

# State Medicaid Cases: Trends and Challenges

Eric Carlson, Directing Attorney

Anna Rich, Staff Attorney

Evin Isaacson, Borchard Law and Aging Fellow  
National Senior Citizens Law Center

Jessica Hiemenz

National Consumer Law Center

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**NSCLC**  
National Senior Citizens Law Center

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- Access articles and resources

## Presenter – Eric Carlson



- An attorney for the National Senior Citizens Law Center (NSCLC), has specialized in long-term care since 1990.
- His fields of expertise include facility-based long-term care (nursing homes and assisted living facilities), along with community-based services and the Medicaid programs that help pay for them.
- He counsels attorneys and others from across the country, and co-counsels cases on behalf of consumers.

## Presenter – Anna Rich



- An attorney for NSCLC since 2006, provides advocacy and technical assistance to advocates on Medicare and Medicaid for low-income seniors and people with disabilities.
- She has represented plaintiffs in federal class action litigation to defend access to prescription drug benefits, Social Security and SSI, in-home care, and other home and community based services.

## Presenter – Evin Isaacson



- Is a 2011-2012 Borchard Law and Aging Fellow at NSCLC.
- Her project is focused on using litigation and advocacy to preserve and improve senior access to Medicaid home and community-based services in hostile budget climates.
- She is a recent graduate of Harvard Law School (cum laude) and previously worked for the Service Employees International Union as a long-term care industry/policy analyst and legislative advocate.



# NSCLC

**National Senior Citizens Law Center**

Protecting the Rights of Low-Income Older Adults

February 29, 2012

# State Medicaid Cases

## Trends and Challenges

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Eric Carlson  
Anna Rich  
Evin Isaacson



The top of the slide features a collage of five blue-tinted photographs. From left to right: a woman's face, two people in a doorway, a woman holding a cat, an elderly man's face, and two elderly women embracing. The NSCLC logo is overlaid on the first photo.

# NSCLC

National Senior Citizens Law Center

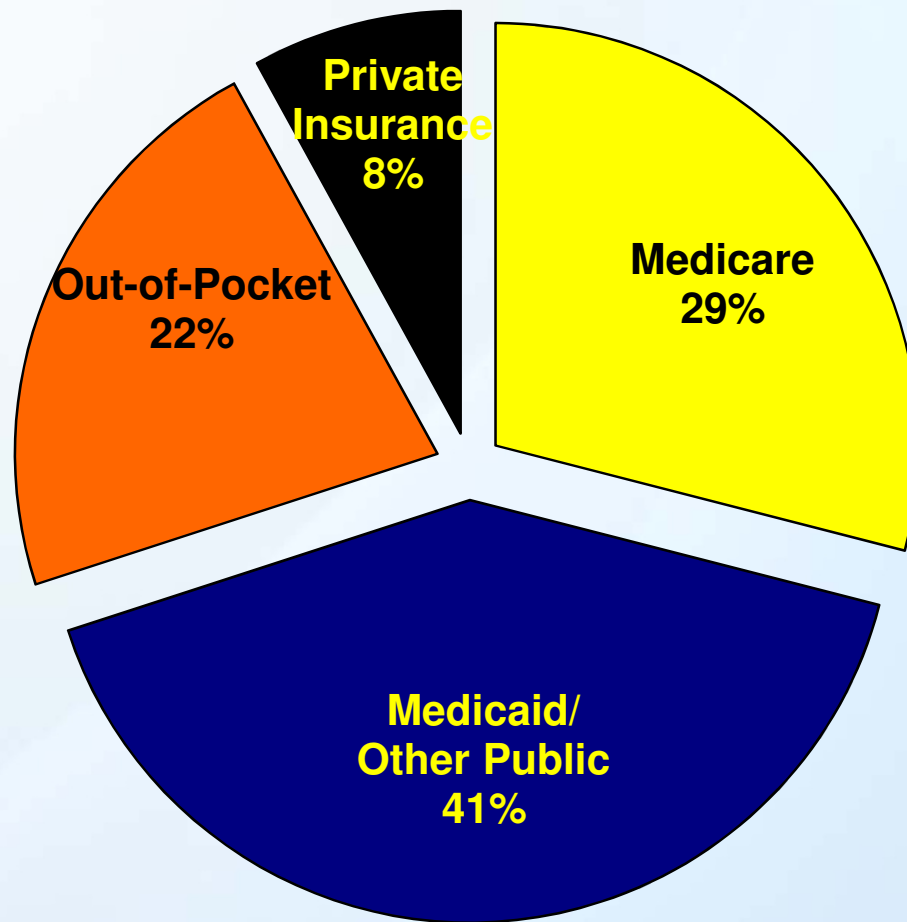
*The National Senior Citizens Law Center is a non-profit organization whose principal mission is to protect the rights of low-income older adults. Through advocacy, litigation, and the education and counseling of local advocates, we seek to ensure the health and economic security of those with limited income and resources, and access to the courts for all. For more information, visit our Web site at [www.NSCLC.org](http://www.NSCLC.org).*



# Webinar Roadmap

- Medicaid HCBS Basics
- Key Threats
- Legal Protections
- Litigation Case Studies
- Paradigm Shift: Medicaid Managed Care

# Total US Long-Term Care (LTC) Expenditures, 2011 \$221 billion



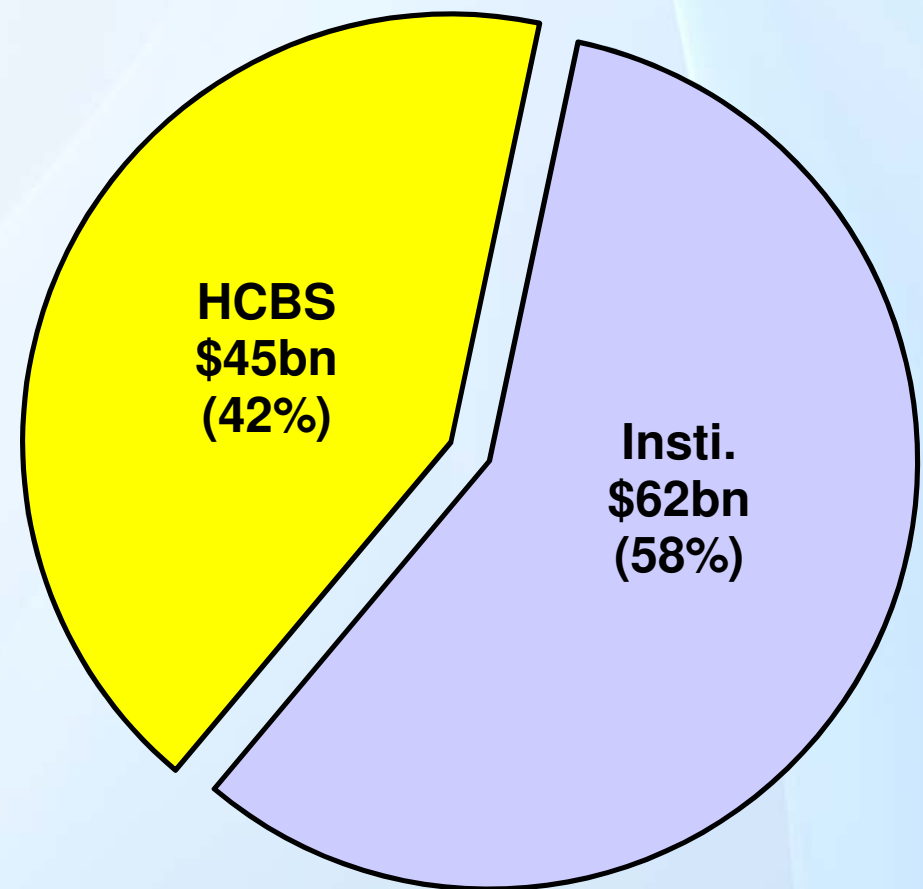
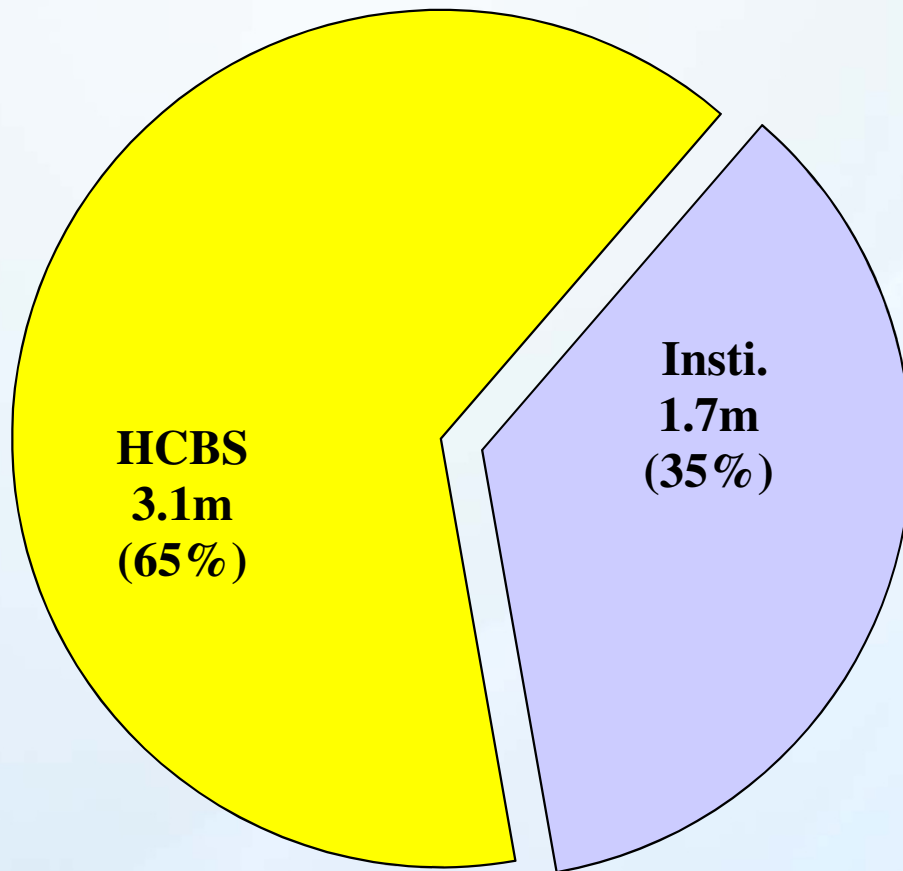
# Medicaid Long Term Services and Supports (LTSS)

- Medicaid:
  - America's Health Care Safety-Net
  - joint state/federal program
  - primary payer for LTC
- Medicaid LTSS Services:
  - Nursing Home (Medicare = max 90 days)
  - Home and Community-Based Services (HCBS):
    - Home Health, Personal Care Services (PCS), Adult Day (Health) Care, Homemaker Services, etc.

# The Institutional Bias in Medicaid LTC, 2008

Participants: 4.8 million

Expenditures: \$107 billion



Source: HCBS (Ng and Harrington, 2011), Institutional (CMS Form 64 Data, Medstat 2010; MSIS 2008 Data)

# Medicaid-Funded LTSS

	State Plan Services (statewide entitlement)	HCBS/1915(c) Waiver Services (permits geo/diagnostic targets, enrollment caps)	Managed Care (1915(a),(b) waivers; 1932(a) SP; 1115 demo)
Mandatory	<ul style="list-style-type: none"> <li>Nursing Home (51)</li> <li>Home Health (51)</li> </ul>		---
Optional	<ul style="list-style-type: none"> <li>Personal Care (32*)</li> <li>Adult Day Care</li> </ul> <p>New:</p> <ul style="list-style-type: none"> <li>1915(i): HCBS+</li> <li>1915(j): Self-Dir. Personal Asst.</li> <li>1915(k): Comm. First Choice Option</li> </ul>	<ul style="list-style-type: none"> <li>Personal Care</li> <li>Home Health</li> <li>Adult Day Care</li> <li>Case Management</li> <li>Homemaker</li> <li>Respite</li> <li>Home Mod., etc.</li> </ul> <p>(283 waivers; 49 states**)</p>	varies by waiver/ authority***

Optional Services = Easy Targets

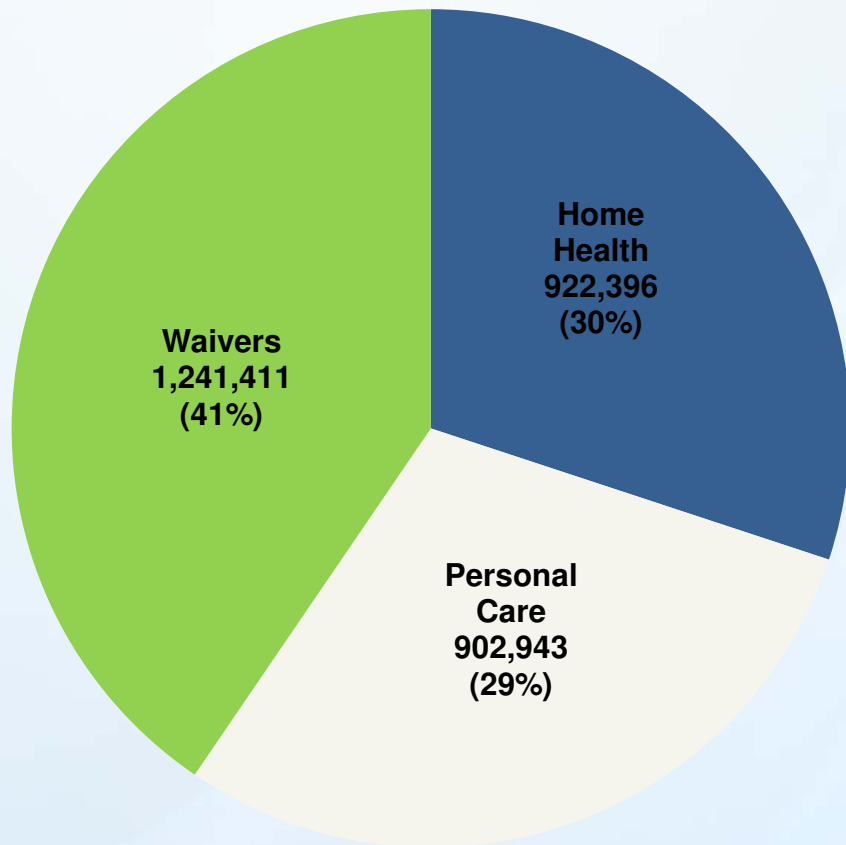
\*2010 figures, UCSF Annual Survey

\*\* 2008 figures, CMS Form 372 Reports

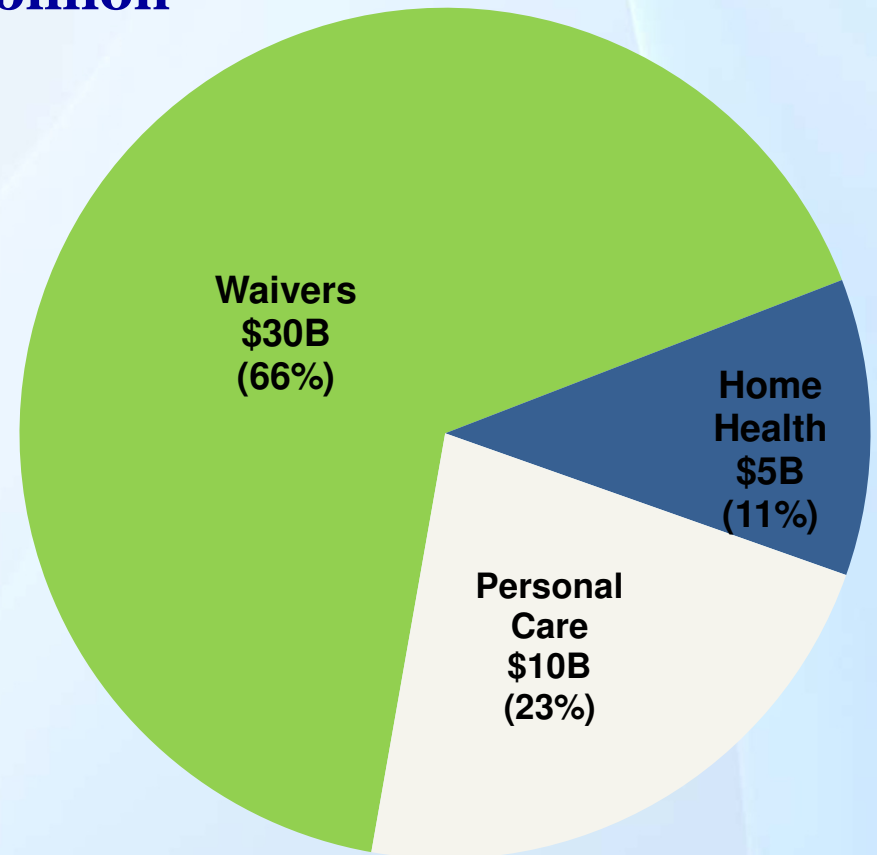
\*\*\* VT and AZ use 1115 managed care waiver & RI started in 2009 (courtesy of C. Harrington)

# Medicaid HCBS Participants & Expenditures by Program, 2008

**Total Participants: 3.07 million**



**Total Expenditures: \$45 billion**





# Budget-Driven Trends that Threaten HCBS

- Benefit and Service Reductions/Caps
- Eligibility Restrictions
- Service Eliminations
- Shift to Managed Care
- Others:
  - state plan → waiver; cost-sharing; rate reductions; wrongful terminations
  - Others?

# Legal Protections: Medicaid Act

“Once a State voluntarily chooses to participate in Medicaid, the State must comply with the requirements of Title XIX and applicable regulations.”

–*Alexander v. Choate*, 469 US 287, 289 n.1

- “Comparability” Requirement (waiveable)
  - 42 U.S.C. § 1396a(a)(10)(B); 42 C.F.R. § 440.240
- “Reasonable Standards” Requirement
  - 42 U.S.C. § 1396a(a)(17)
- “Amount, Duration and Scope” Requirement
  - 42 C.F.R. § 440.230(b)
- arbitrary denial/reduction based on diagnosis
  - 42 C.F.R. § 440.230(c)

# Legal Protections: Medicaid Act, cont.

- “Reasonable Promptness” Requirement
  - 42 U.S.C. § 1396a(a)(8); 42 C.F.R. § § 435.911, 435.930
- “Equal Access” Requirement
  - 42 U.S.C. § 1396a(a)(30)(A)
- “Federal Approval” Requirement
  - State Plan Services: 42 U.S.C. § 1396a(a); 42 C.F.R. § § 430.12, 430.15, 430.18
  - HCBS Waiver Services: 42 U.S.C. § 1396n(c)(1)
- “Maintenance of Effort” Requirement
  - 42 U.S.C. § 1396a(gg)(1)

# Legal Protections: Due Process

## Requirements:

- adequate, timely prior notice
- opportunity for fair hearing

## Authorities

- U.S. Const.:
  - amend XIV; *Goldberg v. Kelly*, 397 U.S. 254 (1970)
- Medicaid Act:
  - 42 U.S.C. § 1396a(a)(3); 42 C.F.R. §§ 431.200-431.250
- State and Local Statute/Regs

# Legal Protections: Anti-Discrimination Laws

- **Discrimination on the Basis of Disability**
  - Americans with Disabilities Act (ADA) - 42 U.S.C. § 12132
  - Rehabilitation Act - 29 U.S.C. § 794
  - Improper Eligibility Requirements - 28 C.F.R. § 35.130(b)(8) (ADA)
  - Defense : Fundamental Alteration - 28 C.F.R. § 35.130(b)(7) (ADA)
- **Integration Mandate**
  - ADA: 42 U.S.C. § 12132; 28 C.F.R. § 35.130(d)
  - Rehab Act: 29 U.S.C. § 794
  - *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999)
- **State and Local Anti-Discrimination Laws**

# Enforcement

- CMS (Medicaid)
- DOJ (Medicaid and ADA/Rehab)
- HHS OCR (ADA/Rehab)
- Private Litigation
  - 42 U.S.C. § 1983
  - Supremacy Clause



# Brantley v. Maxwell-Jolly

656 F.Supp.2d 1161 (N.D.Cal 2009)

- Challenge to 2009 budget cuts to California's center-based Adult Day Health Care, a Medicaid optional benefit.
  - Across-the-board reduction from 5 to 3 days.
  - District Court found likely violation of ADA.
    - Plaintiffs faced serious risk of institutionalization.
    - Alternative services not identified or in place.

# Cota v. Maxwell-Jolly

688 F.Supp.2d 980 (N.D. Cal. 2010)

- New budget cuts based on more restrictive eligibility criteria, including fewer ADLs/IADLs.
  - New eligibility criteria likely violate Medicaid Act's reasonable standards and comparability requirements.
  - Reduction in qualifying limitations is arbitrary.

# Darling v. Douglas (same CA case, new name)

- State legislature eliminated ADHC state plan benefit entirely, to replace with waiver.
- Funding cut: from \$176.6 in state general funds to just \$85 million for transition and new waiver programs for “highest acuity” participants.

# Darling v. Douglas (same CA case, new name)

- Settlement approved in January 2012.
- ADHC benefit continues to be available as entitlement, but through managed care.
- Advocates negotiated new eligibility standards.

# V.L. v. Wagner

669 F.Supp.2d 1106 (N.D. Cal. 2009)

- Challenged budget cuts to California's personal care services, a Medicaid optional benefit.
  - Court found likelihood of success on ADA, Medicaid Act and due process claims.
  - Reductions in IHSS lead to risk of institutionalization.
  - Elimination of shopping and meal prep type services violates Medicaid sufficiency requirement.

# V.L. v. Wagner

669 F.Supp.2d 1106 (N.D.Cal. 2009)

- Flawed eligibility tools violate Medicaid Act comparability and reasonable standards requirements.
  - Ranks and scores based on ADLs/IADLs and type of need used to reduce services.
    - For instance, would discriminate against those with mental and cognitive impairments.
    - Individualized assessment can't be replaced with mechanical cuts.
- 9<sup>th</sup> Circuit appeal of district court decision is still pending.



# M.R. v. Dreyfus

663 F.3d 1100 (9<sup>th</sup> Cir. 2011)

- Washington state case challenging cuts to personal care services hours.
  - Ninth Circuit held that “serious risk of institutionalization” is sufficient for *Olmstead* claim.
  - Budget concerns not enough for state to make fundamental alteration defense.

# Douglas v. Independent Living Centers

- Recent Supreme Court decision involves challenges to provider rate cuts under 1396a(a)(30)(A), based on Supremacy Clause.
  - CMS acted on state plan amendments after Supreme Court oral argument.
  - SC majority remanded to Ninth Circuit for consideration of impact of availability of APA action following CMS approval.

# Douglas v. Independent Living Centers

- Supreme Court dissent asserted that there is no ability to enforce 30(A) via Supremacy Clause.
- NSCLC webinar March 5 with Dean Erwin Chemerinsky, Supreme Court counsel of record Stephen Berzon, and Federal Rights Project Director Rochelle Bobroff
- <http://www.nsclc.org/index.php/nsclcs-2012-monthly-webinar-series/>

# Observations and Opportunities

- Medicaid Act and Americans with Disabilities Act claims are complementary.
  - Medicaid Act entitlement v. ADA balancing test.
- Senior and disability rights groups provide strong partners.

# Observations and Opportunities

- Defining program eligibility as linked to need strengthens beneficiary protection.
- Medical model v. social model.
- Litigation in a time of scarcity.
  - Optional benefits are optional.

# Observations and Opportunities

- Opportunities for Advocacy
  - With CMS
    - When considering state plan amendments.
    - During waiver creation and renewal.
    - Raise ADA, language access issues.
  - With state legislature.
    - Do real cost-benefit analysis.



# Observations and Opportunities

- Need for compelling stories
- Devil's in the Details w/ MMC contracts

# Thinking About Managed Care in LTSS

- What's the supposed managed care advantage?
  - Coordination of care for more better outcomes and less expense
  - More use of cost-effective HCBS
- What's the downside?
  - Saving money by shorting enrollees on care

# Managed Care Waivers

- Different legal structures:
  - 1115 demonstration waivers
  - 1915(b) waivers

# Section 1115 Demonstration Waivers

- 42 U.S.C. § 1315
- Secretary must examine 3 issues:
  - Project is experimental or demonstration
  - Project is likely to assist in promoting objectives of Medicaid Act
  - Extent and period for which project is necessary
    - *Newton-Nations v. Betlach*, 660 F.3d 370, 380 (9<sup>th</sup> Cir. 2011)

# Other Advocacy Handles

- Un-waived Medicaid statutory provisions
- ADA
  - An advocacy hurdle: Unlike HCBS Waiver application, demonstration waiver application does not demand specific answers to standard questions
    - Back and forth correspondence with CMS may provide some additional details

# New Regs on Public Input in Demonstration Waivers

- 77 Fed. Reg. 11,678 (Feb. 27, 2012)
  - Implementing § 10201(i) of Affordable Care Act

# State Level Review of Demo Waivers

- Application and other documents posted on-line
- Public notice period of at least 30 days
- At least two public hearings, at least 20 days prior to submission of application to CMS

# Federal Level Review of Demo Waivers

- 30-day comment period
- Application and comments posted online (along with special terms and conditions, if and when application approved)
  - Question-and-answer correspondence between state and feds not posted, in order to maintain privacy of deliberations



## e.g., New Jersey

- Submitted demonstration waiver application on 9/9/11
- Almost all N.J. Medicaid would be placed in managed care plans
  - Much of N.J. Medicaid *already* is in managed care

# Claim to Increase Access to HCBS

- Access to services for those
  - Meeting NF level of care requirements, or
  - *At risk* of meeting NF level of care requirements
    - Some ambiguity of how the “at risk” category would be applied
      - N.J. waiver application, pp. 84, 86

# Will MCOs Make Right Decisions re: NF v. HCBS?

- HCBS services limited to “most cost effective placement”
  - Generally no more expensive than NF care, unless
    - Extra expense related to transfer from facility, or
    - Need for excess expense related to condition expected to last no more than six months
      - N.J. waiver application, p. 88

# What If OK'd HCBS Hours Are Inadequate, Due to Expense?

- Either
  - Move into nursing facility, or
  - Stay in HCBS
    - MCO required to enter into “managed risk agreement” with consumer
      - What is a “managed risk agreement”?
        - » Informed consent, or
        - » Waiver of liability
          - Liability waiver never is advisable for consumers

# Losing Entitlement to NF Care, for Better or Worse

- MCOs with authority to require HCBS over NF when more cost-effective
  - N.J. waiver application, p. 88

# Extent of LTSS Determined by MCO Case Manager in NJ

- Compare to IHSS, ADHC litigation based on statutory and regulatory standards

# Can We Trust MCO's Case Management?

- NJ establishes minimum qualifications for case managers
- NJ oversight:
  - MCO gives State an annual case management plan
  - MCO must perform audits and reviews
  - MCO must give state analysis of data, along with Quality Improvement (QI) strategy
    - N.J. waiver application, pp. 89-90

e.g., Florida

- Combining 1915(b) and 1915(c) waivers



# Limits on Waiver Services

- On Florida's 1915(c) waiver application (pp. 123-24), Florida says no limits on waiver services aside from those listed in the description of services.

# Limits Explicitly **Not** Employed in Florida

- These limits not used.
  - Maximum for one or more sets of services.
  - Maximum per enrollee.
  - Assignment to levels with maximum expenditures.

# Service Planning

- Service plans developed by case manager. (Florida application, p. 124)
- In this waiver, OK for case manager to be part of entity that also provides direct waiver services.

# State Review

- Retrospective review
  - Sample sizes range from 32 to 80, depending on plan enrollment.
    - FL 1915(c) Waiver Application, pp. 127.

# Review By Plans

- Quarterly reviews.
  - Various specified review elements.
- Same entity both provides services and monitor service plan implementation, but this is OK b/c State requires that responsibility for monitoring is “independent of any direct waiver services.”
  - FL 1915(c) Waiver Application, p. 128.

# What Are the Standards?

- Compare this deference to care managers to statutory/regulatory standards implicated in litigation discussed earlier
  - “You can trust us” – e.g., recently-filed Idaho litigation where state claimed formula for calculating Medicaid budgets was “trade secret”
- What about professional standards of care for care planning?

# Policy Advocacy Necessary ASAP

- Certain unavoidable downsides to capitated managed care.
  - Some disadvantages avoided through PCCM (Primary Care Case Management)
    - Coordination w/o potentially dangerous incentives of managed care

# How to Influence Care Planning Process

- More beneficiary participation
- Care planning subject to standards
  - Regulatory standards
  - Professional standards of care



# National Senior Citizens Law Center

Evin Isaacson, [eisaacson@nsclc.org](mailto:eisaacson@nsclc.org)

Anna Rich, [arich@nsclc.org](mailto:arich@nsclc.org)

Eric Carlson, [ecarlson@nsclc.org](mailto:ecarlson@nsclc.org)

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Reminder – Webinar on Medicaid Preemption Claims After *Douglas v. ILC* next Monday (March 5); register at <https://www3.gotomeeting.com/register/453413310>

