

Slide 1:

Hello everyone, my name is Kenneth Bausell and I am the IDD manager at North Carolina Medicaid. This presentation is related to LME/MCO Joint Communication bulletin 297 and how it relates to the North Carolina Innovations Waiver.

Slide 2:

- So what is the purpose of this presentation and what is the purpose of Joint Communication Bulletin 297?
- In November of 2017, the Department of Health and Human Services (DHHS) received a notice of non-compliance from plaintiffs' counsels with respect to the *L.S. vs. Wos* settlement agreement. The Department has reviewed the information provided by the plaintiff's counsel, and it's agreed to take certain corrective actions as outlined below.
- So, Joint Communication bulletin 297 addresses those corrective actions that we're going to talk about in this presentation.
- When we talk about the department, that means the Department of Health and Human Services (DHHS).

Slide 3:

- First, we're going to look at how this impacts NC Innovations Residential Supports and Supported Living definitions. It is also important to note that this information is being updated in the NC Innovations Waiver Application and the Innovations Policy (Clinical Coverage Policy 8p).
- The level of Residential Supports or Supported Living requested in the plan of care or approved by utilization management must be based on the medical necessity of each participant's individual case.
- The SIS Level is only one piece of evidence that may be considered.
- This SIS core may be considered as a guideline only and should not be the sole piece of evidence and determining the level of services.
- Next, we are going to see how this change really plays out in the definition.

Slide 4:

- Now, we are going to talk about the Levels.
- Residential Support Levels are determined by the individual budget tool and other evidence of support need. The SIS levels is only one piece of evidence that may be considered.
- Traditionally, if a person needed supports outside of their "SIS" level, the LME/MCO would have to do an Enhanced Rate, per the Operational Rules of the waiver.
- Now with this change, if a person has needs out of their "SIS" level, the person could be approved for a higher Residential Level instead of the Enhanced Rate.
- Earlier in the year, during our I/DD clinical meetings we discussed how two LME/MCOs made the choice to prove the higher Residential Level and how the enhanced rate request can lead to more complexities as the request is leaving Utilization Management.
- At the bottom of the slide you see the language that the results of the system the IBT base budget are guidelines that do not constitute a binding limit that may not be exceeded on the amount of services including the level of this service that may be requested or authorized in the plan of care.

- As an example, in the current policy if someone had a SIS Levels A, the person would default to Residential Level 1, if the person had a SIS Level B, then the person would default Residential Level 2. If someone has needs that looked more like a SIS Level C (Residential Level 3) they would have to go through the Enhanced Rate Committee to request a higher rate.
- Based on this change, a person can just ask for the higher level of Residential Support and then if it meets medical necessity criteria that level could be approved.

Slide 5:

- This is the Supported Living Example.
- Basically, this is the same as the Residential Supports Slide.
- Again, you can see that the SIS Levels are only one piece of evidence that may be considered. If we go down the slide you will see the same language that the results of the SIS and the IBT base budget are guidelines that do not constitute a binding limit that may not be exceeded on the amount of services including the level of this service that may be requested or authorized in the plan of care.
- Again, this is both being updated and the Waiver Application and the Clinical Coverage Policy 8P.
- So again, if someone had a SIS Level A or B, but the person feels like s/he has needs that more looked like someone who needed residential supports level to they could request and be approved for that if medical necessity was meant

Slide 6:

- So now we're just going to look at one example of how a training slide is going to be changed and will be updated on our NC Medicaid Website.
- If we look at the bottom of the slide you will see struck through information that says the Supported Living the level is based on the SIS Level.
- Now we know, based on the guidance we discussed on the previous slide, that the Supported Living Level is partly based on this SIS, but it also takes into consideration support needs.

Slide 7:

- For the Residential Supports definition, there is very similar information to what we just looked at.
- Here the struck through language says that “~~The Residential Supports two levels are determined by the individual budgeting table category~~”
- Again, if someone needed to request a higher level of service the person could be approved for that higher level of service if the request met medical necessity.

Slide 8:

- Making requests. This is our second kind of part of the presentation.
- It is essential that individuals and families are supported to request whatever level of Innovations Waiver Services they believe are needed regardless of the sis core or the assigned budget guideline.

- Any discouragement of individuals or families from requesting the level of support they believe is needed is strictly prohibited.
- “Level of Support” means the service, the amount, the frequency, and the duration.
- Care coordinators can and should offer education on NC Innovations Waiver requirements service planning and service definitions, but cannot refuse to submit a request even if the care coordinator believes that it contradicts waiver policy.
- It is clear that we must support individuals to request whatever service array they want.
- We can provide education on waiver rules and limits but cannot refuse to make a request.
- A simple example would be someone making a request from vehicle modification that is not on the exhausted list We would still make the request for the vehicle mod. We could educate on the waiver definition and if the person wants to make the request we would then make the request.
- Another example is that if a person wanted to request Community networking in a non-integrated location we could educate on the definition, but will still make a request if that was desired by the individual.
- In terms of education on the SIS, we can let people know that the Supports Intensity Scale assessment will help the person and their planning team identify potential supports that are needed.
- In conversations with the members and families, we must stress the importance of using this assessment as a planning tool to identify needs.
- We should not be focusing on budget category assignment.
- So, to recap, the SIS can be used to determine the needs of the person, assist with forming goals, and potentially assist with the selection of services through comparison.
- We can also discuss how the SIS, as a tool, offers more useful information than an IQ test or the SNAP.
- In terms of education on the Individual Budget Guideline, the Individual Budget Guideline is really a starting or assessing point.
- The guideline is based on the array of services that would meet the needs of individuals similar to the person.
- This can look very different if the person is new Services or is within their guideline versus if person is outside of their guideline 07:56 - 07:58.
- For people new to services, the IBT can really be used as a starting point to ground people on what others typically use and as a guide to guard against over-serving.
- If someone is outside their budget guideline, we can begin investigating why and how supports could be better.
- Again, the Individual Budget Categories and the SIS are tools to help us understand how much support the person may need and where that support may be needed.
- But the denial letter should be specific to the person's and his or her needs which we'll talk about a little bit later.

Slide 9:

- When reviewing request for waiver Services, which exceed the assigned budget the decision must be based solely on the needs of the individual waiver participants based on all available evidence a denial must not be based upon a finding that the participant is not an outlier to his or her assigned budget category or does not have a typical needs when compared to other participants in the same budget category.

- Again, this is just like what we talked about on the other slide. Medical necessity must not be determined based on the budgeted amount or any comparison to the needs of any other waiver participant.
- A denial of services must be based on medical necessity for the services requested, based on the needs of that waiver participant, and based on all available evidence.
- A denial of services must not be based upon a finding the participant is not an outlier to his assigned budget category or does not have atypical needs when compared to other participants in the same budget category.
- The Budget Categories and the SIS are tools to help us understand how much support the person may need, but the denial letter should be specific to the person and his/her needs.
- Any denial of service was not be based upon a finding that the participant is not an outlier to his or her assigned budget category or does not have a typical needs.
- So that's what we just talked about. The budget categories and the SIS are just tools to help us figure out how much support the person may need but the denial letter should be specific to the person and his or her needs.

Slide 10:

- So how does this impact the utilization management utilization review process?
- We know that the following three components are included in the plan review process for all people the UM Clinicians. They look at the health and safety of the individual.
- They look at the waiver compliance - know does the request for the services meet the requirements of the waiver and the policy and then the Support Needs of the individual.
10:19 - 10:26.

Slide 11

- Examples of **unacceptable denial reasons** and this is just what has been seen in some of the letters.
- Some of the ones that are not acceptable:
 - Member appears to have been receiving Services previously that are not in alignment with the assigned budget category level and individual base budget category
 - The assigned budget with typically meet the needs of someone with similar support needs
 - Authorization should mirror use of services within the budget
- There are more examples in the actual Joint Communication Bulletin, but you'll notice that these denials examples are focused on the budget and not the person.
- Again, these are actual real denial letters and you can see that they are not focused on the person's needs. They are really focused on that budget, which we know is a guideline.

Slide 12:

So here are some examples of adverse decisions that are acceptable:

- Based on the clinical information provided including the system assessment medical necessity is not met for the requested service hours the information the assessments provided do not justify the increase in service hours.
- The information provided does not indicate that the individual would benefit from the combination of service hours requested.

- These adverse decisions that they're focused on the individual and how that Individual is unique and it really documents the uniqueness of the situation and not focused on the budget. really focused on we're just going to skip back a few possibly health and safety possibly support needs possibly waiver compliance, but all the information relates to the individual
- In contrast, these unacceptable denial reasons, are really focused on at Individual Base Budget. They are not addressing how the request relates to:
 - Health and safety
 - Waiver compliance, or
 - Support Needs

Slide 13

- Now we're going to talk a little bit about how this impacts intensive review.
- Participants requesting services over their individual budget must not be required to request the Intensive Review process in order to obtain services over budget.
- A participant may request Intensive Review, but such a request is independent of the LME/MCO's obligation to determine the need for services based solely on medical necessity in that case.
- For the first point, this is really why a person does not have to request Intensive Review and the UM/UR Clinician can send requests directly to IR.
- In our previous NC Innovations iteration, before resource allocation spread throughout the state, many people would go through intensive review before making their service request. Currently, that request to IR before a Service Request does not need to happen.
- There is not a sperate UM process for individual's over their budget guideline and another process for people within their budget guideline.
- This also means, as we have discussed before, the UM reviewer or peer reviewer can disagree with the recommendations of the IR committee. Again, the IR Committee is not making the Medical Necessity.

Slide 14

- The Intensive Review Committee makes recommendations about the appropriateness of the Intensive Review Category.
- So this is really making sure that when requests come in there's a separate set of eyes looking at the request from a multidisciplinary perspective.
- The Intensive Review Committee May request additional information or make alternative recommendations if appropriate.
- If the Committee determines that Intensive Review is not appropriate, the individual will not be assigned to the Intensive Review Group the Intensive Review Response Letter will be sent to the Care Coordinator / Legally Responsible Person noting that the person has not been recommended for the Intensive Review Group and an Individual-specific budget has not been set.
- The recommendations on the Intensive Review Letter should not be focused on the individual coming into their his/her budget category.

Slide 15:

- If an LME/MCO authorizes a requested service for a duration less than as requested, the beneficiary must receive written notice with appeal rights at the time of that limited authorization.
- The notice must include the clinical reasons for that decision.
- Also, we have to note that this does not apply if the specific service has a maximum benefit duration contained within the Innovations Waiver and the LME/MCO authorizes the service request up to that maximum.
- For example, Community Living and Support only being authorized up to six months at a certain duration.
- If services are approved for less than the maximum authorization period based on an expectation that the individual's needs will change during the plan year, the LME/MCO must provide written notice of the adverse benefit determination based upon this limited authorization of the service, and this notice must include the specific reason services are expected to be needed only for a limited time.
- Again, we're really talking about how the notice must include clinical reasons for the decision if we're authorizing the service for less time than requested.
 - For Instance the notice should include why the auth is for less time, what the needs are or what information is missing, what do we suspect may change, etc.
 - Occasionally you could have a higher level of service and expect that service to taper off because you'd expect those services to be effective.
- A temporary auth must be based on the waiver or on the persons needs not a temporary authorization based on the expectation that services will be reduced to meet budget or SIS guidelines. *For example, it is not permitted to approve services for less than the plan year because "it is unclear if [name] has needs not typical to his assigned budget category."*
- Again, if there is a Temporary Authorization we must speak to what the temporary need is. What do we expect to change?
- To recap, Joint Communication Bulletin 297 is really looking at:
 - Residential Supports and Support Living and the levels of support
 - The UM process and making sure the UM Process is based on the individual's needs,
 - That we are allowing people to make requests for what they feel like is needed, and
 - Making sure adverse decisions letters and reasons are based on the needs of the individual, based on the individual's health and safety, support needs, and Waiver Compliance.