



FLORIDA HEALTH JUSTICE PROJECT

Comments regarding Florida's 1915(b)(c) Long-term Care (LTC) Waiver Renewal Sent via email to FLMedicaidWaivers@ahca.myflorida.com

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Thank you for the opportunity to submit comments on the Medicaid Agency's Proposed Renewal to Florida's 1915(b)(c) LTC Waiver.

The Florida Health Justice Project (FHJP) is a nonprofit health advocacy organization whose mission is expanding access to healthcare with a focus on Florida's most vulnerable populations. Accordingly, we have prioritized work on behalf of low-income frail and disabled seniors who require home and community-based services (HCBS) in order to remain safely at home and out of an institution.

Among other things, FHJP has published an *Advocates' Guide to the Long-Term Care Waiver*, see <https://www.floridahealthjustice.org/guide-to-long-term-care-medicaid-waiver.html> (now in its 4th edition) and a consumer video, see <https://www.floridahealthjustice.org/medicaid-hcbs.html> that explains this complex and critical program for vulnerable Floridians and their families. We also provide trainings and technical assistance to other advocates and work with individuals who wish to share their stories underscoring the lack of resources in this critically underfunded program. See <https://www.floridahealthstories.org/long-term-care>. In the course of this work we have heard from numerous stakeholders who have first hand experience with the LTC Waiver.

At the outset, and on behalf of our clients, storytellers and the other needy Floridians who rely on the LTC Waiver, we extend heartfelt thanks to the hard working and dedicated staff who help to administer the program. We also want to express gratitude for the increased number of individuals who will receive LTC waiver services—notably, the number of unduplicated recipients went from 75,698 in 2017 to 115,989 in year five (5) of the renewal request.

Our comments, questions, concerns, and requests are below.

Development of care plan; over reliance on natural supports and monitoring due process rights

The language pertaining to the duties of the case manager in providing for the personal centered plan of care and ensuring due process rights is appropriate and admirable. *See* 1915(c) application for renewal at 44, 174-80. We appreciate the focus in the application renewal on the identification of an individual’s needs, input from their support system, and the focus on personal goals. We agree that it is important that the “entire care planning process is to be documented in the case record” (174) and that if the individual disagrees, the case manager must provide the individual with a written Notice of Adverse Benefit Determination that explains the right to appeal and assist the enrollee with filing the appeal. We also support the focus on choice, including choice of services, providers, and services from among the array of settings, including non-disability specific settings. We believe these features are consistent with the person centered planning rules at 42 C.F.R. § 441.301(c)(1).

However, in addition to first hand experiences of our clients and storytellers, FHJP also receives anecdotal reports from social workers and elder law attorneys who work with new enrollees that this is not the standard practice. Instead, new enrollees are told that they can only get a limited amount of services (e.g. fewer hours of home care than what was prescribed by treating physician); their right to appeal is not explained; and they simply sign the plan believing it represents all the services they are eligible to receive. All of these practices contravene the assurances the State is making in the waiver application, do not conform to the requirements for 1915(c) waivers, and interfere with due process rights.

In order to better ensure that case managers are representing the best interests of the enrollee, including at the care planning stage, we offer the following recommendations:

- 1) Specific survey questions should be sent to new enrollees and their caregivers, asking if new enrollee (or their designated caregiver) understands:
 - a. the full range of services covered by their LTC plan;
 - b. their entitlement to any of these services which are medically necessary;
 - c. that the determination of “medical necessity” must include their treating physician’s recommendations;
 - d. that there cannot be an over reliance on “natural supports” and what that means; and
 - e. that they have the right to appeal any or all of the plan of care presented by the case manager.

- 2) The Aging and Disability Resource Centers (ADRCs), which help individuals gain eligibility, should be funded to provide individual meetings with new enrollees to ensure that the new enrollee (or their caregiver) understands the requirements of the person centered plan of care and all of their appeal rights; and provide contact information for the local legal aid program if the individual wishes to appeal. Simply stating information

regarding care planning and due process rights in the Member Handbook provided by the plan is not sufficient.

3) Issue guidance to the plans regarding the illegality of planning practices that may violate an enrollee's due process rights. *Here is an example from North Carolina detailing what should and should not happen during the person centered planning process, including how the results of an assessment should be used in that process.*

<https://files.nc.gov/ncdhhs/Joint-Communication-Bulletin--J297--LME-MCO-LS-V-Wos-Instruction--002-.pdf>.

4) Similarly, the plan's role in person centered planning and whether those planning processes compel natural supports needs to be addressed through guidance and performance measurement. The planning process does not always take into consideration whether natural supports are able and willing to supplant waiver services. Under the HCBS rule changes in 2014, CMS made it clear that natural supports from family, friends and other caregivers cannot be compelled in lieu of paid waiver supports. The planning process outlined does not clearly set forth a process for evaluating an individual's needs, determining the Medicaid services, including waiver services, available to meet those needs and then asking if natural supports are able and willing to provide those services instead of using Medicaid services. There should be performance measures ensuring such natural supports are not compelled in violation of 42 C.F.R. § 441.301(c)(2)(v).

Additionally, family members who provide the in-home care needed to keep their loved ones safely at home need to be provided with adequate hours in the care plan. As illustrated by the experiences of Thelma and Diwante, this did not happen. *See,*

<https://archive.floridahealthstories.org/thelma> and

<https://archive.floridahealthstories.org/diwantie>.

5) Change the performance measures for person centered planning (see 1915(c) at 183-198). For example, the performance measure of comparing care plans with identified needs (183-4) is not an effective measure when plans are only identifying needs they are willing to provide the services to meet, or are discouraging enrollees from identifying needs for which they cannot get services. We also do not agree that whether a plan is signed or not is a helpful performance measure. Even if the planning process, in practice, matched the planning process described in the waiver renewal, the measure of whether a plan is signed or not only measures administrative tasks and not whether the enrollee is satisfied or truly agrees with the plan. It would be a more effective performance measure to survey enrollee satisfaction with the planning process or their plan of services and whether those individuals have any unmet needs. As described by CMS, the service plan implementation and monitoring section of the waiver is intended to “ensure that waiver services are furnished in accordance with the service plan, meet the participant's needs

and achieve their intended outcome” and are supposed to, among other things, determine whether services are meeting the needs of participants.¹ We would specifically recommend performance measures that will measure overreliance on or the compelling of natural supports and on discouragement of requesting desired waiver services. Based on our experience and that of others representing waiver participants, the State’s quality assurance mechanism are not ensuring that the planning service is, in practice, complying with policies and procedures, or assurances to CMS.

Questions Regarding Rates

Rates for assisted living facilities: The 1915(c) renewal application notes that the state does not make enhanced payments for HCBS services. Related to enhancements, we have 2 questions: is the rate for ALSFs enhanced; and are there supplemental payments to nursing facilities? (*see* pg. 245.)

The rate for assisted living seems high, i.e. \$ 311 per day for year one. (*see* 1915(c) at 256). This would make the cost of an ALF greater than that of a nursing facility.² What does that daily rate include? It is our understanding that the ALF payment from the MCO does not include room and board. Is that correct? Does the assisted living rate include adult day or are they also sending people to adult day for part of the day?

This rate is also strange because it says that the average ALF recipient only uses 34.45 units. Does that mean that the average ALF service is only approximately a month?

Finally, it is also troubling that more people appear to use ALF services than adult companion. Are more people living in ALFs on this waiver than at home?

Rates for home health aides: There is a current lack of direct care workers due to low wages. Direct care workers, including personal care assistants (PCA), receive between \$10 and \$12/hour.

¹ CMS, 1915(c) Instructions, Technical Guide, and Review Criteria, at 200-201 (Jan. 2019), https://wms-mmdl.cms.gov/WMS/help/35/Instructions_TechnicalGuide_V3.6.pdf.

² *Compare* Statewide Medicaid Managed Care (SMMC) Long-Term Care (LTC) Program Monthly Base Rates for non-HCBS care ranging between approximately \$ 5900 and \$ 6800/month, *see*, https://ahca.myflorida.com/medicaid/Finance/data_analytics/actuarial/docs/LTC_Final_Base_Rates_RY20-21.pdf, with the proposed ALF rate of over \$ 9000/month. Note also that the ALF rate proposed in the renewal application is significantly higher than the rate cited in the current waiver, \$ 189.90/day. *See*, current 1915(c) waiver at 268.

We have questions regarding whether that low pay (which is resulting in workforce shortage and network adequacy violations), is because the rate is too low to be actuarially sufficient, or the medical loss ratio (MLR) requirement is not being enforced? For example, the rate in year 1 for personal care under the renewal is \$ 4.99 per 15-minute increments. This is only a \$ 1.28/hour increase in the rate from Year 5 of the current waiver. (*see* current Waiver at 270). We understand that there is a credibility adjustment factor in Medicaid managed care plans, but assuming there is approximately an 80% MLR requirement, shouldn't PCA workers be getting at least \$ 15-16/hour? What is happening to the \$ 8-10/hour that is allocated to that service and not going to the worker? (*see* 1915(c) renewal request at 255.). How much is kept by the MCO? How much is kept by the agency employing or contracting with the PCA? Regardless, the rate is insufficient (both under the current waiver and in the waiver renewal) for waiver participants to find appropriate and sufficient home health aides and this needs to be addressed in the waiver amendment. *See, e.g.* story of [Alene Shaheed](#).

Additionally the lack of sufficient rates for in-home services creates a bias to more congregate placements. This is contrary to the intent of the HCBS Waiver program.

Subscriber assistance program

Why is it referenced? It is our understanding that the state statute authorizing it was repealed. *See* 1915(c) at 214.

Notices and fair hearing rights

The language in the fair hearing right section of the renewal is excellent. *See* 1915(c), Appendix Appendix F-1: Opportunity to Request a Fair Hearing at 212.

However, the number of enrollees who receive free legal services assistance in pursuing an appeal is *de minimis*.

We would urge that the state amend the template Notice of Adverse Benefit Determination that plans are required to use to include reference to the availability of free legal assistance and a link to local legal aid providers, as well as to the Florida Health Justice Project.

Independent assessments

We are puzzled that the 1915(b) renewal request twice states that the Agency does not intend to continue the contract for additional independent assessments. *See* 1915(b) at 24 and 47.

There are serious consumer concerns with the LTC waiver. Rather than discontinue independent assessments, they should be expanded, and the research questions tailored more to specifically ascertain if people are receiving the HCBS services they need. Moreover, these reviews should be annual and consumer advocates should be involved in developing the questions and reviewing the results.

Network Adequacy

As noted above in our comment regarding the 1915(c) rates, there are significant issues with network adequacy. FHJP clients and storytellers who are bedridden, or wheelchair bound and need help with basic activities of daily living like bathing and changing, are being left alone for days. *See*, for example, the stories Shirley Green (<https://archive.floridahealthstories.org/shirley>) and Alene Shaheed, <https://archive.floridahealthstories.org/alene-ltc-2>

The state's desk review of provider networks by looking at provider directories (*see* 1915(b) at 58, does not give an accurate picture of this issue. We would suggest that secret shopper surveys of local home health care providers be conducted to determine if providers are able to staff aides, particularly on the weekend. As Alene Shaheed described, she called all of the home health agencies in Jacksonville to find a weekend aide (her case manager said she had tried and been unable to find one); they all told her that they could not take on additional Medicaid patients because the rate was too low. *see* <https://archive.floridahealthstories.org/alene-ltc-2>.

We urge the Agency to use recent ARPA funding to do a full review of HCBS network adequacy and rate sufficiency, including using some of the approaches suggested by CMS for HCBS rate sufficiency, available at <https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-training-series/index.html>.

Ombudsman

The 1915(b) renewal application indicates that Florida's LETC Waiver has an Ombudsman program, "the Independent Consumer Support Program (ICSP)." *See* page 47-section k.

However, the advocates, and clients we have worked with are totally unaware of this program. Moreover, the description of this program does not meet the requirements for the required beneficiary support system for LTSS managed care at 42 C.F.R. § 438.71. It is not clear from the description that the ICSP performs outreach to enrollees and potential enrollees, or that it provides meaningful assistance with education on enrollee rights and navigating the grievance and appeal process.

Importantly, the description does not reflect a role, nor have we seen any of the results of, the ICSP reviewing data or otherwise providing guidance on identification, remediation, and resolution of systemic issues. While the renewal states that the ICSP participates in problem solving and taking complaints, there is a significant difference in resolving complaints versus helping an individual understand their right to grieve or appeal, and providing a degree of assistance in navigating that process, even short of representation which we acknowledge is not an allowable function of a beneficiary support system under the regulation. However, there is significant room for coordination between the functions of ICSP and the services available from legal services and other advocacy organizations. There should be a coordinated effort between DOEA, Medicaid complaint hub officials and consumer organizations such as Florida Health Justice Project to ensure that there is increased awareness of this resource.

Data regarding client complaints

The only data regarding enrollee complaints and concerns is confusing. The title, which is difficult to read, appears to be “Quarterly the Independent Consumer Support Program” report and it only reflects one quarter of complaints, apparently to the ICSP. The number of complaints, (with the exception of eligibility, which the ADRCs are involved with) is not reflective of the reality of complaints/ concerns.

We believe it is important to include reports of all complaints and appeals, including those that go to the AHCA complaint hub and the AHCA office of fair hearings and appeals. *See* 1915 (b) at 59.

Performance Improvement Projects (PIPS)

Why is this waiver looking at improving birth outcomes? Who in the current LTC waiver population would be impacted? *See* 1915 (b) at 60.

Conclusion

Thank you for the opportunity to submit comments. Please do not hesitate to contact me if you have any questions. It is my understanding that there is not a federal comment period. Thus, we are respectfully copying CMS officials.

We look forward to hearing from you and working with you.

Respectfully submitted,

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