CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

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February 12, 2010

TO: ADHC PT (43) Provider Letter #A-37
HCB PT (42) Provider Letter #A-79
SCL PT (33) Provider Letter #A-34

RE: Michelle P Waiver Policy Clarifications and Updates

Dear Kentucky Medicaid Providers:

The Department for Medicaid Services is very appreciative of your continued desire to assist us in providing services to those with intellectual disabilities and developmental disabilities through the Michelle P. waiver (MPW). This letter contains important information regarding the MPW.

Policy Clarification

- Sixty (**60**) days from the date of level of care (LOC) issuance will be allowed for submission of **initial** MPW Prior Authorization (PA) of services to SHPS. All yearly re-assessment packets will continue to be required within thirty (**30**) days from the date of LOC issuance per policy. This will be effective immediately.

- It is the case manager/support broker responsibility to notify the CMHC of the client's need for a yearly MPW reassessment. Referrals may be initiated thirty (30) days prior to the expiration date of the current LOC. The client relies on the case manager/support broker to ensure continuation of MPW services without lapse of coverage. The MPW regulation stipulates one role of the Case Manager is to "provide for reassessment at least every twelve (12) months".

(please see reverse side)

Important Information

Eligibility for the MPW, as with all Medicaid waivers, is a two-part process. The first part of the process determines medical eligibility. The second part involves financial eligibility. Each part is equal in its importance and must be accomplished in that order for the client to successfully enter their respective waiver program.

Medical eligibility is determined through the assessment and PA packet submission process with SHPS. *Financial eligibility* is determined through the client or family's application with the local Department for Community Based Services (DCBS). Potential members should apply at the local DCBS office based on their current county of residence.

Financial eligibility standards are dependent on the Level of Care (LOC) determination. Individuals who meet nursing facility (NF) or ICF/MR LOC more easily qualify since a higher income standard is allowed.

Financial eligibility should be determined only *after* the client's completed packet has been submitted to SHPS and a PA has been issued. For this system to work properly, the electronic data file sent from SHPS to the DCBS computer system must be present before the DCBS specialist can determine eligibility.

It is vitally important for the client/family to be educated by the assessor/case manager of the appropriate steps in this two-fold application process. Financial application should only occur after the PA is received by DCBS. If clients are sent to DCBS prior to the PA, Medicaid eligibility cannot be accurately assessed. Consequently, some clients are denied eligibility due to the higher income standards not being applied correctly.

In addition, DCBS cannot backdate a Medicaid initiation date for more than three (3) months prior to the date of the financial application. DCBS only will backdate if the client informs the DCBS specialist *at the time of application* the existence of prior unpaid medical bills.

As always, we hope this information has been very helpful to you and assists you in providing services to clients across the Commonwealth. Should you have questions or concerns, please contact Rena Warner, Division of Community Alternatives at (502) 564-7540.

Sincerely,

Elizabeth A. Johnson, Esq.
Commissioner

Xc: ADHC PT (43) Provider Letter #A-37
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