North Carolina
Department of Health and Human Services

PCS STAKEHOLDER WEBINAR

Personal Care Services Program Updates (Pettigrew v. Brajer)

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Pettigrew v. Brajer

- Pettigrew v. Brajer, (previously, Pashby v. Wos) is a federal lawsuit filed on May 31, 2011. This lawsuit is certified by the Court as a class action lawsuit on behalf of persons age twenty-one and older denied or terminated from in-home Medicaid personal Care Services since May 2011.

- In this lawsuit, plaintiffs allege that the N.C. Medicaid agency decided their eligibility for personal care services in their homes under different criteria and procedures than those used for persons needing PCS in residential settings. **DMA denies those allegations.**

Settlement Agreement

The lawyers representing the parties in this case have reached a Settlement Agreement to settle the lawsuit. In reaching the Settlement Agreement, DMA is agreeing to modify the procedures for determining eligibility for personal care services under the N.C. Medicaid program.

The Settlement Agreement includes detailed description of the steps that will be taken to, among other things:

- Assure that the eligibility criteria for PCS are the same regardless of setting.
- Assure that in assessing the need for PCS, the practices and procedures used by the Medicaid agency will be comparable;
- Assure that proper notice and the right to a hearing are provided when personal care services are denied, reduced, or terminated;
- Reassess or reinstate services to some class members whose PCS was previously denied or terminated

Actions

- DMA will assure that the PCS eligibility criteria used to authorize or reauthorize or determine the number of PCS hours for Medicaid beneficiaries is the same regardless of residential setting

- DMA will assure, in authorizing and reauthorizing PCS, including independent assessments of the need for PCS, that the practices, forms, procedures, and instructions shall be comparable to the extent practicable regardless of setting, including but not limited to assessment of the following;
  - The need for assistance with ADL;
  - Whether the need for assistance is met or unmet
  - Whether informal caregivers are able and willing to provide the needed assistance.

Actions

SCHEDULING

- When scheduling an in-home PCS assessment, DMA will assure that its contractor contacts the beneficiary or, if appropriate, the beneficiary's authorized representative to schedule the assessment. If the beneficiary requests the scheduler contact a third person to schedule the assessment, the scheduler will do so.

- Prior to issuing a technical denial for failure to schedule an in-home assessment or reassessment, DMA will assure that the contractor makes at least the following efforts to reach the beneficiary or representative to schedule the in-home assessment:
  - Three attempts by telephone on three different days;
  - Checking all available data sources as needed to obtain the beneficiary's/authorized representative's current telephone # and address.

Actions

SCHEDULING

- DMA will ensure that the posting of an electronic notification through the provider portal of QiReport to the PCS provider that the beneficiary has an upcoming annual assessment
- In the case of reassessment, if the scheduler is unable to verify a current working phone number for the beneficiary/authorized representative, the scheduler will contact the PCS provider.
- DMA will assure that the PCS provider is copied on the notice of termination of PCS for failure to schedule or a attend a reassessment.
- If the beneficiary/authorized representative contacts the scheduler within 10 business days of the notice of termination for failure to schedule or attend a reassessment, the termination of PCS will be set aside provided that the beneficiary has not initiated an appeal.

Actions

SCHEDULING

- When Scheduling the assessment or reassessment for PCS, DMA will assure its contractor verbally asks the beneficiary of his or her authorized representative whether he or she wishes to have a trusted person with knowledge of the beneficiary's condition (e.g. family member, friend, social worker, PCS caregiver), present during the assessment. If the beneficiary or authorized representative elects to have one or more additional persons present, DMA will assure that the contractor makes reasonable efforts to schedule the assessment for a date and time when the selected person(s) may attend and provide information to the assessor.

- The contractor need not unreasonably delay the assessment to accommodate the schedule of the third person(s). Contractor will inform beneficiary/authorized representative that medical records made available at the time of assessment will be reviewed by the assessor.

Actions

SCHEDULING

- If contractor has no notice of an authorized representative but the beneficiary's PCS referral form or a prior assessment indicates a diagnosis suggesting a cognitive impairment or difficulty communicating which may result in diminished capacity to remember, understand, or communicate, or if the contact to schedule the assessment suggests that the beneficiary is likely to need assistance in communicating or decision making, or if both conditions exist, contractor will make reasonable efforts, if appropriate, to identify an appropriate alternative contact person to schedule the in-home assessments.

- DMA will assure that its contractor will use all reasonable efforts to schedule or reschedule the assessment, regardless of residential setting, at a time when a third person has indicated that he or she can be present.

Actions

Conducting Assessments

- DMA will assure that the need for assistance with the Eating ADL will be assessed in a comparable manner regardless of residential setting. DMA will assure that each PCS applicant or beneficiary will be assessed for each ADL task and IADL task, if applicable that comprise the eating ADL.
- DMA will assure that for in home PCS, meal preparation will be considered a qualifying ADL task, subject to all other remaining policy criteria, if the beneficiary needs at least limited hands on assistance with meal preparation and that need is not fully met by willing and available caregivers seven days a week.
- DMA will assure PCS is authorized in a manner that complies with federal and state law for Medicaid beneficiaries and that the independent assessors will uniformly apply the assessment criteria in the assessment tool irrespective of residential setting.

Actions

RECONSIDERATION

For initial requests for PCS, initial authorization for less than 80 hours per month:

- After receiving an initial approval for an amount of hours less than 80 hours per month, a beneficiary must wait 30 days from the date of the notification to submit a request for reconsideration of the level of service determined during the initial approval. This 30 day requirement does not apply to the beneficiary's submission of a Change of Status request which may be submitted at any time if the change of status criteria is met.

- The request for hours in excess of the initial approval not based on a Change of Status must be submitted with supporting documentation that specifies, explains, and supports why more authorized hours of PCS are needed and which ADLs and tasks are not being met with current hours.

ACTIONS

RECONSIDERATION

- Documentation should provide information indicating why the beneficiary believes that the prior assessment did not accurately reflect the beneficiary's functional capacity or why the prior determination is otherwise insufficient.

- Upon receipt of a completed request for additional PCS hours up to 80 hours per month, DMA will reconsider the request. At DMA's discretion, a reassessment may be scheduled.

- If the reconsideration determines a need for additional PCS hours as request, additional hours will be authorized according to policy. This constitutes an approval and no adverse notice or appeal rights are provided.

Actions

RECONSIDERATION

- If the reconsideration determines that the PCS hours authorized during the initial assessment are sufficient to meet the beneficiary's needs, an adverse decision will be issued with appeal rights.

- A beneficiary must submit a request for hours in excess of the initial approval within 60 days of the date of the initial approval notification. A request after the 60 day time period must be in the form of and meet the requirements for a Change of Status request. The non-Change of Status reconsideration request shall be submitted no more than one time during the initial benefit period.

Actions

RECONSIDERATION

- DMA will develop a “Reconsideration Request” form for beneficiary’s and authorized representatives to complete. The request form and supporting documentation is to be submitted to the IAE contractor for review. **Additional information on the details of this process and how to submit requests is forthcoming.**

Actions

REINSTATEMENT and REASSESSMENT

- Upon implementation of all actions of this settlement agreement, DMA will identify, reinstate the same number of hours prior to termination, if previously receiving PCS and then terminated, and reassess under the identified procedures the following members of the Plaintiff class for whom PCS was denied or terminated under Clinical Policy 3L prior to the date upon which DMA has fully implemented and is in compliance with Section III (Actions) of the Settlement Agreement, unless the class member is currently receiving PCS, is currently ineligible of Medicaid, or is currently receiving nursing home or home and community based waiver services: (1) all persons who were determined by DMA to be ineligible for PCS for whom no third person was present during the PCS assessment or reassessment if there is any indication that the beneficiary had a cognitive impairment or a mental diagnosis;

Actions

REINSTATEMENT and REASSESSMENT

(2) All persons denied or terminated from PCS because of the receipt of hospice services.

- If the reassessment required demonstrates eligibility for PCS, PCS will be promptly approved (or continued of the class member has already been reinstated) at the level determined through the assessment.

- If the reassessment does not demonstrate eligibility for PCS under Clinical Policy 3L or its successor and this agreement, the beneficiary will receive a notice of denial of PCS with appeal rights, except that such notice is not required if the class member already has a pending OAH appeal of the prior decision that was reassessed.

Actions

REINSTATEMENT and REASSESSMENT

- Upon Reinstatement and Reassessment, selected providers will receive notification on the provider portal. Liberty Healthcare will contact the selected providers of beneficiaries seeking reinstatement to verify acceptance prior to sending a referral.

- Providers selected by beneficiaries who receive a reassessment will receive a referral through the provider portal.

- Providers with questions may contact Liberty Healthcare at 1-855-740-1400 or DMA PCS program at 919-855-4360.

Implementation

- The specified actions in this agreement will not be implemented all at once, but will be implemented over varying time periods.

- Several actions of this agreement are currently implemented by DMA.

- DMA will issue a Medicaid Bulletin once the settlement has been finalized that will identify additional details regarding implementation of each action.

Questions

Please enter your questions via the webinar link. DMA will respond timely to questions and post via the PCS webpage.