Civil Rights Protections & Managed Long-Term Services and Supports

NATIONAL DISABILITY RIGHTS NETWORK
Protection & Advocacy for Individuals with Disabilities

member n4a
Advocacy. Action. Answers on Aging.

DREDF
Disability Rights Education & Defense Fund

Aging and Disability Partnership
for Managed Long-Term Services and Supports
www.mltssnetwork.org

DREDF

Disability Rights Education & Defense Fund

- National law and policy center dedicated to protecting and advancing disability civil and human rights
- Vision: “A just world where all people live full and independent lives free of discrimination.”
- Our constituents are people with disabilities (PWD) of all ages and parents of children with disabilities
- Disability Rights are Civil Rights, and Health Care Rights *are* Disability Rights

National Disability Rights Network (NDRN)

NDRN is the membership organization for the federally mandated Protection and Advocacy (P&A) Systems and Client Assistance Programs (CAP) network.

NDRN's mission is to promote the integrity and capacity of the P&A\CAP national network and to advocate for the enactment and vigorous enforcement of laws protecting civil and human rights of people with disabilities.

Housekeeping

- Web Based Live Captioning is available via Caption Colorado live captioned text services at the following URL: http://www.captionedtext.com/client/event.aspx?CustomerID=830&EventID=2202047
- We will stop periodically for questions, which can be submitted through the chat function on your computer or on the phone through the operator
- a transcript and audio of this webcast will be posted on the Website of the Aging and Disability Partnership for Managed Long Term Services and Supports: http://mltssnetwork.org/events/webinar-civil-rights-protections-and-mltss/; NDRN website: http://www.ndrn.org/en/events/webcasts.html, and the and DREDF at www.dredf.org

Overview of Presentation

- Managed care basics and common concerns
- Medicaid managed care consumer protections
- Medicare managed care non-discrimination
- Federal disability rights and accessibility provisions (ADA/504/ACA)

What is Managed Care

- Capitation
  - Per member per month payment (PMPM)
    - Health plans (for profit), HMOs, MCOs
- Managed care contract
  - Legal document
  - Defines scope of benefits w/in health plan
  - Defines responsibilities of health plan

Medicaid MLTSS funding

- ACA dual eligible demo. To provide acute, behavioral, and LTSS under Medicaid MC.
  - 58 % of “duals” have a serious mental illness or intellectual disability (nearly 7% of 18 to 64 yr. olds have ID/DD
- States are using 1915(b) or § 1115 authority to expand managed care to older adults, persons with disabilities, and/or HCBS

Concerns for People with Disabilities

- Lack of experience with LTSS and behavioral health
- Provider incentives (withholds, bonuses) that might create disincentive to serving people with disabilities
- Performance measurement focus on acute care treatment outcomes not QOL, inclusion, autonomy, service coordination
- Inaccessible facilities and materials & S&S not consumer directed
- Limited access to specialists, DME, non-medical services, and hidden formularies/rates
- Internal appeal delays and no aid paid pending

State Overview – MLTSS and Medicaid Integration

- States engaged in/pursuing only Medicaid MLTSS:
  DE, FL, KS, LA, KY, NJ, PA, WV
  States pursuing only Dual Demonstrations:
- CO, CT, ID, IL, IA, MO, OH, OK, RI, SC, VA
  States engaged/pursuing both Medicaid MLTSS and Dual Demonstrations:
  AZ, CA, HI, MA, MI, MN, NM, NY, NC, TN, TX, VT, WA, WI
  States engaged in/pursuing only BIPP:
- GA, MD
- State engaged in/pursuing both Medicaid MLTSS and BIPP: NH

Medicaid: Managed Care Non-Discrimination Requirement

- MC contracts must prohibit discrimination on the basis of health status or requirements for health services in enrollment, disenrollment, and re-enrollment. 42 U.S.C. § 1396b(m)(2)(A)(V)

Federal requirements in exchange for matching funds

- "Medical assistance" must be provided statewide and States must use reasonable standards for determining eligibility and the extent of medical assistance
  - "Amount, duration and scope" of service must be sufficient to achieve its purpose
  - No discrimination based on condition (for mandatory - not optional services)
  - Comparable among similar groups and between medically and categorically needy

Waiver Amendment: waives some of these rights, 42 USC 1396n(c)

- Allows waiver of: statewideness, comparability, financial eligibility requirements
- State must seek an amendment, approved by DHHS for limited time periods
- Must meet State assurances to protect health and welfare, including: adequacy of providers; and state licensing and certification requirements

Some Standards for MCO's

- Must allow emergency care without prior authorization
  - Prudent layperson standard
- Adequate capacity and services
- Quality assessment and improvement
  - External independent review
- Restrictions on marketing
- Sanctions for noncompliance

More MCO requirements

- Choice of at least 2 MCOs
  - Rural exception
  - Default
- Disenrollment “for cause” & during annual open enrollment period
- Grievance and appeal process
- Information, e.g.
  - Providers
  - Covered services

Comparison of FFS/MC* Chart prepared by the National Health Law Program (NHeLP)

Fee for Service	Managed Care
Complaint based on statutes and rules	Complaint may also be based on contract
Complaint involves payment	Complaint involves service
Choice of provider	Lock-in
Provider may be advocate	Can't always depend on provider
Direct access to fair hearing	May have to exhaust at plan level

Medicare: Managed Care Non-discrimination Requirements 42 CFR 422.110, 422.2268(c), 423.2268(c)

Plan sponsors may not discriminate based on race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability or geographic location. Plan sponsors may not target beneficiaries from higher income areas or state or otherwise imply that plans are available only to seniors rather than to all Medicare beneficiaries. Only SNPs may limit enrollment to dual-eligibles, institutionalized individuals, or individuals with severe or disabling chronic conditions and/or may target items and services to corresponding categories of beneficiaries. Basic services and information must be made available to individuals with disabilities, upon request.

Managed Care and Disability Non-discrimination

- Managed care has long had a presence in Medicare (Medicare Advantage plans, D-SNPs, C-SNPs, I-SNPs).
- The promotion of integration under the ACA and fiscal crises of the last few years have prompted states to think about managed care for the Medicaid population with disabilities and chronic conditions, but not only do many MCO have little experience with LTSS, they have little knowledge of federal and state disability discrimination laws.

LTSS Components in Medicare

<u>Medicare does NOT cover</u>:

- Most dental, vision, or routine hearing care
- Most foot care
- **Most long-term care**
- Alternative medicine
- Most care received outside of the US
- Most personal care or custodial care
- Most non-emergency transportation

***Note:** Medicare Advantage plans (or Medicaid) may cover some of these services reach and enrollment

Example of Medicaid/Medicare Intersection

- Both Medicare and Medicaid cover Durable Medical Equipment (DME)
- Medicare limitation for use in the home (e.g., wheelchairs)

Issues for duals Medicaid always payer of last resort

- Medicare usually does not use prior authorization. Only processes claim after delivery. Medicaid won't review claim until after a Medicare denial.
- Suppliers want to know they will be paid before they deliver DME. Dual left without DME.
- Some states have developed work-arounds

Another Medicaid/Medicare Overlap

- Both Medicare and Medicaid cover Home Health
- Medicare “homebound” requirement
- Medicare-must require intermittent skilled nursing or PT, OT or speech-language pathology
- Improvement standard not applicable—true for OT and PT as well

- Issues for duals Like SNF, quality may be better if Medicare pays

Rx Medicaid/Medicare Interaction

- Prescription Drugs Almost all drug categories covered by Medicare, plans not required to cover every drug in a category
- Exceptions: OTC drugs, some uses of barbiturates, off-label uses not in compendiums and others

Issues for duals

- If a drug is a “covered Part D drug”, Medicaid will not pay, even if the Part D plan has denied coverage
- If a drug is not a “covered Part D drug,” dual can seek Medicaid coverage (e.g., OTC)
- Duals and all LIS can change Part D plans at any time

Private Medicare Health Plan Appeals Process

- Organization Determination
  ↓
  Reconsideration by MA plan
  ↓
- Reconsideration by Independent Review Entity (IRE)
  ↓
- Administrative Law Judge (ALJ) Hearing
  ↓
- Medicare Appeals Council (MAC) Review
  ↓
- Judicial Review (Federal District Court)

Lack of LTSS quality standards

- CMS guidance to States using 1115 demonstrations or 1915(b) waivers for Managed Long Term Services and Supports Programs

http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Medicaid-Managed-Long-Term-Services-and-Supports-MLTSS.html

- The National Quality Forum (NQF) preliminary quality measures to CMS for MLTSS programs for duals.

http://www.qualityforum.org/Setting_Priorities/Partnership/Duals_Workgroup/Dual_Eligible_Beneficiaries_Workgroup_Meetings.aspx

- DREDF & National Senior Citizens Law Center – "Identifying and Selecting LTSS Outcome Measures

_http://dredf.org/2013-documents/Guide-LTSS-Outcome-Measures.pdf

Federal Disability Laws and Managed Care

ADA Title III

- Scope of coverage (42 *U.S.C.*, § 12181(7)(F)).
- Failure to make reasonable accommodations and policy modifications
- Failure to provide auxiliary aids and services
- Readily achievable removal of architectural barriers

Federal Disability Laws: **ADA Title II**

When a state or local government entity enters a contract with any private entity to provide an aid, benefit, or service of the state or local government, the government entity must ensure that the contractual functions are carried out in compliance with Title II of the ADA. *See* 28 *CFR,* § 35.102 and Appendix B to Title II: "All governmental activities of public entities are covered, even if they are carried out by contractors. For example, a State is obligated by title II to ensure that the services, programs, and activities of a State park inn operated under contract by a private entity are in compliance with title II's requirements."

Federal Disability Laws: **Section 504 of the Rehabilitation Act of 1973**

- Scope of coverage – state Medicaid agencies, corporate and non-profit MCOs, contracting provider groups and individual providers.

- Cannot directly, or through contractual arrangements, "provide any aid, benefit, or service that denies people with disabilities the opportunity to participate in or benefit from Medicaid, affords people with disabilities an opportunity to participate in or benefit from health care services that are not equal to that afforded others, or provides people with disabilities an aid, benefit or service that is not as effective as that provided to others." 45 *CFR,* §84.4(b)(1)(i), (ii), (iii)

- Federal financial aid recipients are also prohibited from using methods of administration "that have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the recipient's program or activity with respect to handicapped persons." See 45 *CFR,* § 84.4(b)(4).

ACA Non-discrimination Provision

§1557 (42 U.S.C. § 18116) provides Individually Enforceable new authority to prohibit discrimination against individuals with disabilities in applying for health insurance and accessing healthcare services.

Applies Civil Rights Act, Age Discrimination Act, and Rehab Act to any health program or activity which:

1)receives Federal financial assistance, including credits, subsidies, or contracts of insurance; 2) is administered by an Executive Agency; or 3) any entity established under Title I of the ACA (i.e. The Health care Marketplace/exchanges).

Non-discrimination provisions continued

- §1302(b)(4)(B) the Secretary shall "not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in a way that discriminates against individuals because of age, disability, or length of life."
- (b)(4)(C) the Secretary shall "take into account the health care needs of diverse segments of the population, including women, children, people with disabilities and other groups."
- Implications for data collection

Non-discrimination provisions, continued

- (b)(4)(D) the Secretary shall ensure “that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individual’s age, expected length of life, or the individual’s present or predicted disability, degree of medical dependency or quality of life.”
- Lost opportunity for EHB – entrenchment of historical discrimination in marketplace “benchmark plans”

U.S. HHS seeks comments on Anti-discrimination regulations

No proposed rules yet: but seek comments on:

* benefits and barriers for people with disabilities and LEP accessing electronic info on health programs;

* Effectiveness of health entity self-evaluations and other forms of anti-discrimination enforcement

Full text of HHS-OCR's Request for Information is at: http://www.hhs.gov/ocr/civilrights/understanding/section1557/bulletin-1557.pdf