NC Innovations Waiver
Frequently Asked Questions
February 16, 2017

Topic	Question	Response
Alternate Family Living (AFL)	Can a provider who is already in an LME/MCO network (LME/MCO-A) and provides AFL in other LMEs/MCOs (LME/MCO-B), can the provider AFL in LME/MCO-A? If not, what approval process do they need to go through to add the AFL service to their array in LME/MCO-A?	Please contact the LME/MCO to determine what is needed.
All Services	Rates Sufficiency – It is difficult for provider agencies to pay competitive salaries for QP's / Clinicians requiring similar qualifications and performing similar job functions compared to Care Coordinator salaries paid by LME/MCOs. Providers are losing qualified staff to the MCOs; and a similar issue exists with our inability to be competitive with State Operated Facilities salaries / benefits.	Thank you for your feedback. Your feedback has been shared with the appropriate DMA team. This would be something you would consult with your counsel on. You may need to work with the LME/MCO if the requirement exists in their network provider contract.
All Services	We propose that the provider be allowed autonomy in developing the training in each area and have competency tests completed on each skill set per staff member. This would centralize staff training on agency specific skill sets, reduce costs, and increase efficiency.	This would be something you would consult with your counsel on. You may need to work with the LME/MCO if the requirement exists in their network provider contract.
All Services	My concern is regarding the deficiency from the LME-MCO: **2b. Per 10A NCAC 27G.0104(8) and 10A NCAC 27G.0204, *supervision must be scheduled and should be specified in an individualized supervision plan.* <u>The deficiency:</u> Most supervision plans do not include the frequency at which supervision will occur, therefore implementation of the plan cannot be determined.** The LME/MCO is requesting that we include frequency of supervision in our supervision plans. I have reviewed the rules and do not see a requirement that the frequency of supervision must be included in the supervision plan (only requires regularly scheduled assistance). Our QP Clinical Supervisors conducted scheduled (and at times unscheduled) supervision with their staff.	This would be something you would consult with your counsel on. You may need to work with the LME/MCO if the requirement exists in their network provider contract.
Assistive Technology	The new ATES service definition says it covers Category H: "Mobility Aids not covered by DME (Durable Medical Equipment)". We have someone who is going to get a new	Yes, if medically necessary and not coverable under EPSDT.

Equipment and Supplies (ATES)	wheelchair with features that are not covered by Medicare/Medicaid. Will ATES pay for the features that are not covered?	
Assistive Technology Equipment and Supplies (ATES)	Also, does that mean we can get strollers for people who also have a wheelchair?	Strollers would not be medically necessary if the person already uses a wheelchair.
Assistive Technology Equipment and Supplies (ATES)	Can we get manual wheelchairs for people who have power wheelchairs since Medicaid under DME will only pay for one?	Manual wheelchairs could be approved under the Waiver for people who have the physical capability to maneuver the manual wheelchair. This promotes independence and physical exercise.
Assistive Technology Equipment and Supplies (ATES)	For Category J under this definition: "Medical Supplies not covered by regular State Plan formulary". For adults, will this definition cover medical supplies that the State Plan limits how many of an item someone can get per month and they need more than that?	This also covers medical supplies that have limits under the State Plan for adults.
Attachment E: The Supports Intensity Scale (SIS®)	Support Intensity Scale (SIS ®) evaluations resulting in reduction of annual budgets: As individuals transition to the new Innovations Waiver providers are being told that clients are being evaluated using a new assessment tool, SIS®. This tool determines the service category, level of care needs and frequency, which then correlates with an annual budget, and is administered once every three years. Providers report it is unclear who controls or what data is used in the service category funding model/funding bands that determines overall budget. The funding model or funding bands do/does not appear to align with historical, current budget allocation methods, or current consumer needs. Further, during stakeholder discussions it was stated that if the SIS evaluation resulted in a change of more than 10%, the LME/MCO would not undertake more than a 10% change – but this limitation is occurring, putting clients in jeopardy.	The budget is based on age, SIS® score, and residential setting. The model was validated. The validation team included DMA, DMH/DD/SAS, LME-MCOs, providers and a family member.
Attachment F: Individual Budgets	Systematic Reduction of Hours – In calculating the Individual Service Plan (ISP) for the next year and LME/MCO is not utilizing a complete plan year in their calculations, and is systematically	Individuals and/or families should request the services they need on the plan. If services are denied, they have a right to appeal. In addition, individuals/families may file a grievance with the LME/MCO.

	shorting hours. As providers have tried to inform the LME/MCO on the need to annualize the hours (based on twelve months) they have continued to deny the requests and told families to appeal the issue, causing a substantial administrative burden for providers and unnecessary anxiety to the families. Can this be corrected?	
Attachment F: Individual Budgets	Based upon initial implementation – is there an "algorithm" that exists in combination with the SIS ® to systematically reduce services and lower costs rather than determining service levels based upon individual needs? Can we get a copy of this method/procedure/process so that we can be better informed how to advocate for client's needs? What tools other than the SIS® are used to develop a planning budget for Innovations services?	The budgets are a guideline. Individuals may request what they feel is necessary. The budgets are phased in such that if an individual is more than 120% of their budget, the budget would be phased in by their 3rd planning year. There is no algorithm to systematically reduce services and lower costs rather than determining services levels based upon individual needs.
Back-up Staffing	The way it's worded in the final CP 8P – "Service breaks do not require Back-Up Staffing reporting to the PIHP" is not consistent with what you have indicated to me in previous emails. The way it is written doesn't support the MCO in requiring any reporting of service breaks as a result of a provider not providing Back-Up Staffing.	8P states "The beneficiary may miss a service for a variety of reasons. Holidays, family vacations, weather conditions, illnesses, and scheduling conflicts can cause brief interruptions in services." These directly relate to the beneficiary missing a service, not the staff missing a service. If a staff member does not provide a service and the provider agency fails to provide back-up staff, the provider **is required** to report as a Back-up Staffing issue to the MCO.
Clinical Supervision	We request clarification be given to LME/MCOs -The policy does not require any mandate for frequency and duration of supervision of paraprofessionals. LME/MCOs are requiring it. Rules require that a QP provide clinical supervision to the paraprofessional and require that paraprofessionals have a supervision plan that is implemented. There are no frequency or duration requirements in rule.	The policy references statute. If the MCO wishes to make this a part of their contract, they may do so.
Community Living and Support	Someone who was receiving one or more of these 3 services – Personal Care Services (PCS), In-Home Skill Building (IHSB), and/or In-Home Intensive Services (IHIS) as of 11/1/16 can continue to receive the service through the end of plan year, even if a revision is submitted specifically impacting one of these services and a new service authorization is issues for one of these 3 services? **OR** Someone who was receiving one or more of these 3 services as of 11/1/16 should not be forced to transition to Community Living & Supports prior to the end of	If a beneficiary/guardian requests another 90-day authorization for IHIS, the service, if approved, would be authorized under Community Living & Supports (CL&S). However, PCS and IHSB services would remain in place until the authorization ended, unless the beneficiary/guardian opted to switch those services over to CL&S at the time of the request. In addition, if a beneficiary/guardian requests to add another service, PCS, IHSB, IHIS services would not be switched over to CL&S unless the beneficiary/guardian choose that option.

	current authorization period just because they make some other revision to their plan – a revision which does not impact these services?	
Community Living and Support	Although we honor authorization of services from transferring MCO, would we need to switch PCS and IHSB to CL&S when we entered the authorization into our system?	The services shall remain in place that are listed on the transferred authorization. Changes in services would come through a revision at the request of the beneficiary/guardian.
Community Living and Support	Service definition allows beneficiary to receive this service if he/she is living in own home. Clarification is needed: Some LME/MCOs are not allowing this service if the individuals lives in own home and is only allowing Supported Living.	DMA will provide guidance to the MCOs. If the individual needs more than 4 hours of CL&S per day, then Supported Living (SL) is the most appropriate service.
Community Navigator	Are there additional guidelines on what should be covered in the annual session on self-direction?	The information that is noted in the policy/waiver.
Community Networking Transportation	It is stated in item that "Payments for transportation are established per trip charge or mileage." What is the process for billing and receiving payment for mileage>	Please consult with the LME/MCO.
Crisis Prevention and Intervention – Multiple Services	Staff Competency of Crisis and Intervention – For Community Living and Support (and this year / until birthdate) for In-Home Skill Building, In Home Intensive Support, Personal Care and Residential Supports a required staff competency for each service is: *The Support Professional identifies risk and behaviors that can lead to a crisis, and uses effective strategies to prevent or intervene in the crisis in collaboration with others.* Clarification is needed that the following is correct: • Intervening in the crisis is limited to time when the person is currently receiving one of the above services from the provider, not other times of the day when the client is not present with the provider. • When the person is not directly receiving one of the above services and has a crisis episode, the provider of Crisis Services: Crisis Intervention and Stabilization Supports, Crisis Consultation, Out of Home Crisis would be responsible for responding to the crisis. Also, an individual could receive In-Home Skill Building, In-Home Intensive and Personal Care through multiple agencies, and some LME/MCOs expect these periodic providers (non 24 hour services) to respond to a crisis when the person is not currently receiving services from them (example – 11:00pm). Additionally, which	Thank you for your feedback. The provider is responsible for responding to or having an arrangement with an enrolled crisis provider to respond to crisis situations.

	provider has to respond when none of them has been designated or paid to be responsible for "clinical home" functions such as crisis response.	
Crisis Service Standard	In Standard f: Must be qualified in CPR, First Aid and NCI. We understand that any state approved preventative training other than NCI can be utilized and recommend clarification be provided as such. In Standard b: qualified professional in the field of developmental disabilities, who meets competencies established by the PIHP. To assure consistent implementation, these competencies should be standardized in the statewide waiver.	Other DMH/DD/SAS approved curriculums may be utilized in lieu of NCI. https://www2.ncdhhs.gov/hcbs/public_comment.html
Day Supports	It appears that most MCOs have instructed Day Support providers that at least 15 minutes of service into the next hour rounds up to one hourly unit (example: Day Supports provided from 9am – 2:15pm is billed as 6 units). This appears to be consistent with what I understood to be the guidance provided initially. However, we now hear that at a recent PI meeting/training, it was said that this is inaccurate.	Clinical Coverage Policy 8P states "Day Supports is billed in 1-hour unit increments. An individual must receive Day Supports 15 minutes before the 1-hour unit may be billed."
Day Supports	The specific area of confusion is whether a) the cost of transportation is included in the rate and thus the time transporting is NOT authorized service time or b) the service itself includes transportation and time spent transporting IS authorized service time.	Transportation is actual service time when the Day Supports program staff is providing the transportation.
Day Supports	It is stated in the Clinical Coverage Policy that "Transportation to/from the individual's home, the day supports facility and travel within the community is included in the payment rate." Please assure that if the individual needs the same number of hours of Day Supports and additional hours are needed for transportation that the Care Coordinator adds additional hours to the plan and the authorization is revised.	If the individual needs additional units of service, the Care Coordinator should submit a revision.
Day Supports	It is stated in the service definition "Individuals who receive Day Supports only have to attend the Day Supports facility once a week." Clarification is needed on what is involved/required during the once weekly attendance. What does attend consist of? How will providers be expected to document the once per week attendance? How will this be monitored? Can this be	As little as a check-in. Provider documents on the Day Supports documentation. The MCO may waive this requirement.

	waived in the plan as discussed when approved by the LME/MCO?	
Day Supports	Who is responsible for providing the educational session to new participants? Care Coordinators or Providers? If providers how should this be documented?	Care Coordinator will need to inform the individual of the other options for a meaningful day.
Day Supports Hourly Units / Rounding Day Supports Exclusions	It is stated in the Clinical Coverage Policy, "Day Supports is billed in 1-hour unit increments. An individual must receive Day Supports 15 minutes before the 1-hour unit may be billed." Examples: • *If the billing begins at 9:00am and ends service at 3:20pm (6 hours and 20 minutes), this rounds to 6 hourly units.* • *If the billing begins at 9:20am and ends service at 2:30pm (5 hours and 10 minutes), this rounds down to 5 hourly units. It is also stated "This service may not duplicate services, nor shall they be furnished or billed at the same time of day as services…"* Care will be required to prevent the provision or billing of services at the same time of day be coordinating authorizations / the ISP for services billed with hourly units and services billed through 15 minute units (such as Respite). Focus should be on the units of service provided for the hourly service (Days Supports), not on the time of day, even if an individual receiving an hourly service (Day Supports) also receives a periodic service immediately preceding or following delivery of day supports? Example: An individual receiving Day Supports from 9:00am until 3:30pm (billable time is 6 units) and Respite service was provided beginning at 3:30, the services would not be provided at the same time of day.	Even if the hour is truncated by another service, it is not duplicative. That being said, the planning team should schedule such that the individual can attend for the hour whenever possible.
Day Supports Transportation Billing Beginning / Ending	It is stated in the Clinical Coverage Policy that "Transportation to/from the individual's home, the day supports facility and travel within the community is included in the payment rate" and "Transportation to and from the licensed day program is the responsibility of the Day Supports provider." We understand that the hourly billing unit begins at the time the Day Supports provider picks up the individual. If, however, the Day Supports provider arranges the transportation service, the hourly billing	If there is staff, you may bill from the time the individual is picked up. If there are multiple individuals and one staff, it must be group. If someone rides the bus or the van without staff, you may not bill for the time.

	begins at the time of arrival at the day supports facility/service location. The hourly billing unit ends at the time individual is returned by the Day Supports provider to his/her home, or the time the individual leaves the day facility/service location with the transportation service.	
Documentation of Suspected / Observed Abuse / Neglect / Exploitation and Incident Reports	Language is ambiguous and clarification is needed concerning documentation requirements in the service record. If Suspected / Observed Abuse / Neglect / Exploitation is an incident, then language should be made consistent with the language for Incident Reports, which requires only for the occurrence of an incident to be recorded in the service record (service notes). The completed incident report shall not be reference or filed in the service record, but filed in a separate administrative file. Delete in #1, "relevant facts shall be documented in the service record, including reports made by the individual and actions taken by staff."	Please refer this question to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) who oversees the Records Management and Documentation Manual (RMDM). https://www.ncdhhs.gov/providers/provider-info/mental-health/records-management
High School Diploma	What are the requirements to verify high school diploma? Can LME/MCOs require certain accreditation for high schools?	The high school must be accredited.
ISP Monitoring	NCPC requests involvement in the development and training of the "standard monitoring checklist." Additionally, until the checklist has been developed, that LME/MCOs do not create their own checklists.	The MCO is responsible for monitoring the ISP. There is a current checklist that is utilized. The updated checklist, adding HCBS characteristics, is in final draft.
Natural Supports Education	It is stated in the Clinical Coverage Policy under Other Standards – Agency staff that work with beneficiaries: g. High School Equivalency (GED). This is in direct conflict with the waiver. Appendix C: Participant Services C-1/C-3 Provider Specifications for Services – Natural Supports Education under Other Standards: Qualified Professional as specified in 10A NCAC 27G.0204 and according to licensure or certification requirements of the appropriate discipline. Please clarify which is correct.	The waiver is correct. This will be corrected in policy.
Professional Competency by 11/1/18	We would like further clarification on how the provider shows evidence of how staff competencies have been met in 9 areas, and by November 1, 2018	Training curriculum and evidence of staff completion. DMA has not dictated the curriculum in the waiver. The MCO has latitude in specifying a curriculum.
Relative as Provider	Policy states that if the relative provides less than 40 hours of services it must be "reported" to the LME/MCO. We request	This may be a future addition. At this time, we request that you notify the MCO when you do this. This does not always occur at the time of

	that the inclusion of the Relative as Provider in the ISP be sufficient.	the annual plan and notification will suffice without having to do a plan revision.
Relative as Provider	It is stated in the Clinical Coverage Policy, last sentence of the second paragraph, "Waiver beneficiaries under the age of 18 may receive services provided by a relative who is not the parent (biological, adoptive, or step) who resides in the home." This is a direct conflict with the waiver. Appendix C: Participant Services C-2: General Service Specifications (3 of 3) e. Waiver beneficiaries under the age of 18 may not receive services provided by a relative who is residing in their home. Please clarify which is correct.	The intent was to allow for non-parents of the minor children to be able to provide paid support. This is noted in the Additional Needed Information section of the waiver. We will make the correction in policy and with the next waiver amendment.
Residential Support	Therapeutic Leave with Residential Support – Recently, I have been getting a number of questions / accusations from Care Coordinators / monitors from the Partners area specifically about us using therapeutic leave days for Innovations consumers receiving Residential Supports, when they go home for the weekend. This has come up within the last 3 weeks at least 4 different times with different Care coordinators. I can't seem to get a straight answer from the folks at Partners about therapeutic leave days, even though MCO staff announced a couple of years ago that Partners would be allowing 60 days of therapeutic leave for CAP folks just like the ICF's. I realize Innovations is a different service, but we continued to use the therapeutic leave days. Have you heard anything about therapeutic leave days in the Innovations services?	There is no therapeutic leave for Innovations Waiver services.
Residential Support Provider Types	Supervised Living Facilities Type C for adults: 4 beds or less for newly developed facilities; 6 beds or less for existing. There can be new admits to these facilities (Note this needs to be added for clarification so there is no confusion with the four greater than 6 beds where there are no new admits to these facilities.	The waiver reads "6 beds except for facilities licensed prior to June 15, 2001; no new waiver admissions to facilities greater than 6 beds; new facilities cannot be licensed for more than 4 beds." We will correct in the next policy revision.
Respite	It is stated in the service definition "NC Innovations Respite may also be used to provide temporary relief to individuals who reside in Licensed and Unlicensed AFLs, but it may not be billed on the same day as Residential Supports" and under limits on amount, frequency, or duration it is stated "The cost of 24 hours of respite care cannot exceed the per diem rate for the average community ICF-IID Facility." There is no requirements for	All services must be medically necessary.

	providers to submit proof of historical use of Respite by the Respite provider to justify the current need for respite services, as required by one LME/MCO.	
Respite	It is stated in the service definition "NC Innovations Respite may also be used to provide temporary relief to individuals who reside in Licensed and Unlicensed AFLs, but it may not be billed on the same day as Residential Supports." Can Respite be provided / billed on an hourly basis; and, if so, can hourly Respite be provided / billed on the same day as Residential Supports?	Respite can be provided on an hourly basis. Respite may never be billed on the same day of Residential Supports.
Respite	The Clinical Coverage Policy states "Respite services provide periodic or scheduled support and relief to the primary caregiver(s) from the responsibility and stress of caring for the individual" which conflicts with the following statement under Exclusions which states: "B. This service may not be used as a regularly scheduled daily service individual support." In addition, it also states under Limits on amount, frequency, or duration – "the cost of 24 hours of respite care cannot exceed the per diem rate for the average community ICF-IID facility." Clarification is being requested for what the respite limits are.	Respite may be scheduled in advance but should not be used in lieu of a regularly scheduled service. The cost of 24 hours of respite care cannot exceed the per diem rate for the average community ICF-IID facility.
Service Breaks	We request clarification be given to LME/MCOs – Some LME/MCOs are requiring submission of Service Breaks. 8P specifically says not required to be submitted.	We are crafting guidance on this issue for the MCOs. Service breaks requested by the individual / family are not required to have lack of back-up staffing reported.
Specialized Consultative Services	On page 20 of the Clinical Coverage Policy which lists Licensed Professional Counselor (LPC) and Licensed Clinical Social Workers (LCSW), but does not list Licensed Marriage and Family Therapist (LMFT). LMFTs, however, learn some of the same techniques and have experience with evidence based practices. The one difference is Marriage and Family Therapists tend to always look at the whole family and the whole situation. Also on page 100 of the Clinical Coverage Policy, the definition states "other licensed professionals who possess experience with individuals with Intellectual/Developmental Disabilities." Question: Can LMFTs be listed on page 20 and provide Specialized Consultative Services under the statement about "other licensed professionals who possess experience with individuals with individuals with Intellectual / Developmental	The LMFT could provide the service if it's covered under the definition and scope of license.

	Disabilities. If not, what criteria is used to determine what experience with I/DD is acceptable.	
Supported Living	We have the following under the provider qualifications in our Supported Living Definition in the waiver: Supported Living Providers: • Assist in finding a home that meets the individual's needs.	Community Navigator section specifically lists "assist with locating options for renting or purchasing a personal residence…". This was included under the SL in error and will be corrected at the next Technical Amendment or at the waiver renewal.
Supported Living	All persons receiving Supported Living Services who live in the same household must be on the lease unless the person is a live in caregiver." What if the individual receiving Supported Living owns the home?	If they own the home, this needs to be noted.