ICAN
Independent Consumer Advocacy Network

I Need More Hours! Home Care Increases

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MEDICARE RIGHTS CENTER
Getting Medicare right

Agenda

1. **What types of home care services can Medicaid Managed care consumers receive?**
2. **When may a consumer need an increase in their home care?**
   - Change in medical condition or existing medical condition progression
   - Change in social circumstances or environment
   - Current authorization has not been sufficient for some time
3. **How do we assist consumers to request an increase?**
   - Service authorization (Prior Authorization, Concurrent Review)
   - Appeals process
4. **What factors should be considered when building a consumer's case?**
   - Medical conditions and ADL needs, Hospitalizations, Unmet needs, Informal Supports, Overnight Needs and Emergencies

1. Types of Medicaid covered home care

Personal Care Services

Personal care services are assistance of a personal care aide with nutritional, environmental support, and personal care functions. "Such services must be essential to the maintenance of the patient's health and safety in his or her own home" ordered by the attending physician; based on an assessment of the patient's needs and of the appropriateness and cost-effectiveness" of services. 18 NYCRR 505.14(a).

There are two "levels" or types of PCS in New York State.

- **Housekeeping or "Level 1"** - for those who because of disability need assistance with housekeeping, cleaning, meal preparation, grocery shopping, and laundry, but they do not need help with "personal care" tasks such as bathing or dressing. These services are limited by state law to EIGHT hours per week. 18 NYCRR 505.14(a)(5)(as amended 12/2015).
- **Personal Care or "Level 2"** -- includes all the Housekeeping (Level 1) tasks plus assistance with bathing, dressing, grooming, toileting, walking, feeding, assisting with administering medications, preparing meals with special diets, bed mobility, and routine skin care.

Consumer Directed Personal Care Services

(3) "consumer directed personal assistance" means the provision of assistance with personal care services, home health aide services and skilled nursing tasks by a consumer directed personal assistant under the instruction, supervision and direction of a consumer or the consumer's designated representative."
18 NYCRR 505.28

To be eligible for CDPAS the consumer must be:

- Eligible for Medicaid
- Eligible for long term care
- Be Self-Directing or have a designated representative
- Need assistance with one or more personal care services, home health aide services or skilled nursing tasks

24-hour home care

24 hour live in

- The provision of care by one personal care aide for a patient
- Needs during a 24-hour period should be infrequent so that the aide is reasonably able to get **5 hours of uninterrupted sleep on a regular basis**
- Patient's home should have sleeping accommodations for aide

24 hour split shift

- The provision of uninterrupted care, by more than one personal care aide, for more than 16 hours in a calendar day
- Need for assistance is so frequent a that live-in 24-hour personal care aide would be unlikely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight-hour period of sleep."

18 NYCRR 505.14(a)

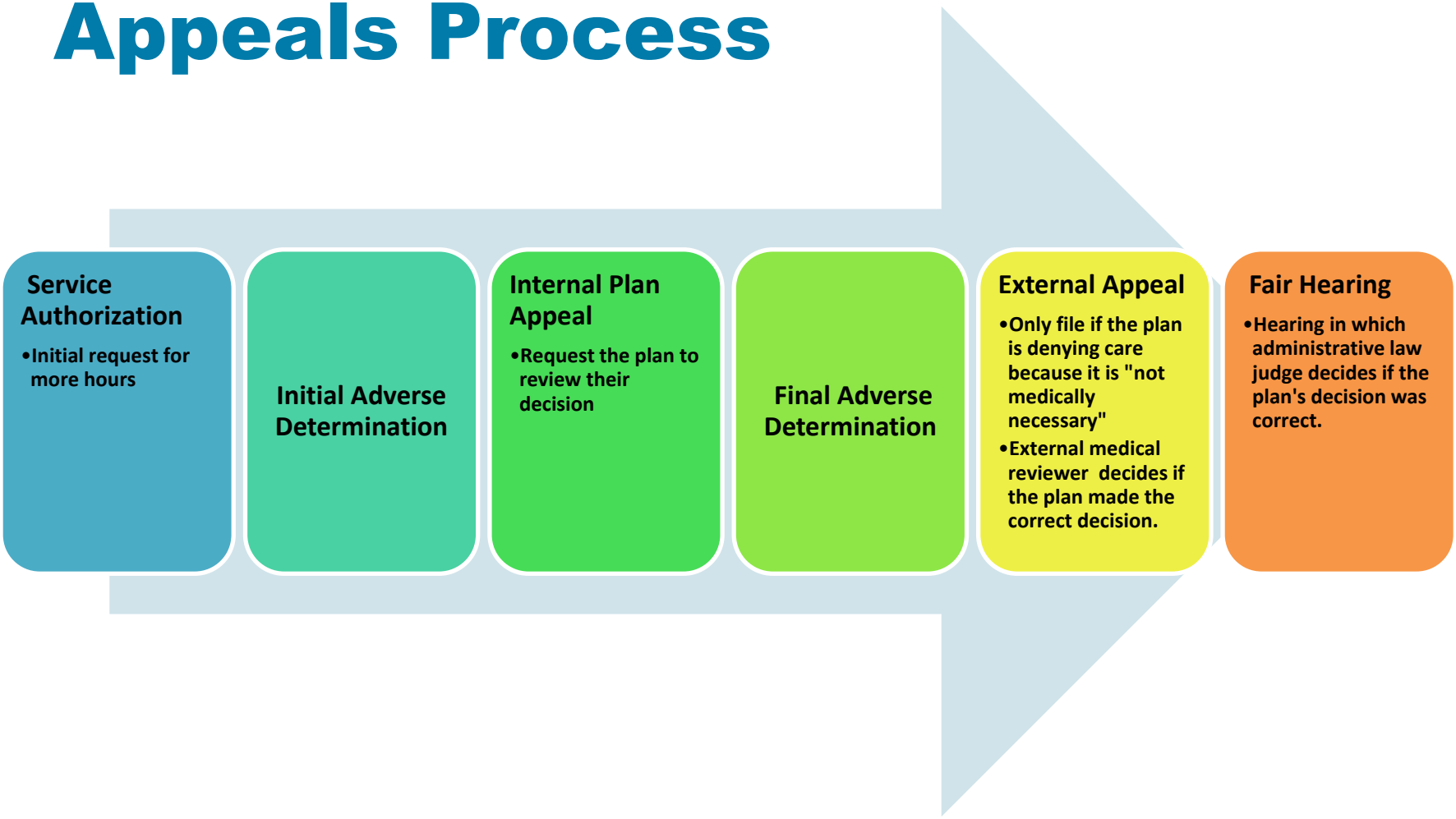
2. Why might the consumer need more hours?

1. **If there is a change or progression of their medical condition**
   If the consumer has a progressive condition for example Parkinson's, Alzheimer's, osteoarthritis, muscular dystrophy, COPD etc. They are likely going to decline in their ability to perform Activities of Daily Living (ADLs).
2. **If there is a change in their social or environmental circumstances**
   For example: The consumer's family member who used to live with them and provide informal caregiving has moved out and is no longer able to assist with their care.
3. **If the care has not been sufficient for some time**
   Many consumers accept what the number of hours that plan has authorized because they are not aware they can appeal or have tried to appeal and have not been successful.

3. How to ask for more hours?

Ask and you shall… probably need to appeal

Service Authorization and Appeals Process



Service Authorization

- Initial request for more hours

Service Authorizations

There are 2 types of service authorizations

1. **Prior Authorization** – When the consumer or their representative ask the plan for a new service
2. **Concurrent Review –** When the consumer or their representative ask for more of a service already receiving

- The plan must provide a written decision within 14 days (or as short as 72 hours if fast-tracked)
- The plan's decision on a service authorization is an action that can be appealed.

N.Y. Dep't of Health, MLTC Model Contract, Appendix K.

How to ask for Increased or New Services – Service Authorization Request

- Service authorization requests can be done orally or in writing
  - If you are advising a consumer or their representative who has made an oral request, you should advise them to confirm an oral request with written request.
  - Submit a written request with a detailed doctor's letter
    - If there is a delay in obtaining the doctor's letter - do not wait

Plan Decision Timeline

Type of Request	Maximum time for Plan to Decide
Standard	**14 calendar days from receipt of request,** though plan may extend up to 14 calendar days if needs more info*.
Expedited	**72 hours from receipt of request,** though plan may extend up to 14 calendar days if needs more info.*

- Plan may have an extension of up to 14 days to decide a service authorization, IF:
  - The enrollee, or the provider, requests extension; or
  - The plan justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.
- Plan should send an Extension Notice giving deadline to submit additional info and explaining reason for extension to consumer and/or their representative as well as their provider if the provider made the service authorization request.

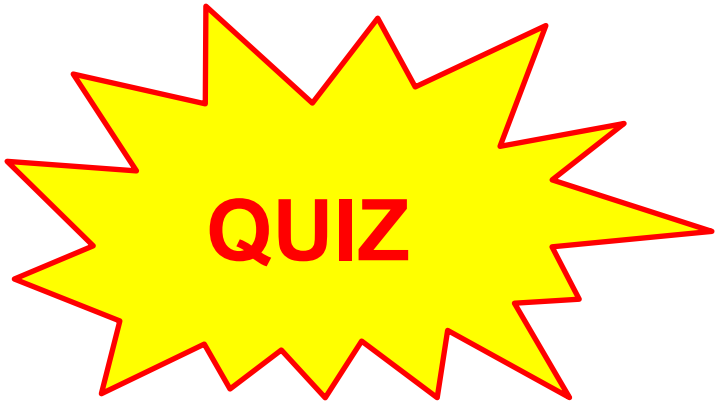
Initial Adverse Determination

- **Notice that the plan has denied the request.**

The Appeals Process

What is an Appeal?

- An initial adverse determination is a notice of the plan's initial decision
- After this notice is received the consumer can request an appeal or for the plan to review the adverse determination or action
- A consumer has the right to appeal if a Medicaid managed care plan denies a new service or increase in an existing services as well as if it reduces or stops services that the consumer was already receiving.



You must _____ before you can request an internal appeal

A.) Have a need for 24-hour care

B.) You don't need to do anything; you can just request one

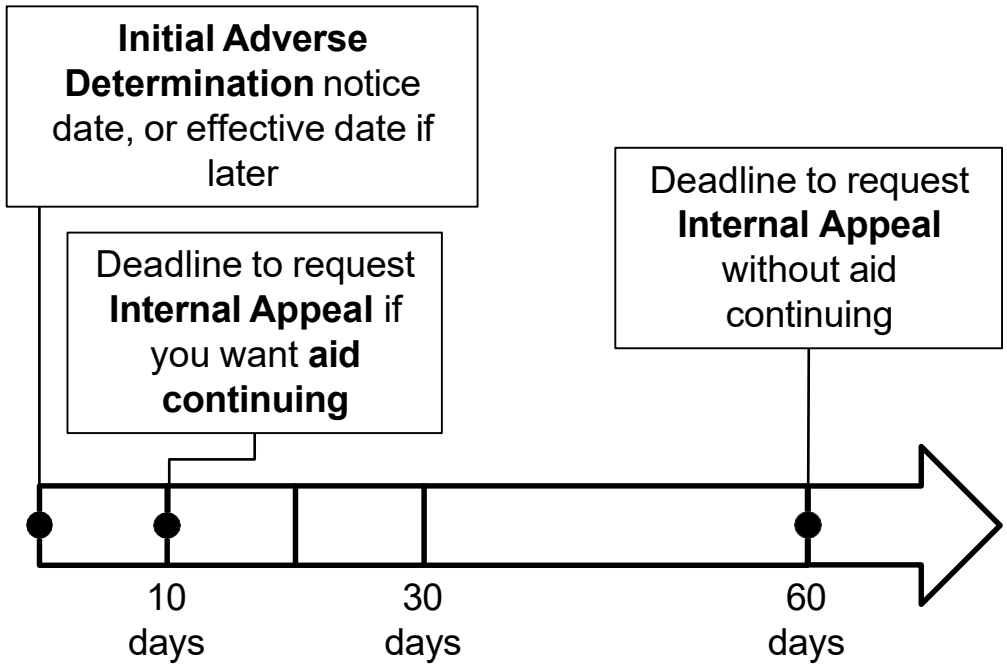
C.) Receive a Final Adverse Determination

D.) Receive an Initial Adverse Determination

Internal Plan Appeal

- Ask the plan to review its decision

Internal Appeals



- This is the first step after an adverse plan action.
- **You must exhaust internal appeals process with plan before you can request a fair hearing or external appeal.**

How to Request a Plan Appeal

- **FAX** the request - fax number should be on the Notice.
  - Use Appeal Request Form that should be part of the notice from the plan.
  - Keep FAX CONFIRMATION.
  - Federal regulations require the member to sign the appeal request, or to give written consent for a health care provider or an authorized representative to request an appeal or file a grievance, or to request a State fair hearing. § 438.402(c)(1)(ii).
- **Call** plan member services and ask for APPEALS UNIT.
  - Must confirm an ORAL request in WRITING unless you request it to be "expedited" (Fast Track). See more about Fast Track later.
  - Date of CALL locks in Aid Continuing and meeting appeal deadline. 42 C.F.R. § 438.402(c)(3).
  - WARNING: You have no proof you called. You may get bounced to wrong unit and request won't be logged in. Confirm by fax or letter! Get name of person who took appeal request.
- **E-mail** – if an e-mail address is on the NOTICE received from the plan (optional for plan). Attach the Appeal Request Form that should be part of the notice '

Request Expedited or "Fast Track" Appeal

- Member or provider has the right to request an **expedited or "Fast Track" appeal**. 42 CFR 438.410(a).
- If need “fast track” – best if PROVIDER requests it or supports the enrollee’s request because:
  - If enrollee requests expedited appeal – then PLAN decides if meets criteria;
  - If Provider indicates that taking time of standard appeal would meet criteria above, then plan **must** expedite
  - Also **must** be expedited if the decision on appeal is a **concurrent review**
- The **Appeal Request Form** that is part of the IAD **has a check-off** for requesting a **Fast Track Appeal**. May attach provider letter in support.
- If request Expedited Appeal, do not have to confirm ORAL appeal request in writing.

Plan must provide case file to enrollee and rep even without request

- Plan must provide the enrollee and his or her representative the enrollee's case file, including medical records, other documents, and any new or additional evidence considered, relied upon, or generated by the plan in connection with the appeal. This information must be provided free of charge. 42 CFR 438.406(b)(5).
  - Unless other requested, plan must send by regular mail
  - Differentiates “evidence packet” provided for fair hearing
- Must be provided “sufficiently in advance of resolution timeframe.”
- Plan must provide file even if not requested.

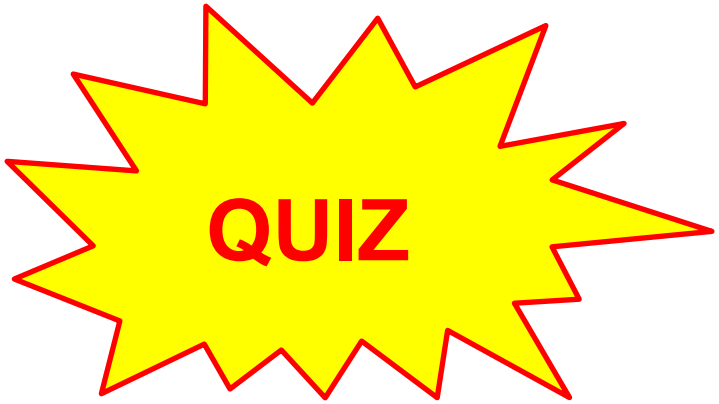
Right to present new evidence

- Plan must consider new evidence submitted in appeal. 42 CFR 438.406(b)(2)(iii)
- Must provide enrollee a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The plan must inform the enrollee of the limited time available for this sufficiently in advance of the resolution time frame for appeals. 438.406(b)(4)
- **TIP: On the Appeal Request Form that plans must attach to their IAD notice, there is a checkbox if you want to include additional documents with the appeal request, or if you want to give information in person. You could also write in that you would like time to submit additional documentation**.

Confirming ORAL appeals in writing

- Must confirm an ORAL request in WRITING unless you request it to be "expedited." 42 C.F.R. § 438.402(c)(3).
- An FAQ asked DOH, “How are plans to proceed with a verbal Plan Appeal if the enrollee does not follow up in writing?”* DOH Response to Mainstream plans was:
  - “... Plans should always notify enrollees of the need to follow up a verbal Plan Appeal in writing when a standard Plan Appeal is filed verbally. **Plans may elect to send a summary of the Plan Appeal to the enrollee, for the enrollee to sign and return.** The time of the verbal filing "starts the clock" for the plan determination. The time to make a determination and notice is NOT tolled while waiting for the written Plan Appeal, and the **plan must make a determination even if a written Plan Appeal is not received**.”
- FAQ should apply to MLTC as well as MMC.

*FAQ # V. 5, revised Feb. 7, 2018 (available at https://www.health.ny.gov/health_care/managed_care/plans/appeals/2018-02-07_2016_final_rule_faqs-jan.htm#v)



How many days do you have to file an internal appeal (without aide continuing)?

A.) As many as you need

C.) 10 days

B.) 60 days

D.) 4 months

When Must Plan Decide Appeal?

- Plan must send written notice within 2 business days of decision for all appeals, but no later than:
- **STANDARD APPEAL** - within **30 calendar days** of receipt of the appeal request, subject to extension described below.
- **FAST TRACK or EXPEDITED APPEAL** - within **72 hours** after the plan receives the appeal, subject to extension.
  - Plan must make a reasonable effort to give oral notice first
- **EXTENSION** – Plan may extend its time to decide standard OR expedited appeal by up to **14 calendar days** if additional info is needed and the delay is in the enrollee's interest.
  - Member can ask State DOH to require plan to show extension justified. 42 CFR 438.408(c). Procedure unclear. Probably file DOH complaint 1-866-712-7197
  - Member may request plan grievance to dispute extension.

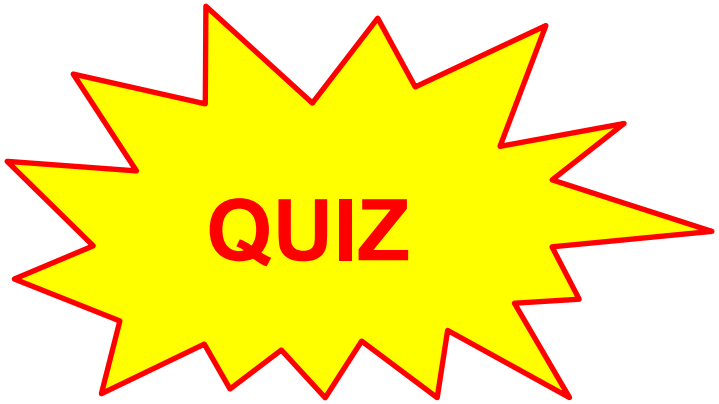
If Plan Extends its time to Decide Appeal

If the plan has extended the time to decide -- it must

- make reasonable efforts to give enrollee prompt oral notice of the delay, and
- within 2 calendar days, give written notice of the reason for the delay and of the right to file a grievance about the delay. Plan should send extension notice at https://www.health.ny.gov/health_care/managed_care/plans/appeals/docs/2017-11-20_ext_notice.pdf
- Plan must resolve appeal "as expeditiously as the enrollee's health condition requires and no later than date the extension expires." 42 CFR 438.408(c)(2).

IAD Sample Review

- p. 1 Be mindful of the deadline to request Plan Appeal.
- p. 2 Double check that the consumer's request is correct. Most commonly, the consumer wants split-shift and the request is written as live-in.
- p.2-3 Final Adverse Determination (FAD) usually ends up being a regurgitation of the IAD, so you can prepare refuting the IAD arguments.
- p.3 For 24-hour requests, plans have gotten into the habit of encouraging members to seek care through the NHTD waiver.
- p.6 PCS increases should be fast tracked!
- p.7 If PCS increases aren't answered on the expedited track, try asking for an auto reversal
- p. 9, 10 Reviewing how to fill out Plan Appeal Request form



How many days does a plan have to answer a Standard Internal Appeal?

A.) 30 days

B.) 60 days

C.) 72 hours

D.) The plan has no deadline to respond

Final Adverse Determination

- **Exhaustion has been met**

Final Adverse Determination

- If the plan decides to uphold their initial decision, then the consumer has exhausted their appeals.
- If the consumer's additional hours have been denied because the plan deems them not "medically necessary" file an external appeal

4. Factors to consider when building a case

Activities of Daily Living (ADLs)

Mobility Issues/Fall Risk

- ☐ Getting in or out of chairs
- ☐ Getting in or out of bed
- ☐ Walking-specify if requires physical support from aide, avoid saying needs aide to supervise her walking so she does not fall
- ☐ Locomotion-walker, wheelchair
- ☐ Bed mobility

Toileting

- ☐ Using the toilet-getting on and off, cleaning self, pulling pants down and putting pants back on
- ☐ Adult diapers-need to change every two hours
- ☐ Changing bed linens when soaked in urine

Personal Hygiene

- Getting into the bath/shower
- Washing self
- Grooming
- Dressing

Medication Management

- Administering medication
- Remembering to take medication

Meals

- Preparing meals
- Eating

Housekeeping

- Laundry
- Cleaning
- Shopping

Medical Diagnoses and Conditions

- What medical conditions/diagnoses are mentioned in the plans' records? (UAS, PCSP, Tasking Tool, Case Notes).
- Does the provider/doctor's letter of medical necessary support the client's need for more hours? Does it mention specific ADL needs?
- What diagnoses are listed on the client's medical records?
- How does the client's medical conditions impact their ability to function/perform ADLs?

Hospitalization(s) and/or onset of new conditions

- Has there been a change in medical condition, new diagnoses, recent falls or hospitalizations?
- What diagnoses are listed on the client's medical records?
- How does the client's medical condition impact their ability to function?

Informal Supports and Unmet needs

- How is not receiving the hours they need impacting the client's health, safety, and ability to remain in the community?
- Are the needs being met by informal caregivers but involuntarily?
- Does the client live alone, with family or loved ones? Are there family members or caregivers that are available to provide care outside of what the plan has approved?
- Do plan records accurately reflect the availability of informal supports?

Overnight Needs 24-hour care

- Does the consumer require assistance with their ADLs at night? (e.g. toileting**, walking, transferring, turning and positioning, and/or feeding)**
- Is the consumer's need for overnight assistance currently being met?
- How frequent are their night-time needs on average?
  - Did the plan order a sleep study? (most likely not)
  - Can an aide, family member, or representative can keep overnight logs to track the frequency of assistance needed at night?
- Frequency of needs will determine if they quality for 24 hour live-in or 24 hour split shift.

Thank You!