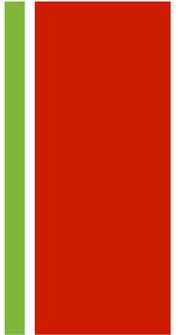


Civil Rights Protections & Managed Long- Term Services and Supports





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

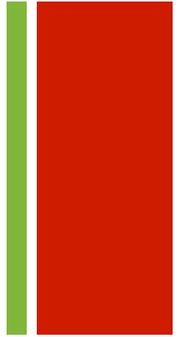
Aging and Disability Partnership

for Managed Long-Term Services and Supports

www.mltssnetwork.org



National Disability Rights Network (NDRN)

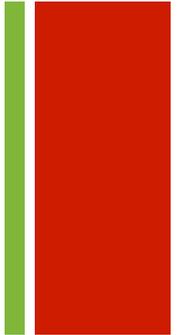


NDRN is the membership organization for the federally mandated Protection and Advocacy (P&A) Systems and Client Assistance Programs (CAP) network.

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



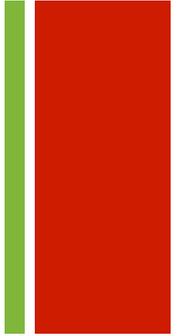
- Closed Captioning is available by pressing Control and F8 on your computers (or select “show closed captioning” from the “Window” drop down menu in your tool bar)
- We will stop periodically for questions, which can be submitted through the chat function on your computer
- a transcript and audio of 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 website at www.dredf.org



Aging and Disability Partnership

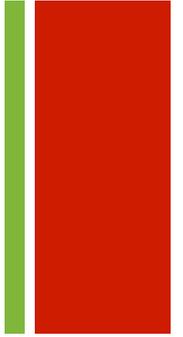
for Managed Long-Term Services and Supports

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Overview of Presentation

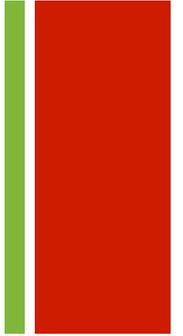
- Review - managed care basics
- Common MLTSS concerns & practical solutions
- Medicaid & Medicare non-discrimination provisions
- Federal disability rights and accessibility provisions (ADA/504/ACA)
- *Olmstead* - implications for MLTSS



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



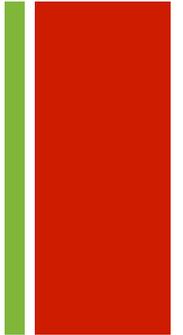
Medicaid MLTSS funding

- 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

MLTSS and State Medicaid Integration

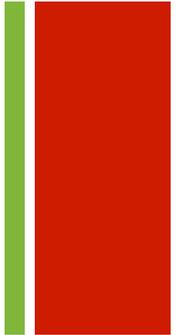
- Currently fewer than 390,000 people, < 10% of Medicaid LTSS users, are enrolled in capitated managed care
- Change is imminent
- States engaged in/pursuing Medicaid managed LTSS: AZ, HI, KS, NM, PA, TN
- Both Medicaid Managed LTSS and Medicare-Medicaid Coordination Initiative (duals): CA, DE, FL, IL, MA, MI, MN, NH, NJ, NY, NC, OH, TX, WA, WI

+ Concerns for People with Disabilities



- Lack of experience with LTSS and behavioral health
- Lack of experience with people with chronic conditions
- Provider incentives (withholds, bonuses) that might create disincentive to serving people with disabilities
- Performance measurement focus on acute care treatment outcomes not QOL, inclusion, self-direction, 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

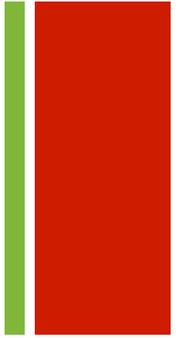
+ Real People—Real Problems (California SPD 1115 waiver – 2012)



■ Marta

- 61 y/o living in Los Angeles
- Rheumatoid arthritis
- Wheelchair user; needs assistance w/ all ADLs
- Needs regular cortisone shots
- Continuity of care request initially denied; then approved for 3 months instead of 12
- Couldn't get needed injections
- Couldn't get expedited appeal

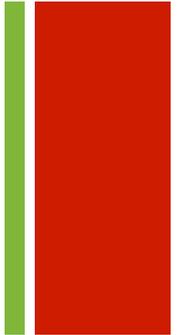
+ Real People—Real Problems (California SPD 1115 waiver – 2012)



■ Marline

- 62 y/o; Santa Monica; SSI
- Thyroid cancer; severe radiation damage; numbness, neurological problems
- Continuity of care request unsuccessful
- Unable to see physicians approved by plan for 6 months
- No access to transit; specialists – 100 miles r/t
- Went w/out care for 6 months

+ Lessons Learned



- The implementation process did not provide beneficiaries with sufficient time or information to make informed choice about plans
- Many beneficiaries lost long-standing relationships with their providers
- There have been disruptions in care or changes in treatment

+ Practical Solutions

- Phased-in enrollment over time with brake mechanisms
- Mandate plan relationships with community-based provider and advocacy consumer organizations
- Additional LTSS assessment, provider network, continuity of care, and out-of-network care managed care standards suitable for populations with chronic conditions and disabilities
- Individual, independent assistance with relevant grievance, complaint and appeal mechanisms
- Capitation and reimbursement rates that incentivize de-institutionalization and appropriate HCBS levels
- LTSS-specific quality measures and quality improvement based on real-time monitoring



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>

+ 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

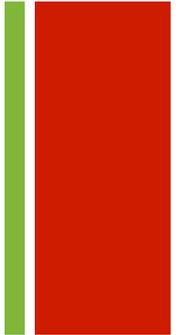
- “Medical assistance” must be provided statewide and States must use reasonable standards for determining eligibility and the extent of medical assistance
 - “Amount, duration and scope” of service must be sufficient to achieve its purpose
 - No discrimination based on condition (for mandatory - not 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



Interaction of Common MCO Regulation & Non-discrimination

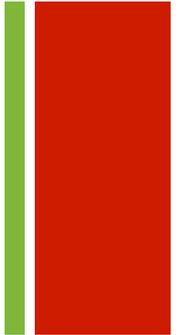


- Adequate capacity and services – often manifested as “time and distance” standards
E.g., “a network primary care provider must be available within 10 miles or 30 minutes”
- Does the standard encompass physical and programmatic accessibility?
- Is it 30 minutes by public transportation?
- Are necessary specialists covered by the same criteria?
- Does the network include critical specialty treatment centers?



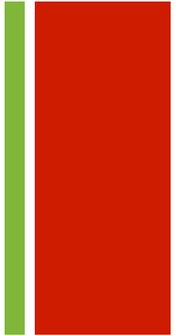
Medicare: Managed Care Non-discrimination Requirements 42 CFR 422.110, 422.2268(c), 423.2268(c)

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 many states to delegate Medicaid service and administration to MCOs, but MCOs have little experience with people with disabilities and chronic conditions, LTSS, and federal and state disability discrimination laws.

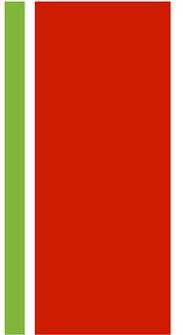
LTSS Components in Medicare

Medicare does NOT cover:

- 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

+ Federal Disability Laws and Managed Care

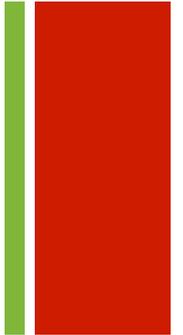


ADA Title III

- 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).

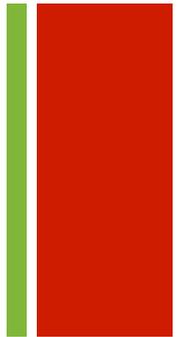


ACA Non-discrimination Provision

§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”



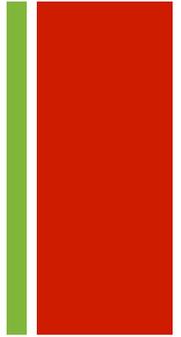
U.S. HHS seeks comments on Anti-discrimination regulations

No proposed rules yet: but seek comments on:

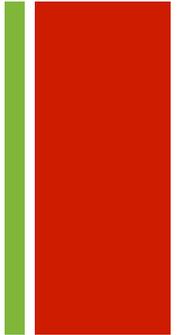
- * benefits and barriers for people with disabilities and LEP accessing electronic info on health programs;
- * Effectiveness of health entity self-evaluations and other forms of anti-discrimination enforcement

Summary and a link to the full text of HHS-OCR's Request for Information is at:

<http://www.hhs.gov/ocr/civilrights/understanding/section1557/bulletin-1557.pdf>



The ADA



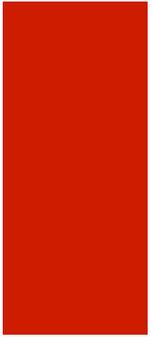
ADA: “No qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.” 42 U.S.C. § 12132.7

DOJ regulation on this provision: (**the integration mandate**): Persons with disabilities must receive services in the most integrated setting appropriate to their needs. 28 C.F.R. § 35.130(d)

- Limitation: ADA requires reasonable modifications to avoid discrimination not fundamental alterations to the nature of the program



After Olmstead We Expected



- A shift of residents and Medicaid and state dollars from institutions to community
- A vast new array of HCBS options
- A “community bias” within Medicaid
- The downsizing and closure of institutions

Olmstead – Relationship to Medicaid LTSS

- The Olmstead decision did not change Medicaid law – rather it establishes that state Medicaid programs must operate in ways that comply with Olmstead.
- More than half of the cost of LTSS today is financed by Medicaid
- Some inherent tensions between the Olmstead mandate and the manner in which Medicaid funds LTSS:
 - an institutional bias;
 - reliance on HCBS waivers – not state plan services
 - funded based on setting and not services provided; and
 - bias towards medical orientation not whether service enables individuals to participate in the community.

+ Olmstead Discrimination and Medicaid

- Providing services beyond what a state currently provides under Medicaid may not cause a fundamental alteration, and the ADA may require states to provide those services, under certain circumstances.
 - Expansion of waiver slots – rarely required
 - Lifting of caps on service hours – several “aging out” cases
 - barring cutbacks of their Medicaid HCBS – mixed
- Method of Administration – leads to preference for institution over community – challenges to these policies largely successful

Olmstead – enforcement

- DOJ has found Olmstead violations can include inadequate: assessments, discharge plans, and educ. about HCBS.
- Case law clarifies that Olmstead Requires most integrated setting not just more integrated setting

Most Olmstead settlements, require:

- Supported individualized housing, as well as group homes;
- Assessment, transition planning and community follow-up;
- Assertive community treatment (ACT) case-management, peer supports, consumer directed supports and crisis services
- More funding for supported employment not “sheltered work”
- Diversion process for people at risk of entering facilities
- Enhanced quality management and data collection; and
- Court monitoring and enforceability

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