NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

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LME-MCO Communication Bulletin J297

Date: July 13, 2018

To: Local Management Entities/Managed Care Organizations (LME-MCOs)

From: Deb Goda, Behavioral Health Unit Manager, DMA
Lisa Haire, Associate Director, Quality Management and Operations, DMH/DD/SAS

Subject: LME-MCO, *LS v Wos* Instruction

In November 2017, DHHS received a notice of noncompliance from plaintiffs' counsel with respect to the *LS v. Wos* Settlement Agreement. The department has reviewed the information provided by plaintiffs' counsel and has agreed to take certain corrective actions as outlined below.

<u>All LME/MCOs must promptly implement the following requirements and follow up regularly to assure compliance:</u>

1. The current clinical policy could be interpreted to suggest that the level of Residential Supports and Supported Living is dictated by the Supports Intensity Scale (SIS) score. This is incorrect. The level of Residential Supports or Supportive Living requested in the plan of care or approved by Utilization Management (UM) must be based on medical necessity in each participant's individual case. The SIS Level is only one piece of evidence that may be considered. The SIS score may be considered as a <u>guideline</u> only and should not be the sole piece of evidence in determining the level of these services.
    - The clinical policy will be revised at waiver renewal to clarify this issue, but all LME/MCOs must implement this change immediately.
    - Any verbal or written information (e.g. training materials, information on your website, bulletins, or instructions) which have been provided to staff, providers, or families stating or suggesting that the SIS score unilaterally determines the level of these two services must be promptly revised.
    - DHHS is currently revising training materials on this issue.

2. It is essential that families are encouraged to request whatever level of Innovations waiver services they believe are needed, regardless of the SIS score or assigned budget.
    - Any discouragement of either families or providers from doing so is strictly prohibited.
    - Encouraging participants to request a level of service within their assigned budgets is strictly prohibited and a violation of both the *LS v. Wos* Settlement Agreement as well as Paragraph 6.11.3(i)(b) of the LME/MCO contract with DMA.
    - The LME/MCO must immediately correct any information provided to staff, providers, or participants suggesting that a participant should or must attempt to request services within the assigned budget.

3. In reviewing a request for services which exceeds the assigned budget, the LME/MCO must make its decision based solely on the needs of that individual waiver participant based on all available evidence.
    - 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.

    Individuals / Teams should submit requests for Innovations waiver services they believe are needed with supporting documentation. Thus, a denial or partial denial may NOT be based on any of the following rationales or any similar reasoning:
    - "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 would typically meet the needs of someone with similar support needs."
    - "She does not appear to have needs not typical to those in her assigned category."
    - "People in this group will likely need minimal to low levels of support."
    - "[Name] has requested an array of services in excess of his base budget-a higher amount of services that would typically be needed to meet the needs of someone with similar support needs."
    - "No clinical rationale was given for his needs exceeding those at that base budget."
    - "Authorization should mirror use of services within budget."
    - "It was determined that [name] is not an outlier to his assigned category."
    - "Documentation shows needs consistent with the assigned budget category."

- "Level D appropriately describes his level of support needs."
- "There is nothing to show that [name] has exceptional needs."
- "Our reviewer has decided that part of the service you asked for is not medically necessary because [name] was assigned to Resource Allocation (RA) level E. … People who have needs described by Level E usually can be supported with 35 or 55 hours per week of Innovations waiver services. This means that the request for 64 hours a week of Community Living and Support (CLS) is more than he or she should need."

Examples of denials or partial denials could include the following rationales or similar reasoning:

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

To the extent any LME/MCO has provided information, verbally or in writing, to staff, providers, or participants which suggests otherwise, this information must be promptly corrected.

4. Participants requesting services exceeding their individual budget must not be required to request the Intensive Review process 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, regardless of whether the request is in excess of the assigned individual budget and regardless of whether the individual has exceptional needs.
    - The total cost of services (including base-budget services, enhanced rates, and add-on services) cannot exceed $135,000.
    - To the extent any LME/MCO has provided information, verbally or in writing, to staff, providers, or participants which suggests otherwise, this information must be promptly corrected.

5. If an LME/MCO authorizes a requested service for a duration less than as requested, unless the service has a maximum benefit duration contained within the Innovations Waiver and the LME/MCO authorizes the service requested up to that maximum, the LME/MCO must provide written notice with appeal rights at the time of that limited authorization, and the notice must include the clinical reasons for that decision.
    - A temporary authorization based on the expectation that services will be reduced to meet budget or SIS guidelines is strictly prohibited. *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."*

- 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 and advise the individual of his or her right to appeal the limited authorization. To the extent any LME/MCO has provided information, verbally or in writing, to staff, providers, or participants which suggests otherwise, this misinformation must be promptly corrected.

6. If a request for services exceeds the assigned budget, but is within the policy/waiver limits, is denied or partially denied, initially or at reconsideration, the notice itself (not just enclosed forms or instructions) must clearly state that services will be approved on appeal if they are medically necessary in that case. To the extent any LME/MCO has provided information, verbally or in writing, to staff, providers, or participants which suggests otherwise, this misinformation must be promptly corrected.

7. DHHS is in the process of revising its templates for notices of adverse benefit determination, i.e., denial, limited authorization, reduction, suspension, termination, and reconsideration.
    - LME/MCOs should remember that appeal forms and instructions for filing an appeal must be enclosed with the notice to comply with both federal regulations and the *LS v. Wos* Settlement Agreement.
    - As soon as the templates are issued, and no later than the applicable timeframe for transitioning to the new templates, LME/MCOs must update their notices and notice enclosures to be consistent with the content of these templates**.**

8. Each LME/MCO must promptly provide all Innovations waiver providers with a copy of this bulletin. DHHS will be conducting training on the contents of this bulletin and each LME/MCO must require its relevant staff and/or managers to participate in that training.
    - Each LME/MCO must promptly train any relevant staff who did not attend the DHHS-offered training on the contents of this bulletin.
    - LME/MCOs are expected to train staff at regular intervals for both new and existing staff members.

9. DHHS will be sending a notice within the next 30 days to all Innovations Waiver participants to explain and clarify the obligations of the LME/MCOs and the rights of the participants addressed throughout this bulletin. As always, regardless of the *LS. v. Wos* Settlement Agreement, if a participant's family or provider contacts his or her care coordinator to request an increase in services, the care coordinator must meet with the family (and provider, if requested) as promptly as possible, and must assure the request for increased services is submitted to UR as promptly as possible following the contact.

The instructions in this bulletin remain in effect until further notice. DHHS staff will be regularly monitoring all LME/MCOs for compliance with this bulletin. The LME/MCOs compliance efforts will also be reported to plaintiffs' counsel.

If you have questions please contact Deborah Goda at 919-855-4297 or Deborah.goda@dhhs.nc.gov; or Kenneth Bausell at 919-855-4296 or Kenneth.bausell@dhhs.nc.gov.

Previous bulletins can be accessed at: https://www.ncdhhs.gov/divisions/mhddsas/joint-communication-bulletins.

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