days following an application. If a state Medicaid program truly wants to stamp out any incentives for nursing facility care over HCBS, it should allow provisional care plans in order to enable prompt coverage of HCBS.

Members and Advocates Should Push Back Against Plans’ Protocols and Criteria

Members often are intimidated by assessment processes. When asked about their needs and concerns, they may respond in a very limited way, both because the process may be intimidating and because most persons tend naturally to downplay their needs or limitations.

This is not the time to be stoic. The member should speak freely about his/her needs and about the services that he/she will need to address those needs.

This is also not the time to be unprepared. A member seeking personal care services should think carefully about her daily needs, and the types of services that would be useful in addressing those needs. The member, perhaps with an advocate’s help, can prepare a list ahead of time to be shared with the assessor. Even if the assessor has a separate assessment protocol — which is likely — the member’s list can inform the assessment and be a powerful tool if and when an assessment dispute reaches an internal plan review or an administrative hearing.

Furthermore, an assessment protocol and algorithm should not necessarily be accepted as the final word. A plan’s assessment document may not include all necessary information, and the algorithm may not accurately measure need. For example, a tool focused on discrete tasks may not reflect the time practically needed to perform multiple tasks in a real-life situation. Advocates should request any and all documents that purport to evaluate or analyze a member’s level of need. Plans sometimes claim that these documents are proprietary and thus exempt from discovery. The member or advocate should contest all such claims. If a plan relies upon certain documents and calculations, those documentations or calculations must be made available to a member or advocate.¹⁶

Applicants Can Appeal Adverse Determinations.

Under standard due process principles, a member of a Medicaid managed care plan has appeal rights to challenge a denial or restricted authorization of requested services. The first step is internal — the member has **60 days from the notice** of an adverse determination to request an internal plan appeal.¹⁷ Generally the plan has 30 days to respond, although the state may designate a shorter timeframe.¹⁸ On the other hand, the 30 days is reduced to no more than 72 hours for expedited determinations, applicable if standard timeframes “could seriously jeopardize the enrollee’s life, physical or mental health, or ability to attain, maintain, or regain maximum function.”¹⁹ Either the 30 days or the 72 hours can be extended for up to 14 days at the member’s request, or if the plan shows that it needs additional information and delay is in the member’s best interest.²⁰

The internal plan appeal is required in order to initiate the next level of appeal — a request for a state fair hearing.²¹ The member must request this appeal within 120 days from the notice from the internal plan appeal.²²

If a member prevails in a hearing, the plan must implement the decision within 72 hours.²³ In most instances when a plan has proposed to eliminate or reduce an existing benefit, however, the member likely retained the benefit during the appeal process. A benefit can be paid pending an appeal decision if the member has **requested continued benefits within 10 days** of the plan sending the notice or the proposed effective date, whichever is later, and the original authorization time period has not expired at that time.²⁴ If the member loses the internal appeal plan, she can continue on aid-paid-pending status by requesting the fair hearing and continuing benefits within 10 days of the notice of the decision on the internal plan appeal.²⁵ The member should understand that they may bear some financial risk: the plan can seek recoupment if the plan ultimately prevails, but only to the extent that the state may seek recoupment in comparable circumstances in fee-for-service Medicaid.²⁶

A member has a right to all relevant documents, without cost, and sufficiently in advance of the hearing or deadline for completion of the process.²⁷ The plan's internal criteria for service authorization is a particularly useful document.

Patient Pay Amount May Be Allocated to Pay for Personal Care Services that Managed Care Plan Has Denied

Even when a managed care plan limits authorization of personal care services, the member may be able to obtain the additional hours without cost by using their patient pay amount strategically. This option is viable only for members with a relatively significant monthly income.

Under Medicaid HCBS rules, a beneficiary is allowed certain income deductions, and must spend all remaining income as cost-sharing for covered health care expenses. Deductions are allowed for the maintenance needs of the beneficiary, spouse, and family, and also for health insurance premiums. Finally, the beneficiary is granted a deduction for “[n]ecessary medical or remedial care recognized under State law but not covered under the State’s Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.”²⁸

Importantly, personal care may be considered “not covered under the State’s Medicaid plan” when a Medicaid managed care plan has refused to pay for that care. This issue has been addressed by the Vermont Supreme Court. Plaintiff Jean Brett requested 115 hours of personal care services every two weeks, but her managed care plan only approved 68.75 hours. The State’s Medicaid program assigned a monthly patient pay deductible of \$1,353, but Ms. Brett appealed this determination, arguing for a reduction because she would have to use that income to pay out of pocket for almost 100 hours of services each month (46.25 hours every two weeks), since the plan had refused to cover those services.²⁹

The Vermont Medicaid program argued that Ms. Brett could not direct her income towards the uncovered personal care services, since the managed care plan had refused to cover those services. The Vermont Supreme Court found that the managed care decision had not foreclosed a Medicaid deduction for out-of-pocket payment for those services. The case was remanded back to the Medicaid program for an additional determination of whether the contested personal care services were medically necessary.³⁰

This decision provides useful authority for Medicaid HCBS beneficiaries from across the country. By using cost-sharing to pay for additional HCBS, rather than applying it to approved services, a beneficiary may be able to access additional HCBS without incurring any additional expense.

Conclusion

Growth of Medicaid managed care and MLTSS programs means advocates must learn how to work with plans to best meet the needs of older adults. Managed care can introduce complexities around issues like service authorizations, assessments, eligibility start dates, and more, but key consumer protections exist, and advocates can use them to their advantage. Persistence and working with managed care plans can pay off.

Case consultation assistance is available for attorneys and professionals seeking more information to help older adults. Contact NCLER at ConsultNCLER@acl.hhs.gov.

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Endnotes

- 1 Elizabeth Lewis, et. al., Truven Health Analytics, The Growth of Managed Long-Term Services and Supports Programs: 2017 Update (January 2018).
- 2 42 C.F.R. § 438.10(e)(2), 438.54(c)(3) (voluntary managed care), 438.54(d)(3) (mandatory managed care).
- 3 42 C.F.R. § 438.54(c)(6) (voluntary managed care), 438.54(d)(6) (mandatory managed care).
- 4 42 C.F.R. § 438.208(b)(3).
- 5 42 C.F.R. §§ 438.54(c)(1)-(3).
- 6 79 Fed. Reg. 2,948 (2014) (regulations effective March 17, 2014).
- 7 See 42 C.F.R. §§ 441.301(c)(1)-(3) (HCBS waiver), 441.725(a)-(c) (HCBS state-plan option). The HCBS waiver often is called a Section 1915(c) waiver, since it is authorized by Section 1915(c) of the Social Security Act, which is codified at 42 U.S.C. § 1396n(c). The HCBS state-plan option often is called a Section 1915(i) program; it is authorized by Section 1915(i) of the Social Security Act, which is codified at 42 U.S.C. § 1396n(i).
- 8 42 C.F.R. §§ 441.301(c)(1)-(2), 441.725(a)-(b).
- 9 42 C.F.R. §§ 441.301(c)(2)(v), 441.725(b)(5) (emphasis added). More authority on this issue is available in Voluntary Means Voluntary: Coordinating Medicaid HCBS with Family Assistance (May 2016), an issue brief from Justice in Aging.
- 10 See, e.g., 10 Colo. Code Regs. 2505-10, § 8.076.1(8)(iii); Iowa Admin. Code r. 441-79.9(2)(c); Ohio Admin. Code § 5160-1-01(C)(6).
- 11 Rachel Gershon and Eric Carlson, Justice in Aging, Medicaid Enrollees Put at Risk When State Medicaid Program Assume Support from Family Caregivers (Oct. 2018).
- 12 42 U.S.C. § 1396a(a)(34).
- 13 42 U.S.C. § 1396n(c); see 42 U.S.C. § 1396a(a)(34).
- 14 Price v. Medicaid Dir., 310 F.R.D. 345 (S.D. Ohio 2015), rev'd by, 838 F.3d 739 (6th Cir. 2016).
- 15 42 U.S.C. § 1396r(b)(2) (written plan of care).
- 16 42 C.F.R. § 438.406(b)(5).
- 17 42 C.F.R. § 438.402(c)(2)(ii).
- 18 42 C.F.R. § 438.408(b)(2).
- 19 42 C.F.R. §§ 438.408(b)(3), 438.410(a).
- 20 42 C.F.R. § 438.408(c).
- 21 42 C.F.R. §§ 438.402(c)(1)(i), 438.408(f)(1).
- 22 42 C.F.R. § 438.408(f)(2).
- 23 42 C.F.R. § 438.424(a).
- 24 42 C.F.R. § 438.420(a), (b).
- 25 42 C.F.R. § 438.420(c)(2).
- 26 42 C.F.R. § 438.420(d).
- 27 42 C.F.R. § 438.406(b)(5).
- 28 42 C.F.R. § 435.735(c)(4)(ii).
- 29 In re Brett, 93 A.2d 120, 124 (Vt. 2014).
- 30 In re Brett, 93 A.2d 120, 130 (Vt. 2014).