From:	Wallace, Thomas J.
To:	Collins, Trey
Subject:	FW: 2022 SMMC Re-Procurement
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Attachments:	SLC & NW SMMC Reprocurement Comments.pdf

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Sent: Friday, June 3, 2022 9:19 AM
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Cc: Chelsea Dunn <Chelsea.dunn@southernlegal.org>; Nancy Wright <newright.law@gmail.com>
Subject: Re: 2022 SMMC Re-Procurement

Dear Secretary Marstiller and Deputy Secretary Wallace:

Attached please find comments from attorneys Chelsea Dunn and Nancy Wright regarding consumer input into the re-procurement process.

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Re: 2022 SMMC Re-Procurement

Dear Secretary Marstiller and Deputy Secretary Wallace:

On May 6, 2022, AHCA released a Request For Information on the re-procurement of managed care plans for the Statewide Medicaid Managed Care (SMMC) program. AHCA stated that its goal was to make information publicly available and engage with stakeholders. The RFI is seeking, among other things, information regarding best practices, maximizing home and community-based services and placement, improved coordination of care, improved recipient experience and timely access to providers and services. All this information is important to providing better care for SMMC program clients. As advocates for Medicaid beneficiaries who are enrolled in Medicaid managed care, particularly the Long-Term Care Waiver, we would like to offer the perspective of the enrollees we have represented and issues that we have seen over the course of this

program that still need to be addressed. We would appreciate an opportunity to talk to you about the problems we are seeing and the best ways we can work together for solutions.

I. Problems Encountered by Enrollees Across Plans

A. Improvement of the Care Planning Process

Federal law requires a person-centered care planning process that puts the beneficiary and people selected by the beneficiary in the lead. However, the whole process falls apart if the beneficiary is not given enough information to make decisions, is not given time to read or amend the Care Plan, and does not have a case manager who is acting as an advocate. Here are some of the consistent problems, across plans, that enrollees encounter:

1. Enrollees do not understand the differences between services. These services are poorly explained in Member Handbooks and online. A request for the "wrong" service (like Adult Companion when the person needs hands-on care) can lead to months of delays after denials and appeals.
2. Numerous caregivers and clients have told us that they tell case managers that more services are needed but are advised by the case manager that there is no point in making the request because it will not be granted, the request is just never submitted, or the request is submitted for the wrong amount or wrong service. In several cases, counsel made a request in writing after there was no movement by the case manager; the plan then advised that they did not accept written requests. In another case, the enrollee was told that the submission had to come through a physician, even though the request was for an unskilled service. Enrollees must have the option of submitting written requests and being able to document the need. The Member Handbook should include information on where to fax, email or mail the request and it should be provided through the Plan help line. The Handbook and Helpline should also direct enrollees what to do if a case manager is not responding and where to make a complaint.
3. Care Plans are written on confusing spreadsheets that are difficult to understand. Some plans ask enrollees to sign the plans on tablets where only the signature line is seen. It is rare that we speak to a client who has even seen a copy of their Care Plan. Enrollees do not understand that they can challenge an inadequate Care Plan.
4. Case managers are not acting as advocates for their clients. There is an inherent conflict of interest with case managers who are employed by the plans. Short of moving to a system where case managers are independent of plans, this is likely to continue. However, in a system without advocates, AHCA needs to consider the need for an HCBS Ombudsmen program.
5. Case managers are not always completing the LTC supplemental assessment. When it is completed, case managers inaccurately report the existence of "natural support" without the understanding or consent of the "natural support." As this support is voluntary, if the plan intends to use them as part of the enrollee's care plan, the support must be willing and able to provide the care and commit to doing so.

B. Service Denials and Challenges

1. When a case manager fails to submit a request, no notice is issued. This results in long delays without adequate service and no understanding by the enrollee of how to challenge the lack of movement.

2. Notices issued by the plans never check off the part of "medical necessity" that the plan believes has not been met.[1] Most also fail to provide individualized reasons for a denial, termination or reduction. An example from many Sunshine Health Notices of Adverse Benefit Determination: "Based on the assessment, the member's currently approved services are adequate to meet the member's care needs." An example of a United Healthcare Notice: "You have asked for XX hours of help in the home. Your care plan for help his based on how much help you need. Based on our evaluation you need outside help for YY hours a week." The enrollee has no idea how to challenge such statements or determine if a mistake was made. In addition, if the reason for a denial is that a requested service is not the less costly, the plan should be required to state which service it believes is less costly and therefore, medically necessary.

3. Federal and state law (and Notices) provide that an enrollee can get a copy of their case file to review when an appeal or fair hearing is requested. Enrollees (and counsel) who request their case file do not receive it, receive it very late, or receive an incomplete file. This prevents them from being able to effectively prepare a case, or even understand if it is worthwhile to pursue a challenge.

4. The AHCA Fair Hearing system is set up to use the plan Notice to define the parameters of the case. However, the Notice itself may inaccurately set out the request. Enrollees should be able to challenge this. In addition, in cases where the "wrong" service is under dispute, the enrollee should immediately be informed of the mistake and be allowed to pursue at the same hearing a request for the "correct" service. The plan is responsible for providing the appropriate "array" of services to meet the needs.

C. Service Issues

1. There are plan internal policies that are more restrictive than State and federal requirements (e.g., Sunshine's policy on Home-delivered Meals)

2. Enrollees are being told to go to an Assisted Living Facility (ALF) or Nursing Home if they need more services.

3. ALFs are given flat monthly fees by plans for LTC Waiver enrollees, regardless of care needs. Unlike the State's capitated payments to plans for managed care, monthly

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[1] Whether it fails to "(i) be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs; (ii) be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; (iii) be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

payments to ALFs cannot be dispersed among clients. Clients who need more help are not adequately provided for under this arrangement.

4. Plans do not have an adequate network of providers or facilities for TBI and ventilator patients.

5. Pay rate for direct care staff (including attendant care or private duty nursing) is non-competitive.

6. Enrollees often do not have sufficient staffing for authorized hours. Voluntary caregivers are being told that they must act as back up for agency care, even nursing care, or the agencies will not take the case. These caregivers then end up doing multiple care shifts when agency staff do not show up. One caregiver worked over 60 hours in a row on consecutive weeks.

D. Coordination of Benefits and Transitions

1. When an HCBS Waiver enrollee or child turning 21 transitions to the LTC Waiver, or there is a transition between one plan to another, the enrollee should be allowed to have services continue pending a challenge to the new plan's decision on services. The failure to assure this resulted in one client who was quadriplegic being reduced from 24/7 medically necessary services to less than 30 hours a week, which was life-threatening.

2. There is a system-wide lack of coordination of benefits, even between LTC and MMA divisions of the same plans. This problem goes beyond managed care and causes long delays or denials of services in every Medicaid program.

II. Steps AHCA Could Take to Address these Problems in the Re-procurement Process

A. Revise the Contracts for Managed Care Plans

We believe the re-procurement process is an ideal time to address some of the above listed concerns, as AHCA will be entering into new contracts with Managed Care Plans. The new contracts could include provisions that address many of the issues our clients experience as they navigate the process of obtaining HCBS through these plans, including but not limited to the following:

1. Require plans to accurately and adequately describe services in Member Handbook consistent with the definitions provided to CMS and set out in the LTC Waiver Coverage Policy. If it is apparent that the enrollee is making a request for the wrong type of service, but a different service is appropriate to meet their needs, the plan must treat the request as a request for that service.

2. Require plans to give enrollees the option of submitting written requests and document the need for services. The Member Handbook should include information on where to fax, email or mail the request and it should be provided through the plan help line. The Handbook and Helpline should also direct enrollees what to do if a case manager is not responding and where to make a complaint.

3. Require plans to provide Care Plans to enrollees in a version that they can understand. The Member Handbook must explain how a member can challenge an inadequate care plan.

4. Require plans/case managers to submit every verbal request for additional or increased services in order to trigger the written notice requirement and allow an enrollee to appeal the denial.

5. Require plans to specifically identify which part of medical necessity has not been met when a service is denied.

6. Require all plan internal policies to be consistent with state and federal law.

7. Require plans to provide payments to ALFs to properly provide for individuals based on their care needs.

8. For enrollees transitioning into the LTC plan at age 21 whose services are being reduced or denied, transitioning between plans, or transitioning from another HCBS Waiver, require that plans continue services at the same level while this decision is being appealed.

B. Training & Policy Changes

AHCA could use this re-procurement to implement and improve the training for plan staff, including but not limited to training on the following topics:

1. Train case managers on completing the LTC Supplemental Assessment.
2. Train appropriate plan staff on how to provide a sufficiently individualized description of why services are being denied, reduced, or terminated in the written notice.
3. Train appropriate plan staff on *Olmstead* requirements so enrollees are not advised to enter more restrictive residential settings when more services are required to keep an enrollee in their home and community.
4. Train case managers on coordination of benefits, including Medicare, State Plan Medicaid or MMA coverage, and iBudget.

Additionally, ACHA could implement three policies to greatly improve the consumer experience, including:

1. Providing incentives to increase the network of providers and facilities for patients with TBI and ventilator patients.
2. Allow a Fair Hearing related to a denial of services to address the entire “array” of services the enrollee is receiving and any potentially appropriate additional services even if not those described in the request.
3. Establish an HCBS ombudsman to take calls/complaints from consumers.

We greatly appreciate your consideration of the issues we have raised around the provision of Home and Community Based services by Florida's SMMC Plans, and our suggestions for how AHCA could use the re-procurement process to address these issues. We look forward to continuing this discussion and may be contacted as described below.

Sincerely,

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