APPENDIX to LME/MCO Training

All of the information below should be provided to enrollees and providers by the LME/MCOs and any documents inconsistent with this information should be updated to reflect the substance of the information below. No single document needs to contain all of this information, but this information should be made available on the LME/MCOs website and in communications in which the information is relevant:

- During the planning process, Care Coordinators will explain the different services to enrollees and work with the enrollee to develop his or her Plan of Care based on the services the enrollee wishes to request. Care Coordinators will also explain the requirements in the Innovations Waiver around those services.

- Care Coordinators will assure that an enrollee's Plan of Care will include the services that the enrollee wants to request, for the length of time that the enrollee wants to request them. The Plan of Care should be used to plan for the entire year, and services that the enrollee expects to need at any point during that year. If the enrollee expects to need services for the entire year, Care Coordinators will assure that the plan requests those services for the entire year.

- Enrollees must have a signed Plan of Care in order to receive services through the Innovations Waiver. That means that an enrollee needs to sign a Plan of Care containing the level of services that the enrollee wants to request, which may be different than the level of services that will be approved. Care Coordinators will draft the Plan of Care based on the enrollee's wishes, will review the plan with the enrollee before it is signed, will answer any questions the enrollee has, and will make any changes to the plan that the enrollee requests before the enrollee is asked to sign it.

- If an enrollee wishes to change or add services during the plan year, the enrollee may ask the Care Coordinator to assist in updating the enrollee's Plan of Care at any time.

- The enrollee (or the enrollee's legally responsible representative) will need to sign the Plan of Care once it is complete. The enrollee will not be asked to sign a plan that does not contain the level of services that the enrollee wants to request. If the enrollee expects to need those services all year, the enrollee will not be asked to sign a plan that does not request those services for the entire plan year.

- The Utilization Management Department of the LME/MCO will determine whether or not the services requested are medically necessary, not the Care Coordinator. A decision on the request for services in an enrollee's Plan of Care will be made within 14 days unless more information is needed.

- If any service requested in an enrollee's Plan of Care is not fully approved (for example, a service is denied, or is approved for fewer hours or for a length of time that is less than what was requested), the enrollee will receive a written explanation of that decision and information about how the enrollee can appeal.

- The LME/MCO will never retaliate against an enrollee in any way if an enrollee chooses to appeal. Care Coordinators can assist enrollees with the forms needed to file an appeal.

- If some services are approved and some are denied, the enrollee can receive the services that were approved while the enrollee appeals the services that were denied. The enrollee may also make a new request for different services while the appeal is pending, if the enrollee wishes to do so.

- The enrollee's Plan of Care will include information on the period of time for which services are requested. If services that have been requested in the Plan have been approved and then are later reduced, suspended, or terminated before the approval period has ended, and the enrollee appeals that decision, the enrollee may be able to continue to receive services during an appeal. The enrollee will receive written notice about that process before any services are reduced, suspended, or terminated.