KANSAS ADVOCATES for BETTER CARE
making elder care better every day

Feb. 14, 2017

Sen. Schmidt and members of the Senate Public Health and Welfare Committee:
I am Barb Conant, public policy coordinator for Kansas Advocates for Better Care (KABC). I appreciate the opportunity to come before the committee in support of SB 160 and the establishment of an independent ombuds program for KanCare/Medicaid home and community based service participants.

Since the inception of KanCare, KABC has strongly advocated for an independent, conflict-free ombuds program charged with representing consumers. The current program, housed within KDADS, is not independent nor can it be free of conflicting influence. It does not have the authority or the resources to represent the people who have the fewest resources but need that advocacy the most. In an early report to Centers for Medicare & Medicaid Services (CMS), the State admitted the KanCare ombuds program was *"narrowed to be responsive to consumer demand with an increased reliance of appropriate delegation to routine or administrative inquiries."* In other words, the program only operates as a resource and referral clearinghouse.

In its recent communication with the State, CMS was correct to point out that Kansas is not following the Special Terms & Conditions regarding the ombuds program, because the current program "does not address all requests for support" and it "does not assist participants through the appeals process as described in STC 42. Kansans who receive their long term supports and services through the HCBS waivers need access to legally-based advocacy that can help them with more intensive grievances and appeals. They also need basic advice and information early in the process from a program that is designed with their rights and needs in mind.

The current system can be likened to the "company doctor" within the worker's compensation system. When a KanCare beneficiary is notified of a denial, cut or termination of a service(s), she/he may appeal to the Managed Care Organization, the same entity which made the decision to cut or terminate the person's service(s). The participant can appeal to the State which contracts with the MCO to request help in the person of the KanCare Ombuds. The KanCare Ombuds is located within and supervised by KDADS, and KDADS prohibits the ombuds from advocating with or for participants in the appeals process. Both the MCOs and the State have a vested financial interest in the outcome of the determination of an appeal.

The limitations of the current system became apparent in the early days of KanCare and continue today. Older adults and their family members often turn to KABC because the ombudsman cannot help them. Recognizing a gap in the information that people needed to navigate the appeals process, KABC developed a guide to the KanCare appeals process. The booklet, KanCare and Your Plan of Care: Know Your Rights was developed in cooperation with Justice in Aging with support from the REACH Healthcare Foundation and the Kansas Trial Lawyers Association Legacy of Justice Foundation. It has been widely distributed at no cost and is available on the KABC website.

It is important to keep in mind that the people who are looking for help, often are represented by family members because they are unable to advocate for themselves, have limited resources and whose health and

well-being heavily depend on the long term supports and services that they receive through the KanCare waivers. They seldom can afford to hire a lawyer to help them navigate the strict deadlines within the complex appeals system. An ombuds program, as outlined in SB 160, would give them such an advocate who truly can represent their personal interests.

States, such as Wisconsin, that operate an established independent, conflict-free ombuds program have found them to be an effective and essential tool in protecting plan enrollees and helps them to better understand and monitor plan performance. In these states, consumers know they have an advocate who works for them. With their own advocate, they are more likely to understand their rights and responsibilities and it often streamlines the process.

SB 160 outlines the components that are necessary for an effective ombuds program that represents the interests and legal rights of individuals being served by KanCare. The bill clearly identifies six areas of responsibility necessary for an independent KanCare ombuds program that exists solely for benefit of the consumer. [Sec. 1(b)]

- Information, technical assistance and training on how to obtain needed services or support items;
- Advice and assistance in preparing and filing complaints, grievances and appeals of complaints or grievances;
- Negotiation and mediation with service providers, state agencies or MCOs;
- Individual case advocacy assistance regarding the appropriate interpretation of statutes or rules and regulations; and,
- Operates for the benefit of actual or potential recipients of HCBS under KanCare.

The current program is only able to perform the first of these responsibilities. The statutory authority to provide the additional five services is needed to assure the intensive advocacy supports are in place for the 25,000 Kansans who depend on HCBS waiver supports and services.

The establishment of an independent, conflict-free KanCare ombuds program is long overdue. Passage of SB 160 brings Kansas into compliance with the deficiencies identified by CMS, but more importantly provides KanCare HCBS waiver recipients with the intensive, legally-based advocacy services to which they are entitled. Please support SB 160.

Mitzi E. McFatrich, Executive Director - On behalf of Board of Directors and Members

KABC is a not-for-profit organization whose mission is to improve the quality of long-term care for elders in all settings – nursing and assisted facilities and in-home. KABC is not a provider of government funded services. For 40 years KABC's role has been as a resource and advocate for older adults and families and as a resource to policy makers on aging and quality care issues. KABC provides consumer education information and tracks and reports on quality care performance issues.

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KanCare and Your Plan of Care: Know Your Rights

What you can do when needed services are reduced, eliminated or denied

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In a managed care system such as KanCare, Medicaid consumers' health care and long term supports and services are provided by health care companies under contract with the State of Kansas. Managed care companies, or MCOs, agree to provide Medicaid benefits in exchange for a monthly payment from the State. Three MCOs provide KanCare benefits in Kansas – Amerigroup, Sunflower and UnitedHealthcare.

"What can I do if I disagree with a decision made by my MCO or if I am unhappy with the quality of the services they provide?"

As a KanCare member, you have the right to file a grievance or an appeal if you are dissatisfied with your plan in any way. More information on the grievance and appeal process is provided at the end of this document. Each MCO has its own internal grievance and appeal process. You must use the process for your MCO. The State also has an appeals and a State Fair Hearing process.

Long-term services and supports (LTSS) assist eligible KanCare consumers who need help with everyday tasks like bathing, dressing, shopping and meal preparation. If you are newly eligible for or currently receiving long term services and supports under KanCare, the services you are approved for are in a written plan called a plan of care.

The plan of care was written by your Managed Care Organization (MCO) care manager, with input and participation from you and your family. You have important legal rights that allow you to disagree with the plan of care and ask for changes whenever your MCO puts together a new or revised plan of care. You also have these rights when your MCO denies, reduces or terminates a particular service (like personal care assistance) you've asked for or were receiving.

Following are the most commonly asked questions by KanCare consumers about long-term services and supports, plans of care and your legal rights to challenge MCO decisions. For more information contact any of the organizations listed at the end of this document.

Q. I disagree with proposed changes to my care plan. What can I do?

A. *Your KanCare MCO must send you a letter called a Notice of Action when it proposes to make a change in your plan of care. You can ask your MCO for a review of any change to your KanCare plan of care that gives you fewer services or fewer hours of a particular service or any change that you disagree with. This review is done through an appeal to your KanCare MCO or through a State Fair Hearing request.*

You have the right to ask the MCO to reconsider its decision through an appeal.

You may request a State Fair Hearing first or you you may do both at the same time.

Q. What is a Notice of Action?

A. *Your KanCare MCO will mail you a letter, called a Notice of Action, which lists the proposed changes to your plan of care. This letter also lists the steps you must take to ask for a review or an appeal of the changes, including the MCO's address, and phone/FAX numbers through which to file your appeal. You may file your appeal by mailing or faxing a written statement, or by calling the MCO.*

The Notice of Action MUST contain the following information:

- Any **proposed changes** to your plan of care. For example, if you were receiving 25 hours a week of personal care assistance, and your MCO wants to reduce assistance to 10 hours a week, the notice must clearly tell you that and why your plan is changing.
- The **legal basis for the proposed changes.** The notice must include a reference to the law or regulation upon which the change is based. This is important because it allows you or someone, including an attorney who may represent you, to look up the law or regulation that the MCO believes gives it the authority to take the action.
- The **reason(s) for the proposed changes** when services are being reduced or terminated. **This is very important.** The MCO must tell you, in language you can understand, how your health or circumstances changed since the last time you were assessed. In other words, the MCO has to explain how you got better or why you are able to do things that you were unable to do before, like get dressed yourself or do your own laundry. One way the MCO can do this is by giving you a copy of your most recent service assessment along with an explanation of how it is different from your previous service assessment.
- **The reason(s) for the denial or limited authorization of a service** when you have asked for a new service and your request was either denied or authorized for less than you requested. Even if it is the first time you are asking for a service or getting a plan of care, the notice must include an explanation of why you are not eligible for a service or why you may be eligible for less service than you requested. For example, if you believe you need 40 hours a week of personal care assistance, but your MCO only allows for 15 hours a week in your plan of care, the notice must explain why you did not receive all 40 hours. One way an MCO can do this is to include your service assessment and an explanation of what it says.
- **What you must do to ask for an appeal or State Fair Hearing.** You should receive two forms called "Request for Administrative Hearing" and the "Authorized Representative Designation Form" which allows someone you choose to speak for you. As the names of these forms indicate, you can use them to request an administrative hearing or designate an authorized representative.
- **An explanation that your current benefits will not be reduced** until any appeal or State Fair Hearing is concluded.
- **Information on how you can ask for a faster (or "expedited") review** and ruling on your appeal or hearing. Not everyone is eligible for this option. You must meet some specific conditions to get an expedited review.

IMPORTANT: Decisions about whether you are eligible for services or about changes to plan of care or personal care hours are classified as "actions." If you don't agree with the decision on such actions, you can ask for an appeal through the KanCare MCO or ask for a State Fair Hearing. REMEMBER: You can ask for an appeal or State Fair Hearing if you are not approved for services, if you believe you are not getting services you need, if your services have been cut, or if your services have been stopped.

Q. Will my services be cut before a decision is made in an appeal or hearing?

A. *No, not if you file an appeal or request for fair hearing within 30 days (plus 3 days from the date you were notified by mail). If a request is made within the deadline, the services you are receiving will continue, with no cuts in services, until a decision is made about your appeal or fair hearing. Your services continue without reduction for 33 days from the mailed date of the notice. This 33-day period allows you time to ask for an MCO appeal or a State Fair Hearing. As long as you request an appeal or a State Fair Hearing within that 33 day timeframe, there will be no cuts to your services until a decision is made in the appeal or hearing. The MCO must resolve the appeal within 30 days.*

Q. If my services are continued without reduction while an appeal or fair hearing is considered, but then the decision goes against me, will I have to pay for the services I received after I made the challenge?

A. *No. You will not have to pay for services provided during the appeal or Fair Hearing process, unless it is determined there has been fraud. The MCO must resolve the appeal within 30 days.*

Q. I am unhappy with the quality of the services I receive through KanCare. What can I do?

A. *You may file a* **grievance** *with the MCO if you are dissatisfied with any matter that is NOT an "action." Examples of "actions" are approvals or (as discussed above) denials, reductions, suspensions, or awards of a less-than-requested level of service. Examples of grievances are poor quality of care or rude behavior by staff. All KanCare MCOs must tell you about the MCO's grievance process for complaints.*

You can file a grievance in writing or by phone within 180 days of the event. The MCO must send you a letter within 10 working days of receiving your grievance. Then, the MCO must respond to your grievance within 30 working days. More than 30 days may be allowed if the MCO needs additional time to collect relevant information. If the MCO doesn't respond to your grievance in a timely manner, you can ask for an appeal.

Q. How do I ask for an appeal with my KanCare MCO?

A. *You must ask for an appeal within 33 days from the date on the Notice of Action. The mailing date should be on the first page directly below the phrase "Notice of Action." Keep the envelope to confirm when the letter was mailed. You must ask for an appeal in writing or by calling your KanCare MCO. If you mail your request, you may want to send it certified mail, return receipt requested, so you have proof that your request was mailed within the appeal timeframe.*

Q. Should I ask for a State Fair Hearing?

A. *The timeline is the same as the timeline for the MCO appeal — 33 days from the date of mailing of the Notice of Action. A request for a State Fair Hearing must be made in writing to the Kansas Office of Administrative Hearings. A hearing date will be set and, at the hearing, a hearing officer will review the changes your KanCare MCO is suggesting. You have the responsibility to explain the reasons you believe the changes are wrong. After the hearing, the hearing officer will make a ruling, either approving, rejecting, or modifying the action proposed by the MCO in the Notice of Action.*

IMPORTANT: You have the right to participate in the State Fair Hearing. You can bring witnesses to the hearing, and you may ask questions of the MCO representative (this is called cross examination) during the hearing. Also, you must be given an opportunity to review your case file before the hearing and at the hearing. You may bring your lawyer with you to the hearing or designate someone to speak for you.

Q. Can I ask for both an appeal and a State Fair Hearing?

A. *Yes, you can ask for both an MCO appeal and a State Fair Hearing. Or you can ask for a State Fair Hearing after the MCO has ruled on your appeal. If you've asked for an "expedited" appeal from your MCO, you must wait for a ruling on that appeal before asking for a State Fair Hearing. As with an appeal, your request for a State Fair Hearing must be made in writing and received by the Kansas Office of Administrative Hearings within 33 days of the date of the Notice of Action you get from the MCO. If you are requesting a Fair Hearing after receiving a negative ruling from an MCO appeal, your request for a State Fair Hearing must be received within 33 days of the letter advising you of the appeal's outcome.*

Q. Can I appeal my plan of care even if this is the first time I've had one?

A. *Yes. You may challenge a plan of care that gives less or different services than what you believe you need. You can do this through an MCO appeal or through a State Fair Hearing. Your KanCare MCO must give you a copy of your plan of care and the Notice of Action if the services authorized in the plan are different from or less than what you requested. You can't waive your right to the notice of action – the plan must give it to you.*

Q. I'm afraid my health may deteriorate while I'm waiting for a decision. Can I ask for quicker review and resolution?

A. *Yes. You can request a quick appeal, called an "expedited appeal," when your health requires a fast decision. The request can be made by phone or in writing. The MCO must resolve an expedited appeal within three (3) working days after receiving the request. The State may extend the 3-day time period, if more information is needed to make a decision. If the MCO denies the request for an expedited appeal, it must notify you both orally and in writing, and then must decide the appeal in the normal appeal timeframe. An expedited Fair Hearing is available only if you have received an expedited appeal from the MCO.*

Q. Can someone help me with an appeal or State Fair Hearing?

A. *Yes. If you want a family member or friend to help you, or an attorney to represent you with your appeal or fair hearing, you must complete and mail back the "Authorized Representative Designation Form" which will be attached to the Notice of Action.*

Q. I need an interpreter. Can someone help me communicate during my appeal?

A. *Yes. KanCare MCOs must provide written information in Spanish and must also provide free oral interpretation services in American Sign or any non-English language to each plan member who needs them. The MCO must tell you how to access those services. These services are available for both appeals and State Fair Hearings.*

Q. Where can I go for more information?

KanCare Ombudsman: *The KanCare Ombudsman is available through the Kansas Department on Aging and Disability Services to provide KanCare members with information about their rights and responsibilities. Contact Kerrie Bacon, KanCare Ombudsman, at 855.643.8180, TTY-771; kancare.ombudsman@kdads.ks.gov*

Disability Rigts Center of Kansas: *The DRC of Kansas is a non-profit organization providing free advocacy and legal services, including help with KanCare appeals, for Kansans with disabilities. Toll-free Voice - 877.776.1541, TTY Toll Free - 877.335.3725, www.drckansas.org*

Kansas Office of Administrative Hearings: *Contact Bob Corkins, Director, 1020 S. Kansas Ave., Topeka, KS 66612, 785.296.2433, FAX - 785.296.4848, www.oah.ks.gov*

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Founded in 1975 as Kansans for Improvement of Nursing Homes by concerned citizens like you.

Know Your Rights

How to navigate the appeals process or file a grievance about your KanCare services

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As a KanCare member, you have rights. You have a right to dispute decisions made about the amount or type of services you receive. You also have the right to speak up if you are unhappy with the quality of your health care or your long term supports and services.

Grievance
Do you have a complaint about the QUALITY of your KanCare services?

Grievances are filed with your MCO. **Call your MCO's Complaint Line.**

Appeal
Do you disagree with changes made or an ACTION taken related to your plan of care?

Appeals can be filed with your MCO. **Call your MCO's Complaint Line.**

State Fair Hearing
Do you disagree with changes made or an ACTION taken related to your plan of care?

A request for a **State Fair Hearing** is filed with the KS Office of Administrative Hearing within 33 days after an action is taken.

Requests can be made in writing or verbally.

You may have a lawyer or a designee represent you or you may represent yourself.

You can request a face-to-face hearing.

For more information KS Office of Administrative Hearings 785-296-2433, 1020 S Kansas Ave, Topeka, KS 66621

An Appeal and a State Fair Hearing can be pursued separately or at the same time.

You can appeal the State Fair Hearing decision:
- Ask for reconsideration
- Secretary Review
- State Appeals Bd. (must be filed within 30 days)
- District Court

Questions?

The KanCare Ombudsman can help

The KanCare Ombudsman can help you understand your options. The ombudsman will help you navigate and access KanCare health services and support.

Contact:
Kerrie Bacon, Ombudsman
Toll Free - 855.643.8180, or
785.296.6270; TTY - 771
Email -
kancare.ombudsman@kdads.ks.gov

Your current services must be continued while you appeal your case or take it through the State Fair Hearing process.