



**CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES**

**Steven L. Beshear  
Governor**

**Division of Program Quality & Outcomes**  
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**Audrey Tayse Haynes  
Secretary**

**Lawrence Kissner  
Commissioner**

**MEMORANDUM**

**TO:** Lawrence Kissner, Commissioner

**FROM:** Patricia Biggs, RN  
Director, Division of Program Quality & Outcomes

**DATE:** January 8, 2015

**SUBJECT:** Request from the MAC concerning a common Prior Authorization process

The workgroup formed to determine the feasibility of a common form or process to be used in obtaining a prior authorization (PA) is continuing to work on this project.

We are in the process of gathering the individual forms used by each MCO with the exclusion of pharmacy related forms. The group will meet to discuss development of a common form that will provide information needed by the MCOs without causing additional delay for our members and additional administrative burden for the providers. The process to develop a common form will be a lengthy process as each MCO has multiple forms to address individual services requiring PA. The next meeting will be scheduled in February.

Concerns that remain include:

- Specific items on the individual MCO form cue the area that is to review the service request.
- Each form is designed to reflect the information needed for the specific request.
- Differences in criteria will impact the clinical criteria and documentation required which if not provided at the time of request could delay the PA process.
- Corporate forms are often utilized and the MCO PA systems are designed to use the specific form.
- Changes to the MCO established systems to accommodate a single form will be very costly and time consuming.
- Multiple fax numbers on one form will increase the chance of error or lost requests.





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DEPARTMENT FOR MEDICAID SERVICES**

**Steven L. Beshear**  
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**Audrey Tayse Haynes**  
Secretary

**Lawrence Kissner**  
Commissioner

November 19, 2014

**TO:** Medicaid Advisory Committee (MAC) Board Chairwoman Partin and MAC Board Members

**RE:** Response to Behavioral Health Technical Advisory Committee (TAC) Testimony Presented at the March 27, 2014, May 22, 2014 and July 24, 2014 MAC Meetings

Dear Chairwoman Partin and MAC:

We are writing to address testimony presented by Dr. Sheila Schuster, spokesperson of the Behavioral Health TAC, at the MAC meetings on March 27, 2014, May 22, 2014, and July 24, 2014.

*Behavioral Health TAC March 27, 2014 Recommendations:*

1. That representatives of the Behavioral Health TAC (or their designees) be invited to attend a meeting of the MCO Medical Directors convened by Dr. John Langefeld (DMS) to discuss this issue of inconsistency of forms and procedures across MCOs, in order to seek some resolution which would reduce administrative costs and burden for providers and facilitate service provision.

*RESPONSE: The appropriate forum for TACs to discuss issues and make recommendations is the process that is currently in place where TACs submit their recommendations to the MAC for DMS to respond. The Director of the Division of Program Quality and Outcomes, Patricia Biggs, has convened a workgroup, which includes medical directors or representatives from all MCOs, to research the*

*possibility of utilizing a common prior authorization form, although there may be some limitations in implementing a common form. She will provide an update to the MAC at the next MAC meeting.*

2. The requested data for PA's and their outcomes for psychotropic medications has not yet been completed by DMS, but will be forwarded to the Behavioral Health TAC within the next month – six weeks. Once that data has been received and reviewed by the BH TAC, further recommendation to improve medication access may be forthcoming.

*RESPONSE: DMS will respond to any forthcoming recommendations from the Behavioral Health TAC when brought forth by the MAC at a meeting in which quorum is met.*

3. That Kentucky DMS review carefully the comments made by providers in response to the published rates, and in particular, examine the rates for services such as intensive case management and outpatient therapies which could prevent higher-cost, more restrictive treatment approaches from being needed.

*RESPONSE: DMS will review the comments made by providers in response to the published rates. DMS will also continue to monitor utilization to determine if changes to fees or regulations are warranted.*

4. Finally, the Behavioral Health TAC wishes to state again this recommendation made a year ago: That a Behavioral Health Ombudsperson be established to provide easily-accessed personal responses to consumers who are experiencing difficulty with the Medicaid managed care system. This would allow consumers to share their personal health information (PHI) as they discuss directly with the Ombudsperson the issues that need to be resolved with the MCOs in order for them to access the care that they need.

*RESPONSE: The CHFS has an ombudsman for the entire Cabinet who deals with issues related to all the programs administered by the Cabinet regardless of subject matter. By law, this office serves as an advocate for all citizens and works to ensure those seeking various public services are treated fairly. The Office of the Ombudsman answers questions about CHFS programs, investigates customer complaints and works with CHFS management to resolve them, advises CHFS management about patterns of complaints and recommends corrective action when appropriate. Currently, the office consists of three branches: Complaint Review, Performance Enhancement and the Institutional Review Board. We are working to integrate all the functions of the Ombudsman's Office within a proactive, data-driven agency whose contributions to the Cabinet will be essential to overall quality improvement. The Ombudsman may be contacted through an online form at <http://chfs.ky.gov/dail/kltcopcontact.htm>, by phone at 1-800-372-2973 or 1-800-627-4702 (TTY), through email at [AndreaT.Day@ky.gov](mailto:AndreaT.Day@ky.gov) or by mail at:*

*The Office of the Ombudsman  
Cabinet for Health and Family Services  
275 E. Main St., 1E-B  
Frankfort, KY 40621*

*In addition, it is important for members to follow the proper appeal process for denied services as outlined in the member handbook provided by the assigned Manage Care Organization. DMS continually monitors the appeals to ensure MCO compliance and to determine if there are areas of concern.*

*Behavioral Health TAC May 22, 2014 Recommendations:*

1. The requested data for PA's and their outcomes for psychotropic medications – as well as other requests made by our TAC as far back as July, 2013 were approved by the MAC in January and submitted to DMS for response. That response and initial data was received by me from Beth Partin, MAC Chair, late yesterday, May 21<sup>st</sup>. In a very brief review, I noted that the table prepared by Ms. Guise (sic) of DMS regarding Prior Authorizations of services did not address our question, as it creates a single category for Mental Health & Substance Abuse Services and does not break out the individual services. Our question was about specific services and whether PAs were required, as well as whether PAs were differentially required, depending on whether the service was being provided by a CMHC or by a private provider. Obviously, the Behavioral Health TAC has not had an opportunity to read, review or digest the response from DMS nor the data provided. A number of the data tables were illegible and I will contact Erin Hoben at DMS to obtain clean copies for our review. Once that material has been thoroughly reviewed by the BH TAC, further recommendations to improve medication access and to address other issues may be forthcoming.

*RESPONSE: Leslie Hoffmann, the Behavioral Health Policy Advisor for DMS, will convene a meeting with DMS and the appropriate representatives from each MCO to discuss their prior authorization (PA) process for behavioral health services and will present an update to the MAC at the next MAC meeting. Legible data tables were presented in print to the MAC at the March MAC meeting and included in the binder. Because the TACs do not receive the binders from the MAC, Erin Hoben will be sending larger copies to Sheila Schuster.*

2. That DMS immediately post on their website and disseminate basic information about the Open Enrollment Period now underway. This information, at a minimum, should be sent to the MAC members, all of the TACS and to the advocacy and provider groups typically notified by DMS about the MAC meetings. I have attached a copy of the announcement flyer and of the accompanying MCO information that is being disseminated through the KY Mental Health Coalition and other advocacy groups for this purpose.

*RESPONSE: DMS has posted information about open enrollment on their website. That information can be found here:*

*<http://www.chfs.ky.gov/dms/member+information.htm>. Additionally, DMS mailed the attached provider letter regarding open enrollment to all Medicaid providers and notified advocacy groups of open enrollment through an email notification.*

3. That representatives of the Behavioral Health TAC (or their designees) be invited to attend a meeting of the MCO Medical Directors convened by Dr. John Langefeld (DMS) to discuss this issue of inconsistency of forms and procedures across MCOs, in order to seek some resolution which would reduce administrative costs and burden for providers and facilitate service provision.

*RESPONSE: DMS convened a workgroup with the MCOs to explore opportunities for consistency among forms and processes. The workgroup is being led by Patricia Biggs, Director for the Division of Program Quality and Outcomes. DMS will report back to the MAC when it has more information to share about the workgroup's progress.*

4. That Kentucky DMS carefully monitor the hospitalization/ institutionalization/out-of-state placements of Medicaid members and re-evaluate the reimbursement rates for services such as intensive case management and outpatient therapies in light of this data.

*RESPONSE: DMS is continually monitoring utilization of behavioral health services and will consider changes to fees and regulations as necessary.*

5. That a Behavioral Health Ombudsperson be established to provide easily-accessed personal responses to consumers who are experiencing difficulty with the Medicaid managed care system. This would allow consumers to share their personal health information (PHI) as they discuss directly with the Ombudsperson the issues that need to be resolved with the MCOs in order for them to access the care that they need.

*RESPONSE: Please see response to Recommendation 4 under the March 27, 2014 recommendations.*

#### *Behavioral Health TAC Recommendations July 27, 2014:*

1. That Kentucky DMS carefully monitor the hospitalization/ institutionalization/out-of-state placements of Medicaid members and re-evaluate the reimbursement rates for services such as intensive case management and outpatient therapies in light of this data.

*RESPONSE: Please see response to Recommendation 4 under the May 22, 2014 recommendations.*

2. That a Behavioral Health Ombudsperson be established to provide easily-accessed personal responses to consumers who are experiencing difficulty with the Medicaid managed care system. This would allow consumers to share their personal health information (PHI) as they discuss directly with the Ombudsperson the issues that need to be resolved with the MCOs in order for them to access the care that they need.

*RESPONSE: Please see response to Recommendation 4 under the March 27, 2014 recommendations.*

Sincerely,

Erin Hoben  
Chief Policy Advisor  
Commissioner's Office  
Department for Medicaid Services

cc: Lawrence Kissner, Commissioner, Department for Medicaid Services  
Neville Wise, Deputy Commissioner, Department for Medicaid Services  
Lisa Lee, Deputy Commissioner, Department for Medicaid Services  
Mary Begley, Commissioner, Department for Behavioral Health, Developmental and Intellectual Disabilities  
Dr. John Langefeld, Medical Director, Department for Medicaid Services  
Leslie Hoffmann, Behavioral Health Policy Advisor, Department for Medicaid Services  
Barbara Epperson, Resource Management Analyst III, Department for Medicaid Services



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**Audrey Tayse Haynes**  
Secretary

**Lawrence Kissner**  
Commissioner

To: All Medicaid Providers  
Provider Letter A-97

Date: October 1, 2014

Re: **Medicaid Managed Care Open Enrollment**

Beginning October 27, 2014 and ending December 12, 2014 the Commonwealth of Kentucky Medicaid Managed Care members will be in their Open Enrollment period. All Medicaid members will have the option to change MCOs or remain with their current plan. The MCO choices are: Anthem (not available in the counties in Region 3 – Breckinridge, Bullitt, Carroll, Grayson, Hardin, Henry, Jefferson, Larue, Marion, Meade, Nelson, Oldham, Shelby, Spencer, Trimble and Washington) Coventry Cares, Humana, Passport, and Wellcare. MCO changes made during this Open Enrollment period will be effective on January 1, 2015. **Note:** If a member does not proactively change their MCO during the Open Enrollment period, they will remain with the same MCO for 2015.

Should you have questions about this Open Enrollment period, please contact the Department for Medicaid Services Call Center at 800-635-2570. Should your patients have questions or wish to make a change to their MCO, please refer them to our Call Center. For those members who came into Medicaid through the Kentucky Health Benefits Exchange - *kynect*, they can return to the *kynect* website to make MCO changes. The web address for *kynect* is: [kynect.ky.gov](http://kynect.ky.gov) Please also know that members can make their MCO changes on a *kynect* Kiosk. These kiosks are located in many of our Commonwealth's hospitals, for the member's convenience.

Should you have questions, please contact the Division of Provider and Member Services, Provider Services Branch at 855-824-5615. Many thanks for providing services to our members. We appreciate everything you do for the citizens of this Commonwealth.





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Commissioner

MEMORANDUM

TO: Lawrence Kissner, Commissioner

*cop> FOR STAFF MTG  
+ MAC*

FROM: Patricia Biggs, RN *RB*  
Director, Division of Program Quality & Outcomes

DATE: November 17, 2014

SUBJECT: Request from the MAC concerning a common Prior Authorization process

At the request of the MAC, the Department for Medicaid Services has formed a workgroup to explore a common Prior Authorization (PA) process to be utilized by the Managed Care Organizations (MCO). The task is to determine the feasibility of a common form or process to be used in obtaining a prior authorization.

The workgroup is composed of representatives of each MCO plus representatives from the Department for Medicaid Services. Members are: Dr. Stephen Hoagland, Medicaid Director Passport; Dr. Fred Tolin, Medical Director Coventry; Dr. Howard Shaps, Medical Director WellCare; Dr. Vaughn Payne, Medical Director, Humana; Jeff Sutherland, Manager II Healthcare Management Services Behavioral Health Anthem; Matthew Fitzner, Director of Healthcare Management Services Anthem; Patricia Biggs, Director and Cindy Arflack, Assistant Director, DMS Program Quality & Outcomes.

Research has been conducted to assess how other states have tackled this issue. Ohio developed a common form for an authorization request. A copy of the form is included for review. Ohio also developed a grid that details PA requirements for category of service across their Managed Care plans. It is not detailed as to specific codes but rather the type of service being authorized.

Nevada shared that though they only have two (2) Medicaid MCOs, there were differences with certain prior authorization requirements. A spreadsheet was developed with the codes in question. PA requirements were listed for each of those codes and they then tried to align the requirements. Nevada has fax and online portal submissions for the prior authorization process. They did not develop a common form for submission.

At the workgroup meeting on October 29, 2014, the positive and negatives aspects of the common PA form/process was discussed. A summary of the discussion points is below.

**PRO:**

- Less administrative burden for providers.
- Tracking of services authorized may be easier when a member moves from one MCO to another.
- Improved documentation and/or completion of the form if a standard form is utilized by all MCOs.
- No reason for use of a provider developed "homegrown" form for submission.

**CON:**

- Specific items on the form cue the area that is to review the service request as well as the form is designed to reflect the information needed for the specific request.
- Differences in criteria would impact the clinical criteria and documentation required.
- One form expected to cover all documentation needed for multiple services would be lengthy.
- A common formulary for medications would have a dramatic impact on pricing/costs due to the different PBM contracting that exists within the industry.
- Corporate forms are often utilized and the MCO systems designed to use the specific form.
- Changes to the MCO established systems to accommodate a single form will be very costly and time consuming.
- Increased likelihood of HIPAA breach since forms would no longer be visually discernable from one MCO to the next.
- The unique form each MCO utilizes contains specific MCO contact information.
- Multiple fax numbers on one form will increase the chance of error or even lost requests.
- Movement to a state specific form would create opportunity for errors and delays to members and providers.

**Workgroup suggestions:**

- The workgroup would like specific recommendations from the MAC as to the changes requested in the PA process.
- Each MCO would be willing to provide training for provider staff in properly completing a PA request form.
- Encourage the use of on-line prior authorization request submission.
- Continue the workgroup discussions until a satisfactory outcome results.

**Take Away:**

- Each MCO is to provide the Department the volume of requests received by each source-phone, fax and on-line portal submissions.
- Each MCO is to provide a list of the codes that require prior authorization along with any special requirement or limitation for the service.



## PRIOR AUTHORIZATION FORM

\* For URGENT requests please contact MCP by phone\*

Today's Date:

MCP Name:

<b>1.</b>	<b>Member ID</b>	<b>DOB</b>	
	<b>Last Name</b>	<b>First Name</b>	
	<b>Member Phone Number (      )</b>		
<b>2.</b>	<b>Is there another Insurance Carrier for this service?</b>		
	<input type="checkbox"/> YES <input type="checkbox"/> NO		
	If yes, name of company		Policy Number:
<b>3.</b>	<b>Referral Service Type Requested</b>		
	Please refer to the Plan's Prior Authorization List for those services that require prior authorization		
	Ambulatory Surgery	<input type="checkbox"/>	Out of Network Provider <input type="checkbox"/>
	Cosmetic/Plastic Procedure	<input type="checkbox"/>	Diagnostic Testing <input type="checkbox"/>
	Elective/Scheduled Admission	<input type="checkbox"/>	Office Procedure <input type="checkbox"/>
	DME/Home Infusion	<input type="checkbox"/>	OB Services <input type="checkbox"/>
	Pain Management	<input type="checkbox"/>	Specialty Referral <input type="checkbox"/>
	Outpatient PT/OT/ST	<input type="checkbox"/>	Other <input type="checkbox"/>
<b>4.</b>	<b>Requesting Provider Information</b>		
	Provider ID Number:		
	Provider NPI:		
	Requesting Provider Name: (Last, First)		
	Specialty:		
	Phone Number:		
	Fax number:		
	Requesting Provider Address:		
<b>5.</b>	<b>Referred to Provider/Facility Information</b>		
	<b>Type: Office</b> <input type="checkbox"/> <b>OP Hospital</b> <input type="checkbox"/> <b>IP Hospital</b> <input type="checkbox"/> <b>Free Standing Facility</b> <input type="checkbox"/>		
	Provider/Facility ID Number:		
	Provider NPI:		
	Provider/Facility Name:		
	Specialty:		
	Phone Number:		
	Fax Number:		
	Provider/Facility Address:		
<b>6.</b>	<b>Service Requested</b>		
	Planned Date of Service	EDC	(OB Notification)
	Primary ICD-9 Code		Description
	CPT Code(s) or HCPC Code(s)		Description
	Visits/Frequency/Duration		
	Clinical Indications for the Request: (May attach clinical or progress notes. Please include pertinent previous testing results):		
<b>7.</b>	<b>PLAN ADMINISTRATIVE USE ONLY:</b>		
	Service request status:		
	Approved <input type="checkbox"/> Pending <input type="checkbox"/> Denied <input type="checkbox"/>		
	Comments:		

# Ohio Medicaid Managed Care Plan PA Requirements

NOTES: ALL NON-PAR SERVICES REQUIRE PA  
 \*\* See specific MCP website for details

Category	Buckeye Health Plan	CareSource	Molina	OH PARACOUNT	UnitedHealthcare	Additional Notes
<b>ANCILLARY/ DME SERVICES</b> Ambulance & Ambulette Services (except emergency)	Yes	Yes	Yes	Yes	Yes	
Durable Medical Equip	To determine if other DME codes require prior authorization, please refer to: <a href="http://www.bchpohio.com/providers/pre-auth-needed/">http://www.bchpohio.com/providers/pre-auth-needed/</a> Yes	Yes (\$750)	Yes - refer to Molina's website for list of codes requiring PA Yes	**Yes, per ODM Guidelines for over quantity limits Yes	Yes, over \$1000, enteral, and custom wheelchairs Yes	
Hearing Aids	Yes	Yes	Yes	Yes	Yes	
Home Health Services	Yes, after initial evaluation and first 12 visits Yes	Skilled Home Care Services do not require Prior Auth. If >29day then PA is required. Home Health Aides require Prior Auth Yes	Yes, after 3 skilled nursing visits **No	Yes after initial evaluation Yes	Yes No	
Lisp/Spk Care	Yes	Yes	**Yes	**Yes	Yes - Bolton, Acthar, IVIG, Xolair, Malerin	
Infect Aides	To determine if other orthotic/prosthetics codes require prior authorization, please refer to: <a href="http://www.bchpohio.com/providers/pre-auth-needed/">http://www.bchpohio.com/providers/pre-auth-needed/</a>	**Yes	**Yes	**Yes	Yes - Bolton, Acthar, IVIG, Xolair, Malerin	
Orthotics/Prosthetics	To determine if other orthotic/prosthetics codes require prior authorization, please refer to: <a href="http://www.bchpohio.com/providers/pre-auth-needed/">http://www.bchpohio.com/providers/pre-auth-needed/</a>	Yes (\$750)	Yes - refer to Molina's website for list of codes requiring PA	No, unless over ODM allowable	Yes, over \$1000	
Therapy -Occupational, Physical & Speech	Yes	Yes > 30	Yes after initial evaluation	No (Yes, if > 30 visits)	No	
Transportation	Yes	Yes - limit 30 one way trips per year	Yes - limit 30 one way trips per year (2 business days notice)	Yes - limit 30 one way per year (48 hours notice)	Yes	
Wound Vacs/ outpatient only	Yes	Yes	Yes	Yes	Yes	
IMPATIENT SERVICES	Hospital Admissions to include TAC/rehab/ospice	Yes	Yes	Yes	Yes	
Nursing Facility Admissions	Yes	Yes	Yes	Yes	Yes	
OUTPATIENT SERVICES	Cardiac Rehab/excludes eval	No PA for outpatient services and per providers No - Outpatient Yes - Inpatient	Yes Yes	Yes Yes	Yes Yes	
Chemotherapy and Radiation	No PA for outpatient services and per providers No - Outpatient Yes - Inpatient	No No - Outpatient Yes - Inpatient	Yes No - Outpatient Yes - Inpatient	No No	No No	
Chiropractic Services	Diagnosis Services at non-contracted facilities	only on non-par providers Yes	Yes	Yes	Yes	
Diagnosis In Testing:	PEI -SPECT	Yes Visit <a href="http://www.radiol.com">www.radiol.com</a> Yes Visit <a href="http://www.radiol.com">www.radiol.com</a>	Yes Yes	Yes Yes	Yes Yes	
MRI/MRA CT Scans	Yes Visit <a href="http://www.radiol.com">www.radiol.com</a>	No-OB US Yes-Fetal NST > 10	Yes Yes	No Yes	Yes Yes	
OB Ultrasound	No	No	No	No	No	
Ultrasound (non OB)	No	No	No	No	No	
Dialysis	No	No	Notification Only	No	No	

**BEHAVIORAL HEALTH TAC RECOMMENDATIONS  
TO THE MAC – MARCH 27, 2014**

**RECOMMENDATION:** That representatives of the Behavioral Health TAC (or their designees) be invited to attend a meeting of the MCO Medical Directors convened by Dr. John Langefeld (DMS) to discuss this issue of inconsistency of forms and procedures across MCOs, in order to seek some resolution which would reduce administrative costs and burden for providers and facilitate service provision.

**PREVIOUS RECOMMENDATION:** The requested data for PA's and their outcomes for psychotropic medications has not yet been completed by DMS, but will be forwarded to the Behavioral Health TAC within the next month – six weeks. Once that data has been received and reviewed by the BH TAC, further recommendation to improve medication access may be forthcoming.

**RECOMMENDATION:** That Kentucky DMS review carefully the comments made by providers in response to the published rates, and in particular, examine the rates for services such as intensive case management and outpatient therapies which could prevent higher-cost, more restrictive treatment approaches from being needed.

Finally, the Behavioral Health TAC wishes to state again this recommendation made a year ago:

**RECOMMENDATION:** That a Behavioral Health Ombudsperson be established to provide easily-accessed personal responses to consumers who are experiencing difficulty with the Medicaid managed care system. This would allow consumers to share their personal health information (PHI) as they discuss directly with the Ombudsperson the issues that need to be resolved with the MCOs in order for them to access the care that they need.

## **BEHAVIORAL HEALTH TAC RECOMMENDATIONS TO THE MAC – MAY 22, 2014**

**PREVIOUS RECOMMENDATION:** The requested data for PA's and their outcomes for psychotropic medications – as well as other requests made by our TAC as far back as July, 2013 were approved by the MAC in January and submitted to DMS for response. That response and initial data was received by me from Beth Partin, MAC Chair, late yesterday, May 21<sup>st</sup>. In a very brief review, I noted that the table prepared by Ms. Guise of DMS regarding Prior Authorizations of services did not address our question, as it creates a single category for Mental Health & Substance Abuse Services and does not break out the individual services. Our question was about specific services and whether PAs were required, as well as whether PAs were differentially required, depending on whether the service was being provided by a CMHC or by a private provider. Obviously, the Behavioral Health TAC has not had an opportunity to read, review or digest the response from DMS nor the data provided. A number of the data tables were illegible and I will contact Erin Hoben at DMS to obtain clean copies for our review. Once that material has been thoroughly reviewed by the BH TAC, further recommendations to improve medication access and to address other issues may be forthcoming.

**RECOMMENDATION:** That DMS immediately post on their website and disseminate basic information about the Open Enrollment Period now underway. This information, at a minimum, should be sent to the MAC members, all of the TACS and to the advocacy and provider groups typically notified by DMS about the MAC meetings. I have attached a copy of the announcement flyer and of the accompanying MCO information that is being disseminated through the KY Mental Health Coalition and other advocacy groups for this purpose.

**PREVIOUS RECOMMENDATION:** That representatives of the Behavioral Health TAC (or their designees) be invited to attend a meeting of the MCO Medical Directors convened by Dr. John Langefeld (DMS) to discuss this issue of inconsistency of forms and procedures across MCOs, in order to seek some resolution which would reduce administrative costs and burden for providers and facilitate service provision.

**RECOMMENDATION:** That Kentucky DMS carefully monitor the hospitalization/institutionalization/out-of-state placements of Medicaid members and re-evaluate the reimbursement rates for services such as intensive case management and outpatient therapies in light of this data.

➤ Finally, the Behavioral Health TAC wishes to state again this recommendation made more than one year ago:

**RECOMMENDATION:** That a Behavioral Health Ombudsperson be established to provide easily-accessed personal responses to consumers who are experiencing difficulty with the Medicaid managed care system. This would allow consumers to share their personal health information (PHI) as they discuss directly with the Ombudsperson the issues that need to be resolved with the MCOs in order for them to access the care that they need.

**BEHAVIORAL HEALTH TAC RECOMMENDATIONS  
TO THE MAC – JANUARY 22, 2015**

**RECOMMENDATION:** That the NCCI billing edits issues be resolved quickly, with a standardized implementation timeframe and with a minimum of administrative burden on providers.

**RECOMMENDATION:** That data from the MCOs reported on the DMS dashboard be made available to the Behavioral Health TAC, specifically: Lengths of Stay in Psychiatric Hospitals and Crisis Stabilization Units; Percentage Denials for each behavioral health service: inpatient and outpatient; Readmissions to Psychiatric Hospitals and Crisis Stabilization Units; and HEDIS measure reported by each MCO of ambulatory follow-up post discharge from acute level of care. We request that the data in each instance be separated by children (up to age 18) and adults.

**RECOMMENDATION:** That the data being used by Dr. Langefeld for addressing the “Super-Utilizers” of the ER be shared with the Behavioral Health TAC.

**RECOMMENDATION:** That DMS work with the Behavioral Health TAC and with the MCOs to further discuss appropriate reporting and measures for documenting integrated care and its outcome.

**RECOMMENDATION:** That the enrollment numbers of members across the MCOs be shared with the Behavioral Health TAC.

**RECOMMENDATION:** That a date certain be established for making the ABI waiver slots actionable and be communicated to the Behavioral Health TAC and the IDD TAC.

**RECOMMENDATION:** That all of the MCOs communicate with DMS and with the Behavioral Health TAC their policy with regard to access to Abilify in its generic form (expected date: April 1st). Will prior authorization continue to be required for each member for whom it is prescribed?

## **BEHAVIORAL HEALTH TAC REPORT TO THE MAC – JANUARY 22, 2015**

Good morning. I am Sheila Schuster, serving as Chair for the Technical Advisory Committee on Behavioral Health (BH). Our TAC had its most recent meeting at the Capitol Annex on January 13, 2015. We invited all five (5) of the Medicaid MCOs and their Behavioral Health representatives to attend and all were represented. In addition to the MCO representatives and the five TAC members who were present, we had other members of the behavioral health community in Kentucky, including members of the KY Mental Health Coalition. We also had staff from the KY Department for Medicaid Services and representatives from the Governor's Budget office. We had invited the KY Department for Behavioral Health, Developmental & Intellectual Disabilities to send a representative, but no one was in attendance.

A copy of the Behavioral Health TAC written report made to the MAC in November of 2014 was disseminated and briefly discussed.

In the invitation to the MCOs to attend the January TAC meeting, a request was made for them to provide the following information:

We are requesting that you provide us – preferably in writing – this information for discussion at the meeting:

- Has your medical necessity criteria changed in the past year? If so, how can the new one be accessed?
- How many behavioral health professionals outside of the CMHCs are now credentialed with your MCO? What is their distribution across the state? Where can an individual go to see a list of mental health professionals in your network?
- What committees/advisory groups do you currently have that have consumer/family member/advocate members? What committees need such membership?
- What will be your goal/focus in the coming year for demonstrating increased integrated care for your members with behavioral health issues?

All of the MCOs discussed their medical necessity criteria, with only Aetna/Coventry/MHNet indicating that there were significant changes in it. All MCOs gave directions to accessing the most up-to-date version of the criteria.

Each of the MCOs reported on the number of behavioral health professionals outside of the Community Mental Health Centers (CMHCs) with whom they have contracted to be on their panels. Written information was provided by all of the MCOs except Anthem, who will forward the information to me separately. The range of behavioral health professionals numbers from 570 (Humana/CareSource) to 1600 (Aetna/Coventry/MHNet). The most useful information was provided by Passport with a breakdown across Medicaid regions for the various types of BH professionals.

Each of the MCOs stated – as they have in the past – that they have consumers, family members and advocates serving on various advisory committees. However, consumer and family members who were in attendance at the meeting noted that the request for participation was frequently not followed up by significant response to input provided. The appeal for the MCOs to provide the Behavioral Health TAC with specific requests for participation by consumers, family members, advocates and providers was again made. Further, a strong appeal was made for meaningful dialogue between the MCO personnel and the advisory committee member about

the nature of the committee, the role that the advisory member could play, and the information needed by the advisory member from the MCOs. The emphasis was on a mutual process! There was again discussion about integrated care and the goals/focus that each MCO had in this area going into 2015.

One of the issues raised was that while all of the MCOs are now paying for Peer Support Specialist services – and the general consensus of discussion in the meeting appeared to be that the use of the peer specialist would be particularly helpful in implementing an integrated care delivery system – the MCOs apparently do not see it as their role to initiate the introduction of a peer specialist with these individuals! One wonders whose responsibility it is to initiate that service. Why it is not being initiated in the case conferences which the MCOs are conducting with their behavioral health and their physical health case managers?

The Brain Injury Alliance of KY rep asked when the ABI Medicaid waiver slots would be opened? No one present knew the answer to that question.

The Children's Alliance rep updated the TAC on progress that had been made regarding the NCIC coding problems. DMS has met with the MCOs around this issue, as has the Children's Alliance members. A concern was expressed by several attendees that it would create a significant burden on providers if they had to go back and re-bill previously submitted claims because of a change in the codes. The MCOs expressed concerns that they would be unable to know which claims were new and which were being rebilled. All present asked the DMS representative to take the issue back to the Department to seek a solution which would create the least administrative burden on providers.

The Behavioral Health TAC agreed on these recommendations to be submitted to the MAC:

**RECOMMENDATION:** That the NCCI billing edits issues be resolved quickly, with a standardized implementation timeframe and with a minimum of administrative burden on providers.

**RECOMMENDATION:** That data from the MCOs reported on the DMS dashboard be made available to the Behavioral Health TAC, specifically: Lengths of Stay in Psychiatric Hospitals and Crisis Stabilization Units; Percentage Denials for each behavioral health service: inpatient and outpatient; Readmissions to Psychiatric Hospitals and Crisis Stabilization Units; and HEDIS measure reported by each MCO of ambulatory follow-up post discharge from acute level of care. We request that the data in each instance be separated by children (up to age 18) and adults.

**RECOMMENDATION:** That the data being used by Dr. Langefeld for addressing the “Super-Utilizers” of the ER be shared with the Behavioral Health TAC.

**RECOMMENDATION:** That DMS work with the Behavioral Health TAC and with the MCOs to further discuss appropriate reporting and measures for documenting integrated care and its outcome.

**RECOMMENDATION:** That the enrollment numbers of members across the MCOs be shared with the Behavioral Health TAC.

**RECOMMENDATION:** That a date certain be established for making the ABI waiver slots actionable and be communicated to the Behavioral Health TAC and the IDD TAC.

**RECOMMENDATION:** That all of the MCOs communicate with DMS and with the Behavioral Health TAC their policy with regard to access to Abilify in its generic form (expected date: April 1st). Will prior authorization continue to be required for each member for whom it is prescribed?

Thank you for providing this forum to bring forward behavioral health concerns on behalf of Medicaid members.

**BEHAVIORAL HEALTH TAC RECOMMENDATIONS  
TO THE MAC – NOVEMBER 20, 2014**

**RECOMMENDATION:** That DMS work with the BH TAC and with the MCOs to further discuss appropriate reporting and measures for documenting integrated care and its outcome.

**RECOMMENDATION:** That the NCCI billing edits inconsistency be resolved quickly.

**RECOMMENDATION:** The Hospital recommendations were reviewed and the Behavioral Health TAC is endorsing these recommendations: To waive the IMD Exclusion; To have the MCOs report on admissions to psych hospitals, re-admissions, Lengths of Stay in psych hospitals, and denials of IOP and Partial Hospitalization services.

## DENTAL TAC RECOMMENDATIONS (01/22/2015)

1. It has been reported to the TAC that one of the MCO Dental subcontractors is reporting dentists to the National Practitioner Data Bank (NPDB) when the dentist decides to no longer participate in the plan, but fails to notify the plan in writing. **And providers have not been notified of this tactic.** Most are too busy trying to comply with ever-increasing rules and regulations to write an additional letter. They just stop seeing the patients covered by the plan. This use of the NPDB is a bastardization of the intent of the Bank. Failure to file paperwork has nothing to do with the clinical practices and actions of the provider. The NPDB is supposed to be a repository of claims and malpractice actions against providers. The TAC recommends that DMS have the plan cease and desist from these reports to the NPDB. Terminating the provider from the plan and no longer processing his or her claims is sufficient sanction for failure to submit paperwork.
2. It is the understanding of the TAC that the MCO Dental subcontractors are required by contract to have a Kentucky licensed Dental Director . This is not the case for each MCO plan. The TAC recommends that DMS review this contractual requirement and mandate any necessary changes. In addition, the TAC requests that these state-licensed dental directors participate in the quarterly TAC meetings as well as the monthly Medical Directors meetings.

**KENTUCKY DENTAL TAC MEETING MINUTES**  
**Transportation Cabinet**  
**Mero Street**  
**Frankfort, Kentucky**

**December 3, 2014**  
**8:00 a.m. EST.**

The meeting of the Dental Technical Advisory Committee (TAC) was called to order by Dr. Susie Riley, Chair.

The TAC members in attendance: Dr. Susie Riley and Dr. Garth Bobrowski. Dr. Rick Whitehouse Executive Director, Kentucky Dental Association.

Medicaid staff in attendance: Dr. Ken Rich, Ms. Carrie Anglin, Mr. Charles Douglass, Ms. Stephanie Bates and Ms. Jan Thornton. Dr. Julie McKee, State Dental Director, Kentucky Oral Health Program.

The Managed Care Organization (MCO) representatives in attendance were: Dr. Fred Sharpe, Dr. Jerry Caudill and Mr. John Rice with Avesis; Ms. Pat Russell with WellCare; Mr. Craig Dalton with Scion Dental; Ms. Peg Patton and Jean O'Brien with Anthem Kentucky; Ms. Christian Bowlin, Ms. Kim Howell, Dr. Vaughn Payne, Ms. Beth McIntire and Ms. Candace Owens with Humana- CareSource; Ms. Morgan Stumbo with MCNA; Dr. Fred Tolin with CoventryCares; Ms. Christina Medina, Mr. Matt Misleh and Mr. Jason Baird with DentaQuest. Appearing telephonically: Ms. Bonnie Urick with Humana-CareSource; Dr. Ronald Ruth, Ms. Mercedes Linares and Ms. Denise Kissane, MCNA. Also in attendance: Ms. Mahak Kalra with Kentucky Youth Advocates and Kentucky Oral Health Coalition.

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The minutes from the September 24, 2014 meeting were reviewed. Dr. Bobrowski noted that Mr. Todd Edwards was listed as Interim Executive Director of the Kentucky Dental Association but the title should be Assistant Executive Director. Dr. Riley made a correction on page 3 of the minutes under Non-Payment of Claims Related to Taxonomy where it stated: ADO's expire April of 2015 and NPI's expire October 30, 2014. Dr. Riley stated that NPI's do not expire and that ADO's expire at different dates. Dr. Riley declared the minutes accepted, as corrected.

**MCO'S/SUBCONTRACTORS:**

**HUMANA – CARESOURCE/MCNA:** Ms. McIntire addressed the TAC. She noted that the dental claims statistics reported on page 3 of their report was inaccurate and that their prompt pay is 93.4%. She will present a new slide and resubmit this to the TAC. All three quarters were reported and Ms. McIntire reviewed the reports.

Dr. Bobrowski asked why the claims denial percentage continues to increase, and Ms. McIntire said they would provide a further breakdown of the denial percentage. Dr. Riley asked why the turnaround time for credentialing is increasing and Ms. Stumbo stated it was due to the large volume of credentialing in the system.

Dr. Bobrowski asked what dentists were doing that causes them to be in noncompliance, and Ms. Stumbo stated that dentists need to keep up with the annual paperwork that is required to be filed. Dr. Rich stated that if providers do not inform the MCO that they no longer want to participate in the program, the providers will be turned over to the National Practitioner Data Bank on the grounds of involuntary termination, and Dr. Rich stated that the MCOs need to let providers know this. Dr. McKee asked if this is a policy that Humana-CareSource can change, and Ms. Stumbo said it would have to be taken back for discussion. It was noted that Avesis, Scion and DentaQuest do not turn providers' names over to NPDB because of their failure to notify.

**ANTHEM/SCION:** Mr. Dalton reviewed the quarterly reports. He noted that Scion has been selected by the American Dental Association (ADA) to be the repository for credentialing information for dental providers. Mr. Dalton spoke about the continuous transport process that Scion had been developing and getting ready to implement where claims will automatically move through the payment cycle daily and be automatically adjudicated. Any claims that have exceptions, however, will be sent for review.

Dr. Bobrowski discussed the shortage of oral surgeons in certain regions of the state. Mr. Dalton stated that if Scion is contacted, they will work with out-of-network providers to try to get the patients the dental care that's needed, and

Mr. Dalton felt that DentaQuest would follow this same process when they become the dental subcontractor for Anthem.

Dr. Riley asked if Scion's system can identify a truly duplicate payment or does it just identify that it has seen that claim before and automatically denies as a duplicate even though it may not have been paid. Mr. Dalton stated that if it's been billed and denied before and it comes in again with the corrected information, it will not be denied again.

Dr. Riley noted that the TAC has gotten used to Scion's robust reporting and asked DentaQuest if this will continue in the future and Ms. Medina assured her it would.

**GENERAL DISCUSSION:** Before making individual MCO/Avesis presentations, Dr. Sharpe addressed several issues. He noted that Avesis will now present reports to the TAC in the same format for all three of their three clients. Dr. Shape stated that there is a movement by the National Association of Dental Plans to standardize credentialing forms on a national basis.

Another issue he spoke about was mobile dentistry. Avesis has been attempting to identify the mobile programs operating in Kentucky, and Avesis has presented to Medicaid Services, to the Kentucky Dental Association and to the Medical Directors a proposed set of guidelines for mobiles operating in the Medicaid Program but has not yet received approval to distribute these guidelines.

Avesis is in the process of setting up a process for credentialing hygienists for the Department for Public Health that is endorsed by DMS and the Governor, and Avesis is working with their clients to ensure proper payments to the local health departments.

Dr. Sharpe stated that Avesis now has a full-time Dental Director who is a pediatric dentist located in Phoenix, Arizona and they have four licensed dentists who are dental consultants located in Kentucky, as well as Dr. Caudill who is a licensed dentist and does reviews. Dr. Sharpe stated that provider notices will be going out to remind providers about the necessary forms needed for licensure renewal.

Dr. Sharpe spoke about the need for more oral surgeons due to a 60% increase in the Medicaid population with the Expansion that has taken place, and he noted that 95% of those new patients are adults. He also stated that the failure/no-show rate is very high among this population. Dr. Riley asked if the dollars were there to support the program since oral surgeons have already taken a 5% reimbursement cut.

**WELLCARE/AVESIS:** Dr. Caudill distributed some reports that were not given to the TAC in advance and he reviewed the WellCare quarterly reports. Dr. McKee stated that the statistics she receives from these MCO reports are used by her office weekly.

Dr. Sharpe noted that pediatric dentists are invaluable to their networks. He stated that the National Pediatric Dental Association decrees that kids should be seen by the age of one, but statistics show that less than 20% of the kids under the Medicaid Program get to a dentist prior to the age of one or at age one.

**COVENTRYCARES/AVESIS:** Dr. Caudill reviewed the quarterly reports and there were no questions from the TAC.

**PASSPORT/AVESIS:** The quarterly reports for Passport were distributed to the TAC. Dr. Caudill stated that Jason Trudeau misunderstood the date of the TAC meeting and, therefore, is not in attendance. Dr. Sharpe stated that there is a continuing growth with the oral surgeons in the network due to the change in the bifurcated billing process.

**GENERAL DISCUSSION:** Dr. Sharpe stated that the TAC or the KDA might want to look into the dental schools doing a training program for general dentists on treating children down to age one. He noted that there is movement in some states to establish a dental home project where both children and parents become affiliated with a dentist as soon as possible and to move the age down as far as the initial visits.

Dr. Riley asked if anyone from DMS could clarify why the TAC is only receiving a one-page report for fee-for-service because the TAC used to receive reports by service type on a quarterly basis. Ms. Anglin stated that Kurt Godshall with DMS who does the reports stated that the report for service type is too large and it would not be beneficial to look at every single service type by accounting.

Dr. Riley stated she had received an email asking Humana-CareSource what percent of the time the pended claim report is used to meet the prompt payment guideline. After some discussion, Ms. Howell clarified that their system automatically sends a pending claims report to providers every two weeks as long as they have pended claims that aren't paid yet, but this does not nullify the requirement of the MCO paying interest if it is paid later than thirty days from receipt.

Another question raised by Dr. Riley was since all third-molar extractions, either simple or surgical, require prior authorization, if the procedure has to be done on an unplanned basis, does Humana-CareSource do retro authorization. Ms. Stumbo stated this would be a case-by-case review, and Dr. Riley asked that she reach out to Dr. Collins concerning this issue.

Dr. Bobrowski asked if WellCare had an answer to his question from the last TAC meeting concerning why fee reimbursements were reduced from 17 to 22% for posterior composites. Ms. Pat Russell stated she still did not have an answer.

**OLD BUSINESS: Revision of Dental Regulations:** Dr. Riley asked if there was any progress on the revision of the dental regulations. Dr. Rich said there was a lot of discussion at a different level but there was nothing to report at this time.

**No Shows/Failures:** Dr. Riley stated that this has been an ongoing topic, and that in the CDT 2015, there will be a code for this. She asked if this code could get incorporated into provider reporting. Dr. Rich stated that if DMS can get the regulation revision done and the codes taken out of the regulation, there will be greater potential to add and/or subtract codes. Dr. Riley made a request to the Dental Directors to consider adding this code since it is budget neutral. Ms. Russell stated when working with the State to see if this can be covered, one thing to look at is the encounter data submitted by the MCOs to make sure that it is eligible and they are set up to receive that information from the MCOs and then there will be a single repository for that information. Ms. Bates made note of that.

**NEW BUSINESS: Medicaid Roundtable Update:** Dr. Bobrowski stated a meeting was held with Secretary Haynes and her staff at the end of October. He felt like it was a productive meeting and noted that smaller groups will be formed to work on areas of interest. No future meeting dates have been set up.

Dr. Rich discussed the Internet link that was sent to the TAC on quality measures published by the Dental Quality Alliance, and he said the TAC should start talking about and considering what measures are going to mean in the future. He stated this link addresses the first two measures that have been approved by the National Quality Forum.

At the next meeting, Dr. Rich will have someone make a report on the Kentucky Health Information Exchange (KHIE). Dr. Riley asked if a presentation on meaningful use could be done at a later date as well.

Dr. Rich said that DMS is working on a portal for credentialing and has been in contact with the Kentucky Board of Dentistry concerning the sharing of data to ease the burden of paperwork.

Dr. Rich stated that Dr. John Langefeld, the State Medical Director for DMS, has given approval for the Dental Directors to start attending the Medical Directors' monthly meetings. This will improve communications on how to collaborate and work together to improve the oral health of the Medicaid population. Dr. Riley also invited the state-licensed Dental Directors to attend the quarterly TAC meetings.

Dr. Bobrowski spoke about the Lee Specialty Clinic in Louisville which is a special-needs program. He also spoke about foster care children and the paperwork hassles involved in treating these children. Dr. McKee stated these regulations are getting ready to change and she will follow up with this issue.

Dr. Bobrowski noted that on February 3, 2015, the Kentucky Dental Association is having is Legislative Day in Frankfort where dentists will have an opportunity to speak with their legislators. He asked if DMS could be available to meet with dentists at a convenient location. Ms. Bates will follow up with this.

The next meeting date is March 25, 2015. The meeting was adjourned.

(Minutes were taped and transcribed by Terri Pelosi, Court Reporter, this the 9<sup>th</sup> day of December, 2014.

## Home Health TAC Meeting Notes 11/18/14

### Role Call:

Erin Varble- DMS  
Niki Martin -HP  
Pam HP  
Helen Humana  
David- DMS  
Rebecca-Well care  
Pat Russell- Wellcare  
Jennifer Thurman  
Holly Garcia- Coventry  
Greg Stratton- DMS  
Rebecca Cartright- Baptist  
Jennifer Thurman- 3 Rivers  
Susan Stewart- ARH  
Billie Dyer- MEPCO  
Arianna Afshari-KHCA

### Old Business:

Pam will follow up with Veronica to send out Private Duty Enrollment for HH agencies in KY

### New Business:

Carewise- Erin will email Pat to find out if there are any changes in local offices for HCBW patients

Wellcare question responses: Pat will follow up with questions prior to the next meeting

1. Pat Russell says she hasn't had a chance to check up on this and will do some research and get back to us

### Coventry question responses:

1. Was in communication with Sharon this morning and the rep is actively reaching out to the provider in which this question pertained to.
2. Needs to research
3. Been actively working with them, needs to get in writing whether the items are closed or not because they are in understanding that they are closed

Regarding Reidy Medical- Pat asked me to email Ted's contact and the person he has been in contact with in order to resolve this issue. Arianna followed up and sent all contacts during the meeting.

Bi-Monthly Meetings to be set for 2015  
1/15, 3/19, 5/14, 7/16, 9/17, 11/17



**CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES**

**Steven L. Beshear**  
Governor

275 East Main Street, 6W-A  
Frankfort, KY 40621  
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**Audrey Tayse Haynes**  
Secretary

**Lawrence Kissner**  
Commissioner

January 16, 2015

TO: Medicaid Advisory Committee (MAC) Board Chairwoman Partin and MAC Board Members

RE: Response to Intellectual Development Disabilities (IDD) Technical Advisory Committee (TAC) Testimony Presented at the September 25, 2014 MAC Meeting

Dear Chairwoman Partin and MAC:

We are writing to respond to the recommendations presented by the IDD TAC and approved by the MAC at the September 25, 2014 meeting.

*IDD TAC Recommendations:*

1. Finalize an appropriate tool for evaluation of children's eligibility for the Michelle P. Waiver. This should be finalized as soon as possible, and should NOT wait until the waiver is revised. We strongly recommend the creation of a special task force made up of providers, family members of children with IDD and staff from the Department for Behavioral Health, Intellectual and Developmental Disabilities (DBDID), and members of HB144 and IDD TAC. This group would be tasked with the creation of a Pediatric Assessment Tool to be implemented within the next 6 months.

RESPONSE: When making changes in the assessment methodology for determining a waiver member's plan of care, the Department for Medicaid Services (DMS) must submit proposed changes and receive approval from the Centers for Medicare and Medicaid Services (CMS). The submission and

approval process through CMS is complex and we are required to submit any proposed changes in tools to CMS for approval .We are working closely with the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) to ensure that our waivers are in compliance with the new CMS Home and Community Based Services Final Rule. Any significant changes, such as a child specific assessment, would result in a public comment period in which all interested parties would have an opportunity to communicate with the Department regarding the changes

2. Consider developing a separate waiver for children who do not meet the institutional level of care, but have a distinct need for services.

RESPONSE: This issue is beyond what can be accomplished or resolved through Medicaid. It would require a substantial increase in cost in state dollars. A resolution should involve multiple stakeholders including the legislature, the Cabinet for Health and Family Services and private and public insurance. DMS recommends legislative advocacy during a future budget year.

3. Establish a mechanism to assist individuals who choose PDS with costs associated with employment requirements. Options include establishing a separate fund specifically to pay administrative costs and re-evaluate the new requirements to determine whether they are necessary or impose an undue burden.

RESPONSE: As this recommendation would require additional state dollars, this should be addressed through legislative advocacy during a future budget session. DMS must work within the allotted budget to provide services to all members. The budget that DMS is given each year is established through the legislature. In addition, DMS cannot pay for such costs with Medicaid funds.

4. Ensure that similar unfunded mandates are NOT included in the revised Michelle P. Waiver or other waivers.

RESPONSE: CMS promulgates final rules that define services that states must cover within their waiver programs. DMS must abide by federal regulations when developing components of our waiver programs.

Sincerely,

January 16, 2015

IDD TAC

Page 3

Erin Hoben  
Chief Policy Advisor  
Commissioner's Office  
Department for Medicaid Services

cc: Lawrence Kissner, Commissioner, Department for Medicaid Services  
Neville Wise, Deputy Commissioner, Department for Medicaid Services  
Lisa Lee, Deputy Commissioner, Department for Medicaid Services  
Veronica Cecil, Chief of Staff and Director, Division of Program Integrity  
Dr. John Langefeld, Medical Director, Department for Medicaid Services  
Leslie Hoffmann, Behavioral Health Policy Advisor and Director, Division of  
Community Alternatives  
Barbara Epperson, Resource Management Analyst III, Department for Medicaid  
Services

## **IDD TAC Recommendations to the Medicaid Advisory Council**

**09/25/14**

The IDD TAC is extremely concerned that all the 10,000 initial Michelle P. Waiver slots have been assigned and that a waiting list has been initiated. Currently, approximately 2,906 individuals are on the "first-come, first-serve" waiting list and this list will continue to grow. While it is promising that additional funding has been allocated and the number of slots will be increased, it is clear that the demand is much greater than can be provided for with allocated funds.

Furthermore, many have expressed concerns that some slots have been assigned to individuals who do not meet the "institutional level of care" standard. Though the waiver was created in response to the needs for adults who were unnecessarily institutionalized, more than 70% of recipients are children. Unfortunately, children are being assessed with the MAP 351, an adult assessment tool resulting in the inappropriate placement of many children in a waiver designed for adults.

Therefore, the IDD TAC makes the following recommendations:

1. **Finalize an appropriate tool for evaluation of children's eligibility for the Michelle P. Waiver.**  
This should be finalized as soon as possible, and should NOT wait until the waiver is revised. We strongly recommend the creation of a special task force made up of providers, family members of children with IDD and staff from the Department for Behavioral Health, Intellectual and Developmental Disabilities (DBDID), and members of HB144 and IDD TAC. This group would be tasked with the creation of a Pediatric Assessment Tool to be implemented within the next 6 months.
2. **Consider developing a separate waiver for children** who do not meet the institutional level of care, but have a distinct need for services.

The IDD TAC is also concerned about the impact of the revision of the Supports for Community Living (SCL2) on those who choose "Participant Directed Services" (PDS). As part of SCL 2, several new employment requirements were imposed for those who provide personal care. These include drug screening, background checks, CPR training and completion of the numerous modules provided through the College of Direct Supports (facilitated by the Department for Behavioral Health, Intellectual and Developmental Disabilities – DBDID). The cost for completing these requirements is up to \$372 per employee. Some individuals have multiple employees, and there is high turn-over in the field.

If an individual receives services through an agency, the agency can absorb these costs through funds that are allocated for administrative purposes. However, individuals who choose PDS do not receive administrative costs and must pay the costs themselves. The cost cannot be billed as a "service" under the current Medicaid system. Furthermore, Kentucky labor laws prohibit the employer from shifting the cost to the employee. Therefore, the IDD TAC recommends the following actions:

1. **Establish a mechanism to assist individuals who choose PDS with costs associated with employment requirements.** Options include establishing a separate fund specifically to pay administrative costs and re-evaluate the new requirements to determine whether they are necessary or impose an undue burden.
2. **Ensure that similar unfunded mandates are NOT included in the revised Michelle P. Waiver or other waivers.**

## Agenda IDD TAC 11/7/14

1. Call to order.
2. Introductions
3. Guest speaker from DCBS office.
4. MAC presentation update.
5. MPW slots. Any updates?

# Intellectual and Developmental Disabilities Technical Advisory Committee (IDD TAC) Minutes September 9, 2014

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## **Technical Advisory Committee (TAC) members present:**

Patty Dempsey- ARC of Kentucky  
Johnny Calles- Independent Opportunities, KAPP  
Chris Stevenson- KAPP/ Cedar Lake  
Christan Stewart- Parent rep for MPW  
Chastity Ross-CCDD

## **Department for Medicaid Services (DMS) staff present:**

Helen Vogelsberg, RN, NCI- Division of Community Alternatives, MH/IDD branch  
Mary Ann Robertson, RN, NCI- Division of Community Alternatives, MH/IDD branch  
Gregg Stratton- Division of Community Alternatives, HCBS Branch Manager  
Lyris Cunningham- Division of Community Alternatives, MH/IDD Branch  
Al Ervin- Office of the Inspector General  
Jennifer Mayes- Office of the Inspector General  
Cynthia Lee- Division of Program Quality and Outcomes  
Erin Varble- Division of Community Alternatives, Director's Office  
Deborah Simpson- Division of Program Quality and Outcomes  
Catherann Terry- Division of Program Quality and Outcomes/EPSTD  
Leslie Hoffmann-Division of Community Alternatives, Director

## **Department for Aging and Independent Living (DAIL) staff present:**

Tonia Wells

## **Department for Developmental and Intellectual Disabilities (DDID) staff present:**

Barbara Rosell  
Barb Locker  
Janet Cox

## **Others present:**

Pam Smith- UM Operations Manager, HP  
Nikki Martin, RN- HP  
MaryLee Underwood- CCDD

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The Intellectual and Developmental Disabilities Technical Advisory Committee (IDD TAC) met on September 9<sup>th</sup>, 2014 at 10 AM. Patty Dempsey chaired the meeting.

- I. Meeting called to order by Patty Dempsey
- II. Introductions were made.

## Intellectual and Developmental Disabilities Technical Advisory Committee (IDD TAC) Minutes September 9, 2014

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- III. Motion was made, seconded to approve minutes from July 14<sup>th</sup> meeting.
- IV. Two guest speakers today.
  - a. Al Ervin-KARES- PDS clients want to get access to grant funds.
    - i. Want to get access to help pay for background checks for waiver clients.
    - ii. CMS says that no, PDS clients cannot use the KARES grant money to help pay for services.
    - iii. Grant runs to May of 2015. Can reapply for another year.
    - iv. Nothing through KARES is "free"
      - 1. Do State and federal fingerprint checks.
    - v. Grant implemented in 2011.
      - 1. Possible statewide fingerprint background database.
      - 2. Currently 25 states participate in the KARES program.
    - vi. System is pretty redundant.
      - 1. No repository for who has been fingerprinted, so every time someone applies for a job that requires it, they have to pay for fingerprinting check again.
    - vii. Currently trying to automate the system for all background checks.
      - 1. Within and out of state- if out of state is listed on application.
      - 2. Currently about 95% "no hit" so no criminal history.
    - viii. Do misdemeanors come back as "hits"
      - 1. Working on this kind of things. Drug/abuse things of that nature are being flagged within the system.
      - 2. Not allowed to hand out someone's "rap sheet"
      - 3. Everything they look at has to have a reason, conviction, etc.
      - 4. Hoping to get licensure boards in on this as well.
    - ix. Continuous Employment System-Kentucky/WrapBack-FBI
      - 1. Once in the system, all your information would be continuously monitored.
        - a. "So if you were fingerprinted two years ago, and last night you got arrested, within a few weeks, the CES system would know about it."
        - b. So if you have a disqualifying event, the system will automatically start the process to alert the providers.
    - x. In relation to waivers-KARES isn't a free program and does not cover the waiver programs.
    - xi. Hoping the CES/Wrapback system will help reduce the costs by keeping everyone's information current.
  - b. Do the provider agencies have the ability to utilize the KARES funds?
    - i. Looking into that idea. Some staffing agencies and things like that can fall under coverage.
    - ii. KARES is not free; they pay 80% or so. So even if they do fall under coverage they will still pay part of the cost themselves.
  - c. Straight background check costs about \$49.
    - i. Usually get criminal history back within 8 hours.
    - ii. This includes FBI, KSP, fingerprint analysis and credit card fee charges.
  - d. Working on getting KARES to work with waivers.

# Intellectual and Developmental Disabilities Technical Advisory Committee (IDD TAC) Minutes September 9, 2014

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- V. Barb Rossell- College of Direct Supports.
  - a. Handout of how to access and complete PDS. (handout KCDS)
  - b. Can take up to 3 days once form is received at state to get an account.
    - i. If questions about PDS, contact Evan Charles in DAIL.
  - c. No cost to get account or classes.
  - d. Payment for completing classes would be discussed between employer/employee.
    - i. Takes approximately 15-20 hrs. to complete.
    - ii. Some people may take more days than hours.
    - iii. May have issue with computer access. (utilize local libraries, public computers)
    - iv. Recommend payment by credit hour, not man hours for completion.
  - e. Has to be taken online. About an 85% completion rate. Once completed, system makes a transcript of proof of completion.
  - f. Has to be completed within 6 months. If not completed, Can no longer provide services until it is completed.
  - g. Had revisions to site. Grandfathered in the new modules. If client completed old modules, must click on both "current" and "archived" modules to get complete transcript.
  - h. 3 days for new or modified acct. 7 if work at multiple locations.
  - i. PDS only pays for hands-on service, so cannot bill for time spent completing modules.
- VI. CMS Final Rules for all waivers- Tonia Wells is seeing if there are any ways to reduce costs.
  - a. CMS Final Rules-looking at all waivers and see if we are in compliance, see if we need to make any changes.
  - b. MPW has been written, but is currently shelved until CMS Final Rule is completed.
  - c. Timeline for getting these costs lowered?
    - i. Tonia-Looking into working with the American Red Cross to see if we can reduce the cost of CPR classes.
    - ii. Currently no timeline, there are lots of steps in order to get these ideas going.
- VII. MPW-Sent in the application for the Waiver renewal to CMS.
  - a. Looks similar to the SCL II waiver.
  - b. But will probably have some modifications, changes, corrections.
- VIII. 2906 people on the waiting list. As of Sept. 8<sup>th</sup>, 2014.
  - a. Sept. 1<sup>st</sup> new waiver year-New slots/money for assessments.
  - b. July 5<sup>th</sup> date on the letter was just a guess, haven't heard anything about when they will come available.
  - c. Cannot yet due new assessments. People already on the MPW are getting reassessments.
- IX. % of children on the MPW waiting list?
  - a. Pretty high-about 69% under the age of 21.
    - i. 60-under 1 yr. old
    - ii. 588- 1-5 yrs. old
    - iii. 537- 6-10 yrs. Old
    - iv. 427- 11-15 yrs. Old

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- v. 385- 16-20 yrs. Old
    - vi. Over 21- 909
  - b. Still would like to get an autism waiver.
    - i. Looking to get the Anger Supports therapy through EPSDT to lower rate of autistic children on waiting list.
  - c. Children's assessment tool?
    - i. Looking into it still.
    - ii. Once Final Rule is completed, can work on everything else.
  - d. 9931 people on the MPW.
    - i. Are in the process of going through and finding clients who have not utilized services in the last 60 days. Once completed then we will have available slots.
- X. New Members-Depends on whether they are governor appointed or entity appointed.
  - a. Should have a liaison at the Cabinet level, don't know who that is. Tonia said she has contact in her office.
  - b. Chris Stevenson-Taking over Terry Brownson's old position. Step down from KARP non-profit rep.
    - i. Need to update the TAC member's list. -Erin
- XI. Website-link <http://www/chfs/ky/gov/dms/IDDtac.htm>
  - a. Dates and locations of meetings. And copy of minutes. List of all TAC members.
- XII. Supported Employment- Johnny- still on a case by case basis.
  - a. Pam has seen some improvement with the paperwork being submitted.
  - b. Pam- get number of people who use supported employment.
- XIII. G-Tube patients- Can we keep them out of institutional care if they only need nursing care for medication administration.
  - a. KY Board of Nursing- stated that giving nutrition and medication through G-tubes with training is okay.
  - b. Friday, September 12<sup>th</sup> - KBN has meeting they are going to clarify this. Public meeting if others want to attend.
  - c. Differentiate between teaching and delegating tasks. Teaching individuals how to do something is not the same as delegating the task to someone.
- XIV. Behavior Supports
  - a. Still having issues getting additional units, despite many letters/proof of need.
  - b. Need to be approaching the end of your allotted slots.
  - c. Been told to continue providing services without the reimbursement-doesn't seem right.
  - d. Glitch with backdating.
    - i. Pam can't backdate if still billing on the old PA.
    - ii. Modifications can be backdated up to 14 days unless claims have been paid within that time.
    - iii. Need to have good communication between case managers, providers, and clients in order for this to work smoothly.
- XV. Impact Plus is fading out.
  - a. Some services are being absorbed by the expansion.
  - b. Rest of the services are being absorbed by EPSDT.

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- c. 9/30/14 last day for anything approved for Impact Plus-fee for service side. Don't know about Managed Care side.
- XVI. Personal Care- Pam was to follow up with Cathy Terry.
  - a. Only 3 or 4 clients under the age of 21 apply for PC.
  - b. Didn't meet guidelines-trying to use for convenience of Caregiver not medical necessity.
  - c. Look at them on a Case by case basis.
  - d. IF EPSDT denies PC services, can it go back under waivers?
    - i. If client under 21, must go through EPSDT.
- XVII. MPW came into existence thanks to a class action suit on SLC waiting list. Any new grumblings about the MPW waiting list?
  - a. Waiting list is very bloated because many of the people on the waiting list will not meet LOC. There is no screening process to get on the waiting list.
  - b. Reputation that "I can get paid to care for my child"
  - c. Clients that really need it are way down the list because of this.
  - d. Should we make a recommendation to the MAC about this?
- XVIII. Lots of denials on PDS.
  - a. MAP 532 denials.
  - b. August 22<sup>nd</sup>- total 107 participants, denied 41. Only 8 of those 41 have chosen to appeal.
  - c. Qualifications are clearly stated.
  - d. Provide all kinds of services to help people get approved.
- XIX. Chris going to have a conference call to come up with some things to present to the MAC. Then bring them to the committee for approval.
  - a. Terry was going to make recommendation about incontinent supplies. No longer with the TAC.
  - b. PDS cost issues.
- XX. Need to elect new chair since Eric is now gone.
  - a. TAC members voted to elect Chris Stevenson and Patty Dempsey (or new Arc rep) to Co-Chair the TAC.
- XXI. MAP 552's –Local DCBS offices having issues with people's eligibility suddenly stopping, for no apparent reason.
  - a. MAP 552 glitch? Piece of paper that has income on it.
  - b. No on answers hotline.
  - c. Case manager has to go to local office, wait in line, to make appt. that is weeks later. Then hope you meet with someone that even knows what a MAP 552 is.
    - i. System glitch, not enough workers?
    - ii. System will say no 552 on file.
    - iii. Clients may have been lifelong Medicaid recipients.
  - d. Johnny has spoken with Commissioner Anderson about this already.
  - e. Get someone from DCBS eligibility to attend next meeting.
- XXII. Adjourned.

## (KCDS) Kentucky College of Direct Support PDS Required Training

To set up a (KCDS) Kentucky College of Direct Support learner account please contact the SCL agency CDS Sub-administrator affiliated with the participants SCL Case Manager.

The sub-administrator will obtain some basic personal information from you needed for your account. They will then submit the paperwork (Permission to Access form) to DDID. Once the SCL agency submits this form to DDID, it may take up to 3 additional days for the agency to gain access to your learner account.

Once the agency has access to your CDS Learner account they will assign the PDS Required Modules and provide you with the link: College of Direct Support website: <http://www.collegeofdirectsupport.com/ky> along with your login and password information. If and when you have questions about CDS please contact the SCL Agency CDS sub-administrator for assistance.

### Participant Directed Service Delivery

For questions regarding training requirements for Participant Directed Service Delivery, please contact Evan Charles at: [Evan.Charles@ky.gov](mailto:Evan.Charles@ky.gov)

Employee Type	Required Training <small>(must complete within six (6) months of hire or date individual begins providing services)</small>
<b>Participant Directed</b> to include these services: Community Access Community Guide Day Training Personal Assistance Respite Shared Living Supported Employment Specialists	<ul style="list-style-type: none"> <li>• First Aid (provided by the American Red Cross, American Heart Association or a nationally accredited organization)</li> <li>• CPR (provided by the American Red Cross, American Heart Association or a nationally accredited organization)</li> <li>• Individualized Instruction about the needs of the person they are supporting</li> <li>• Maltreatment of Vulnerable Adults and Children (College of Direct Support)</li> <li>• Individual Rights and Choice (College of Direct Support)</li> <li>• Safety at Home and in the Community (College of Direct Support)</li> <li>• Supporting Healthy Lives (College of Direct Support)</li> <li>• Person Centered Planning (College of Direct Support)</li> <li>• Other training if required by the participant</li> </ul> <p><small>(Note: DBHDID Medication Administration Training is not required if the employee provides services to less than 3 people)</small></p>
<b>Participant Directed Services</b> provided to more than 3 people	<ul style="list-style-type: none"> <li>• Basic, Phase I, Phase II, and Medication Administration (If administering); and</li> <li>• Annually participates in at least six (6) hours of professional development or continuing education units of competency-based training to teach and enhance skills related to the performance of duties</li> </ul>

**A Report on Supports for Community Living Waiver Program: Paying the Costs of Background Checks and Other Requirements for Direct Service Workers**

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Prepared for the  
Commonwealth Council on Developmental Disabilities

June 9, 2014



**University of Kentucky**

## Executive Summary

The Supports for Community Living (SCL) waiver program is designed as an alternative to institutional care and a home- and community-based program funded by the Kentucky Department for Medicaid Services and administered by the Department for Behavioral Health, Developmental and Intellectual Disabilities.

The SCL waiver program includes many requirements for direct support professionals including CPR training, TB Skin screening, and multiple background checks that cost \$ 372 per employee. This cost becomes a significant issue for individuals who get self-directed services because they cannot require a direct support professional to pay the cost in Kentucky.

This report focuses on showing how this issue is handled in other states. It is based on information collected by reviewing each state's statutes and contacting 15 states by email inquiries (May 22<sup>nd</sup> – June 4<sup>th</sup>, 2014).

- Requirements for direct services and financial responsibility for the requirements vary from state to state (see Table).
  - In brief, the costs for requirements are paid through three ways: by an employer, an agency (as administrative costs), or an employee.
    - a) Employer's responsibility: Kentucky, Minnesota, and Wisconsin (training);
    - b) Administrative costs: Indiana, Missouri (background checks), Michigan, Alabama, Colorado, Louisiana, and Wisconsin (background checks);
    - c) Employee's responsibility: Missouri (training), Ohio, West Virginia, Arkansas, Nevada, Florida, Hawaii, and Idaho.
  - Many states financially assist individuals who self-direct supports in terms of background checks using their agency or administrative funds, and it appears that most states consider that employees are responsible for the costs of training requirements for them.
  
- The costs of a Medicaid provider agency ensuring that its employees meet qualifications identified in rules are built into the reimbursement rate in all responding states.

State	Requirement	Responsibility for Cost for Requirements
Kentucky	CPR, TB Test, background checks	- Employer/Not defrayed by Medicaid
Minnesota	CPR and background checks (optional)	- Training: employer with his/her annual self-directed service budget

**IDD TAC Recommendations to the Advisory Council for Medical Assistance (MAC)**  
**09/25/14**

The IDD TAC is extremely concerned that all the 10,000 initial Michelle P. Waiver slots have been assigned and that a waiting list has been initiated. Currently, approximately 2,906 individuals are on the "first-come, first-serve" waiting list and this list will continue to grow. While it is promising that additional funding has been allocated and the number of slots will be increased, it is clear that the demand is much greater than can be provided for with allocated funds.

Furthermore, many have expressed concerns that some slots have been assigned to individuals who do not meet the "institutional level of care" standard. Though the waiver was created in response to the needs for adults who were unnecessarily institutionalized, more than 70% of recipients are children. Unfortunately, children are being assessed with the MAP 351, an adult assessment tool resulting in the inappropriate placement of many children in a waiver designed for adults.

Therefore, the IDD TAC makes the following recommendations:

- 1. Finalize an appropriate tool for evaluation of children's eligibility for the Michelle P. Waiver.**  
This should be finalized as soon as possible, and should NOT wait until the waiver is revised. We strongly recommend the creation of a special task force made up of providers, family members of children with IDD and staff from the Department for Behavioral Health, Intellectual and Developmental Disabilities (DBDID), and members of HB144 and IDD TAC. This group would be tasked with the creation of a Pediatric Assessment Tool to be implemented within the next 6 months.
- 2. Consider developing a separate waiver for children who do not meet the institutional level of care, but have a distinct need for services.**

The IDD TAC is also concerned about the impact of the revision of the Supports for Community Living (SCL2) on those who choose "Participant Directed Services" (PDS). As part of SCL 2, several new employment requirements were imposed for those who provide personal care. These include drug screening, background checks, CPR training and completion of the numerous modules provided through the College of Direct Supports (facilitated by the Department for Behavioral Health, Intellectual and Developmental Disabilities – DBDID). The cost for completing these requirements is up to \$372 per employee. Some individuals have multiple employees, and there is high turn-over in the field.

If an individual receives services through an agency, the agency can absorb these costs through funds that are allocated for administrative purposes. However, individuals who choose PDS do not receive administrative costs and must pay the costs themselves. The cost cannot be billed as a "service" under the current Medicaid system. Furthermore, Kentucky labor laws prohibit the employer from shifting the cost to the employee. Therefore, the IDD TAC recommends the following actions:

- 1. Establish a mechanism to assist individuals who choose PDS with costs associated with employment requirements.** Options include establishing a separate fund specifically to pay administrative costs and re-evaluating the new requirements to determine whether they are necessary or impose an undue burden.
- 2. Ensure that similar unfunded mandates are NOT included in the revised Michelle P. Waiver or other waivers.**



State	Requirement	Responsibility for Cost for Requirements
		- Checks: employer/Not defrayed by Medicaid
Indiana	CPR, TB Test, background checks	- Provider agency
Michigan	CPR, background checks	- Training: administrative cost - Checks: agency
Missouri	CPR, background checks	- Training: employee - Checks: administrative cost
Ohio	CPR, background checks	- Employee
West Virginia	CPR, background checks	- Employee
Arkansas	CPR, background checks	- Employee
Nevada	CPR, background checks	- Employee
Alabama	Background checks	- Financial management service agency
Colorado	Background checks	- PPL CO agency - Additional requirement: employer
Louisiana	Background checks	- Fiscal/employer agency
Wisconsin	Background checks	- Training: employer - Checks: Fiscal/Employment agent
Florida	Background checks	- Employee
Hawaii	Background checks	- Employee or employer
Idaho	Background checks	- Employee

## Introduction

1. Supports for Community Living (SCL) Waiver Program
  - The SCL Waiver Medicaid program is developed as an alternative to institutional care for individuals with mental retardation or developmental disabilities to allow them to remain in or return to the community in the least restrictive setting (Kentucky Voices, 2012).
2. Federal and Kentucky Statutory Basis
  - §1915(c) of the Social Security Act: The 1915(c) waivers are one of many options available to states to allow the provision of long term care services in home and community based settings under the Medicaid Program. States can offer a variety of services under a Home and Community-Based Settings (HCBS) Waiver program. Programs can provide a combination of standard medical services and non-medical services. Standard services include but are not limited to: case management (i.e. supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care. States can also propose "other" types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community (Center for Medicaid and CHIP Services).
  - 907 KAR 12:010. New Supports of Community Living Waiver Services and Coverage Policies: The SCL waiver program is federally authorized via a 1915(c) Home and Community based waiver.
3. Direct Support Professional (907 KAR 12:020)
  - The direct support professional means an individual who provides services to a participant of SCL waiver programs and has direct contract with a participant when providing services to the participant.
4. The Requirement for Direct Support Professional
  - The Kentucky Labor Cabinet has consistently interpreted KRS 336.220<sup>1</sup> to prohibit an employer/potential employer from passing to the employee/applicant the cost of furnishing any records required by the employer as a condition of employment. This includes background checks, drug screening, etc.

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<sup>1</sup> 336.220 Cost of medical examination required by employer.

(1) It shall be unlawful for any employer to require any employee or applicant for employment to pay the cost of a medical examination or the cost of furnishing any records required by the employer as a condition of employment.

- An employer is responsible for payment for processing drug screen, TB screen, CPR/First Aid, College of Direct Support (CDS), any additional training, possible educational requirements, and background check requirements; the funding for these requirements is the responsibility of the employer; having these requirements paid for the first five employees by Medicaid is not an option (Q & A of Kentucky Cabinet for Health and Family Services).
5. Self-Directed Services
- Self-directed Medicaid services means that participants have decision-making authority over certain services and take direct responsibility to manage their services with the assistance of a system of available supports. Self-direction of services allows participants to have the responsibility for managing all aspects of service delivery in a person-centered planning process (Centers for Medicare & Medicaid Services).

## State by State Information

### I. Neighboring States

#### 1. Indiana

- Requirement (460 IAC 1.2-6-3 and 460 IAC 1.2-14-1)
  - Indiana does not enroll individual rendering providers; this state ONLY holds the entities (or agencies) responsible for meeting overall staffing qualifications and other requirements.
  - Staff providing direct care for HCBS providers must:
    - a) Submit a copy of a current negative TB test or negative chest x-ray that is completed annually.
    - b) Maintain current CPR certification, verification of each training session attended by the employee, and limited criminal history information that meets the requirements of 460 IAC 1.2-6-2(3).
- Costs for Requirement
  - The costs of meeting the employee/staffing requirements are incurred by the prospective or approved provider agency. Indiana has not outlined requirements from whom specifically those costs must be paid.

#### 2. Missouri

- Requirement (Self Directed Supports (SDS) Handbook, 2014)
  - Anyone over age 18 with a High School diploma or GED, who the individual or their designated representative chooses to hire, can be a SDS employee.
  - When participants self-direct supports, they have the freedom as well as the responsibilities that come with being an employer. The Fiscal Management Service (FMS) acts as an agent for them. The FMS assists employers with processing prospective employees' background checks and verifying that their employees have received required training.
  - Employees must meet pre-employee training requirements and must submit documentation for the training. Personal Assistants (employees) may have CPR, First Aid, Med Aide, and Behavioral training unless the training has been exempted by the individual/designated representative. It is the responsibility of the employee to keep all training current during the duration of employment.
  - Background Checks are required for all potential employees prior to beginning employment. The screening is processed by the FMS organization.

- Costs for Requirement (Self Directed Supports (SDS) Handbook, 2014)
  - The services from the FMS are provided as an administrative service and not as a waiver service and do not come out of your individual budget.
  - Employees are responsible for the cost of training requirement.

### 3. Ohio

- Requirement
  - Individuals who wish to be certified are treated as independent contractors and must be qualified in order to be approved to deliver waiver services.
  - Each employee shall meet the following requirements (Ohio Revised Code 5123:2-2-01):
    - a) Hold valid “American Red Cross” or equivalent certification in first aid.
    - b) Hold valid “American Red Cross” or equivalent certification in cardiopulmonary resuscitation (“CPR”).
    - c) Have completed, prior to application for initial certification in the case of an independent provider and prior to providing services in the case of an employee, contractor, or employee of a contractor of an agency provider, eight hours of training in accordance with guidelines established by the department.
  - Background checks are required for each employee (Ohio Revised Code 5123:2-2-01)
- Costs for Requirement
  - An individual who is a participant using the self-directed waiver may hire individuals directly, who must be certified as independent contractors (employees) and so must be responsible for their own training.
  - The individual with a waiver does not have any financial obligation for the costs of DSP training.
  - Meanwhile, independent contractors or individuals not associated with agencies can find training opportunities through their local county agencies that assist families with finding available and qualified providers.
  - Often the trainings are free and paid for by counties and in some cases, as in for CPR, the counties make available a list to providers of available trainers so that the rule requirements can be maintained.
  - Each independent provider has financial responsibility for a criminal record check (ORC 5164.341).

#### 4. West Virginia

- Requirement
  - All Qualified Support Workers (QSW) must have documentation of initial and renewal of training requirements (WV Section 513.9.2.2.1) :
    - a) Documented training on Emergency Procedures, Emergency Care, and Infectious Disease Control;
    - b) Documented training on First Aid and in Cardiopulmonary resuscitation (CPR) by a certified trainer;
    - c) Documented training on Member-specific needs (including special needs, health and behavioral health needs);
    - d) Documented training in Recognition of, Documentation of and Reporting of suspected Abuse/Neglect and Exploitation
- Costs for Requirement
  - The QSW may be responsible for the certain costs, i.e. CPR and First Aid certifications, CIB/NCIC background checks (WV Section 513.9.2.2.1).
  - The employer of record may pay these trainings, but does not have to. If the employer of record does not wish to pay for requirements, then it is the responsibility of the employee to do so.

## II. Other States

### 1. Alabama

- Requirement
  - The self-directed employees need to meet the requirements of the waiver. This includes:
    - a) A 10<sup>th</sup> grade education at minimum;
    - b) Minimum 1 year experience;
    - c) Background check and drug testing.
  - Meanwhile, the certification requirements for a contract provider include the CPR training, TB Skin Test, background check, and drug screening.
- Costs for Requirement
  - Financial Management Services Agency reviews all requirements and runs the background screenings on behalf of the self-directed participant.

- The family could require more than the minimum, but they would have to bear the costs of this.

## 2. Arkansas

- Requirement
  - A criminal background check has been initiated. The Division of Developmental Disabilities Services (DDS) requires criminal background checks for all direct care staff (DHS Policy 1082).
  - Caregivers must submit to a drug screen upon employment and to subsequent random drug screens (DHS Policy 1082).
  - Training Requirements for direct care staff (DDS Certification Standards 301.5):
    - a) CPR (Initial Certification, renewed as required by American Heart Association, Medic First Aid, or Red Cross);
    - b) Medication—Implications, Side Effects, Legality of Administering medication;
    - c) Twelve (12) hours minimum completed within (30) days of employment (does not include First Aid and CPR training).
- Costs for Requirement
  - Caregivers must pay all costs and fees for the required criminal background checks.

## 3. Colorado

- Requirement
  - The Consumer Directed Attendant Support Services program has only a few requirements for employees (Managing Employer Training Handbook):
    - a) Must complete a criminal background check and board of nursing background check on all workers and the person must pass both checks to be employable by PPL CO (Public Partnership LLC – Colorado);
    - b) Must be 18 years old.
  - An attendant<sup>2</sup> (employee) is hired through the contracted FMS<sup>3</sup> organization.
- Costs for Requirement

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<sup>2</sup> Attendant means the individual who meets qualifications in § 8.510.8 who provides CDASS as determined by § 8.510.3 and is hired through the contracted FMS organization (CCR 2505-10 Section 8.510).

<sup>3</sup> Fiscal Management Services organization (FMS) means the entity contracted with the Department as the employer of record for Attendants, to provide personnel management services, fiscal management services, and skills training to a client/AR receiving CDASS (CCR 2505-10 Section 8.510).

- The prospective employee will need to fill out the Criminal Background and Board of Nursing form in order for PPL CO to run the background check. The check identifies the person's criminal history in Colorado.
- If the attendant has worked in other states, an individual who self-direct services would need to run this additional background check at individual's expense.

#### 4. Florida

- Requirement
  - The Consumer-Directed Care Plus (CDC+)<sup>4</sup> Program has a requirement for employees: Background Screening that is a criminal history check and must include, but not be limited to, fingerprinting for statewide criminal history records checks through the Florida Department of Law Enforcement, and national criminal records checks through the Federal Bureau of Investigation, and may include local criminal records checks through local law enforcement agencies (CDC+ Handbook, 2012).
- Costs for Requirement
  - The prospective employee or the CDC+ employer is responsible for the cost of background screening. The CDC+ employer cannot use the CDC+ monthly budget to pay for background screenings (Background Screening, 2010).

#### 5. Hawaii

- Requirement
  - The Hawaii's Medicaid waiver program includes a requirement for a personal assistant (employee): Background Checks including criminal conviction record check and reference checks (Consumer Directed Personal Assistance Handbook, 2013).
- Costs for Requirement
  - Employers will need to pay for the criminal conviction record check or require their applicant to pay for this (Consumer Directed Personal Assistance Handbook, 2013).

#### 6. Idaho

- Requirement

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<sup>4</sup> CDC+ is a Florida Medicaid program that permits certain Consumers to self-direct their own Personal Assistance Services (Developmental Disabilities Medicaid Waivers Consumer-Directed Care Plus Program Coverage, Limitations, and Reimbursement Handbook, 2012).

- Individuals who provide direct care or services (employees) must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06.
  - Otherwise, the Consumer Directed Services rules do not specifically identify provider qualifications that must be met to deliver the supports.
  - It is the responsibility of the participants (employers) to ensure their employees have the skills necessary to deliver supports in a safe and appropriate manner; however, the Consumer Directed Services rules do state if the identified supports require specific licensing or certification within the state of Idaho, the identified community support workers must obtain the applicable license or certification.
- Costs for Requirement
    - Employees are responsible for those costs.
    - Additional funds are not available to defray the costs associated with ensuring that an employee meets those qualifications required by rule or necessary to ensure safe and appropriate care provision to a participant.
    - A participant's individualized budget may not specifically be used to pay the cost of criminal history checks for employees, assist the employee to meet licensure or certification requirements, obtaining testing and/or attend training courses to develop the needed skill sets to provide safe and appropriate care.

## 7. Louisiana

- Requirement (Self-Direction Option Employer Handbook, 2014)
  - The potential employee/applicant must pass criminal history background and direct services worker registry checks.
  - It is the responsibility of the employer to complete follow up background checks every 6 months after hire; The employer is required to:
    - a) Complete a search of the Direct Service Worker (DSW) Registry;
    - b) Complete a search on the Office of Inspector General's List of Excluded Individuals/Entities.
- Costs for Requirement (Self-Direction Option Employer Handbook, 2014)
  - The initial background check and a criminal conviction history check will be completed by the fiscal/employer agent<sup>5</sup>. The follow up background checks are available at the websites.

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<sup>5</sup> The Fiscal/Employer Agent is a required component of the Self-Direction option. The fiscal/employer agent will assist participants in managing some of the financial responsibilities of being an employer. The fiscal/employer

- Fiscal/Employer agent is responsible for monitoring employment related costs.

## 8. Michigan

- Requirement
  - The MI Choice waiver program requires CPR training and background checks for individuals hired directly by the program participant through the self-determination option.
  - There are no specific requirements for TBI Skin Testing through the waiver program itself.
- Costs for Requirement
  - The requirement of CPR training is met in various ways. Some waiver agencies have purchased CPR training tapes or DVDs, and Michigan has the potential employee sign a statement indicating that they have watched and understand the content of the video.
  - Some waiver agencies have staff who are trained CPR instructors and will periodically offer CPR instruction. Other potential employees will take courses offered through the Red Cross or other organization.
  - In addition, Michigan has training as one of the waiver services and, in the definition of this service, Michigan includes training self-determined workers, so can assist with paying for this requirement through that service.
  - Background checks can be done for free by a non-profit agency. If there is a cost, this would be part of the administration for the program.

## 9. Minnesota

- Requirement (Consumer Handbook and Agency Manual)
  - The Consumer Directed Community Support (CDCS) waiver program requires participants to have a case manager/care coordinator through the lead agency and a Fiscal Support Entity (FSE) who is responsible to approve all expenditures requested on an individual's community support plan.
  - The person providing assistance does not need a license, certificate or credentialing unless required by the consumer. Background checks are also optional<sup>6</sup>.

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agent will also notify participants once their potential employees are clear for hire including the criminal history background and direct services worker registry checks.

<sup>6</sup> Consumers (employers) must include information in their plan on which support workers they choose to do background checks on and which ones they will not do background checks on (Consumer Handbook, p.13).

- The person can also define additional provider qualifications such as knowledge of sign language or completion of CPR training.
  - Costs for Requirement (Consumer Handbook and Agency Manual)
    - If the participant is the employer of the support worker, the cost of paid or unpaid support staff training and education comes out of the participant's annual CDCS budget; when a consumer defines additional provider qualifications, the consumer could hire a person and pay for this training for the individual.
    - Background checks are optional, and FSE can help an employer get the background check done and will bill for the cost of the background check. The cost of the background check does not come out of the employers' budget when they choose to have a background check done.
      - a) On the other hand, if employers choose to use an agency as their agency with choice that requires background checks, the cost of the background check is included in the administrative rate for that agency, which comes out of their budget.
      - b) If employers select a waiver or Alternative Care service that requires a formal provider to have a background check, then the cost of the background check is included in the rate for that waiver or Alternative Care service, which comes out of their budget.

## 10. Nevada

- Requirement
  - Nevada requires TB tests, CPR training, and fingerprint based criminal background checks for all potential employees.
- Costs for Requirement
  - It is the individual caregivers who are fiscally responsible for obtaining these requirements. There are no Medicaid or other funds available to offset these costs.

## 11. Wisconsin

- Requirement (IRIS Participant Handbook)

- **Everyone in IRIS<sup>7</sup> has an IRIS Consultant.** Consultants will help participants design a plan that fits into their allocation, make sure all the paperwork is done, and find workers, service providers and items.
  - Background checks are required for all potential employees. The Fiscal/Employment Agent (F/EA)<sup>8</sup> completes all background checks on the workers for employers.
- Costs for Requirement
- The services delivered by the IRIS Consultant or the F/EA are provided as an administrative service through the approved HCBS waiver.
  - The participants are responsible for providing all training to their workforce.

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<sup>7</sup> IRIS is a Medicaid funded, long-term care program offered by the Wisconsin Department of Health Services. IRIS is grounded in the Principles of Self-Determination.

<sup>8</sup> The Fiscal/Employment Agent is contracted by the Department of Health Services to provide payroll services to participants who choose to serve as the employer of record.

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**Advisory Council for Medical Assistance (MAC) – 11/20/14**

**Costs Associated with Employment Requirements Who Choose to PDS Their Services**

**IDD TAC Committee**

**Costs – Responsibility of Employer (Estimated costs \$372)**

*(Information obtained from PDS caregivers)*

\$32.00	Background Check
\$50.00	Drug Screen (varies in areas of the state & if Dr. Visit)
\$25.00	TB Screen (varies in areas of the state)
\$90.00	CPR/First Aid Certification (within 6 months)

**Additional training/costs -- College of Direct Support Modules Required – Online (averages 15-18 hours per person) - Dept. of Labor requires employee be paid for online Course, CPR and First Aid** *(note - information from 2 PDS Caregivers)*

## AGENDA

September 9, 2014

- I. New members- How are we to appoint new members-
- II. Link for website. <http://www.chfs.ky.gov/dms/IDDtac.htm>
- III. Background check reimbursement. Is it possible to use KARES funding to lighten the load on clients?
- IV. Supported Employment- Are clients able to get enough hours to keep their jobs?
- V. G-Tube patients- Can we keep them out of institutional care if they only need nursing care for medication administration.
- VI. Personal Care- Pam was to follow up with Catherann Terry and Patricia Biggs.
- VII. Incontinent supplies- Terry Brownson was going to make recommendation to MAC. Did that happen? What is status of this recommendation.
- VIII. MPW slots. How many did we get with the Sept. 1<sup>st</sup> rollover?

If anyone has any NEW BUSINESS items, please bring them to the meeting tomorrow at 10AM. James Thompson Conference Room. 2<sup>nd</sup> Floor of the CHFS Bldg.

If anyone has any questions, let me know.

# Intellectual and Developmental Disabilities Technical Advisory Committee (IDD TAC) Meeting July 14, 2014

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## **Technical Advisory Committee (TAC) Members Present:**

Johnny Calles- Independent Opportunities/KAPP  
Dr. Eric Wright, Ed. D- CCDD  
Christian Stewart- Michelle P Waiver Parent Rep.

## **Department for Medicaid Services (DMS) staff present:**

Gregg Stratton- Division of Community Alternatives, HCBS Branch Manager  
Sheila Davis- Division of Community Alternatives, MH/IDD Branch Manager  
Lyris Cunningham- Division of Community Alternatives, MH/IDD Branch  
Marla Smaltz-Walker- Division of Community Alternatives, MFP Branch Manager  
Ann Hollen- Division of Community Alternatives, MFP/KY Transitions  
Lori Kays- Division of Community Alternatives, MFP/KY Transitions  
Earl Gresham- Division of Community Alternatives, Assistant Director  
Erin Varble- Division of Community Alternatives, Director's Office

## **Department for Developmental and Intellectual Disabilities (DDID) staff present:**

Janet Cox- SCL Waiver Manager

## **Others Present:**

Marylee Underwood- CCDD  
Pam Smith-UM Operations Manager, HP

The intellectual and Developmental Disabilities Technical Advisory Committee (IDD TAC) met on July 14, 2014 in Frankfort, KY.

Dr. Eric Wright chaired the meeting.

- I. Meeting was called to order by Dr. Eric Wright.
- II. This will be Eric's last meeting; Chasity Ross will be taking his place.
  - a. Several other vacancies will need to be filled.
- III. Introductions were made.
- IV. Link for website- Erin to send out to everyone.
- V. TAC had several items they wish to take to MAC.
- VI. Martin School did a report on the cost of Background checks and other requirements for direct service workers. (see handout-Martin School)
  - a. Kentucky requires several different checks, which can cost up to \$372 per employee. This can get very expensive if you have multiple employees.
  - b. Three different ways to pay for these: Employer paid, Employee paid or Agency paid.
  - c. Many states do offer assistance. Kentucky does not.
- VII. Want to have a recommendation for the writing of the new SCL/MPW Reg within the next year.
  - a. No deadline for MPW.

# Intellectual and Developmental Disabilities Technical Advisory Committee (IDD TAC) Meeting July 14, 2014

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- b. Currently, BHDID rewrote waiver for MPW in 2011. That waiver is good for 5 years; never sent to LRC though.
  - i. Never been able to implement the waiver.
  - ii. Currently in holding pattern waiting on what Secretary wants to do.
- c. Want to recommend some flexibility on who pays for background check services.
  - i. Marla recommends that TAC emails Sharley Hughes and request to be a line item on MAC agenda.
  - ii. Erin to get Eric Sharley's email address.
- VIII. KARES program, federal grant to cover a set number of background checks.
  - a. Is there a way to get PDS users access to these funds?
  - b. There is a finite number of background checks available under KARES- after grant is expired will have to think of something else.
    - i. KARES- doesn't pay for all of it, just a portion or the cost.
  - c. Gregg recommends getting someone from KARES to come talk at next meeting.
    - i. Stephanie Barnes Bramer or Barbara Rossell for CDS.
    - ii. REG: 906KAR1:190
- IX. Where are they going to recommend this money comes from?
  - a. Eric wants to keep it the same as it is in the MPW reg.
  - b. Trouble is the MPW is going to mirror the SCL.
    - i. This is a distinct possibility.
  - c. Currently in SCL there are about 70 people that use PDS out of 4000 recipients.
  - d. MPW is the opposite; currently have about 7000 people using the PDS.
  - e. If one person has already paid for the background checks for and employee, and they also work for someone else, do they both have to pay for checks?
    - i. No, there will be some overlapping of checks. (may already have their TB skin test or CPR certification)
    - ii. However you will have to run a background check, etc.
- X. How much does it cost Independent Opportunities as a Provider?
  - a. Not sure, but we are constantly hiring, training, interviewing. Turnover of about 50-60%.
  - b. Turnover is high for CDS as well.
- XI. Sheila recommended that Eric go back to the Martin School and see if they could give him the number of IDD population in the states used in survey.
  - a. Could get it through UK?
  - b. See if the amount of funding correlates with the population size.
    - i. Smaller the population more state funding?
- XII. Currently for MPW- just have to be 18 yrs. Of age, High school diploma and a clean background check.
  - a. Under SCL II, going to have to be 18 yrs. Of age, clean drug and background check. Participate in 30-40 modules of CDS, CPR certification.
- XIII. Sheila states that the MPW is written exactly like the SCL II. Just never gotten implemented.
  - a. These items are put in place for those parents/caregivers who may not have the knowhow to weed out potential employees who may become abusive or neglectful, or already are and bounce around from person to person.

## Intellectual and Developmental Disabilities Technical Advisory Committee (IDD TAC) Meeting July 14, 2014

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- XIV. Decide to wait on making any recommendations to the MAC, want to revisit the MPW Waiver and see what it says about background checks and whatnot.
- XV. DAIL is also working on a way to minimize some of these training costs.
- XVI. Aqua Therapy- Janet spoke about it at last meeting.
  - a. Physical Therapy in a pool and must be a therapy pool.
- XVII. SCL II transition- Have about half the population transitioned from SCL I to SCL II.
- XVIII. Supported Employment-not having enough hours to keep jobs- it is getting better, but is being addressed on case by case basis.
  - a. Work with providers and case managers alike to create appropriate plans.
  - b. HP also working with providers to get the paperwork filled out correctly to justify the plans of care.
- XIX. Behavioral Supports- A lot of their hours have been cut as well.
  - a. Exceptions are not being approved, but they are looking to see if the supports allotted have already been approved. If not, exceptions are being denied.
    - i. Saying to continue services even though they are not approved and then they will get backdated.
    - ii. Providers saying they can't do that.
- XX. G-Tubes- Several SCL recipients that have to have medicine administered by a nurse. No nurse in the area.
  - a. Want to continue living independently, but since they require nurse to administer meds, they may have to go back to institutional living.
  - b. Kentucky board of Nursing won't allow it.
  - c. Is there a way to work around this?
  - d. This should be taken to the board of Nursing.
- XXI. Changes are coming through the Legislature for children in schools who take insulin and medication.
- XXII. Personal Care- Everything in EPSDT are on a case by case basis. Most examples seem to be that the nurse didn't want to provide the personal care.
  - a. Pam to follow up with Cathy Terry and Patricia Biggs.
  - b. Anything offered through state plan will not be offered through the waivers.
  - c. EPSDT will cover for clients under 21 years of age, if it is deemed medically necessary.
    - i. More than likely, Personal Care for an adult would be covered through a waiver if it is medically necessary.
- XXIII. Incontinent Supplies- HH agencies are backing out.
  - a. Terry Brownson was going to make a recommendation to MAC, however he is not present at this time to find out what happened.
  - b. Pam to send out who the provider that offers supply only incontinent supplies.
    - i. Personal Touch (northern KY) and Professional (Corbin), Nurses Registry (Lexington).
    - ii. EPSDT are covered for children who would not normally be in diapers at that age.
    - iii. Can be reimbursed through CDO budgets as well.
  - c. Can you get a CON (Certificate of Need)?
- XXIV. Nothing new about Community Access.

## Intellectual and Developmental Disabilities Technical Advisory Committee (IDD TAC) Meeting July 14, 2014

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- XXV. Official approval has happened for SCL slots, awaiting CMS funding to use those slots. Will happen mid to late August.
- XXVI. Next meeting is scheduled for September 9<sup>th</sup> at 10AM in the James Thompson Conference Room.
- XXVII. Adjourned.

Medicaid Nursing TAC  
Recommendations  
January 16, 2015

The Nursing TAC has been informed of multiple cases where the issuance of provider numbers with the Medicaid MCOs are delayed, after applications have been accepted, beyond reasonable time frames. One provider has been waiting since January 2014 for a provider number. Since the provider has been seeing patients in good faith, anticipating issuance of a provider number, those visits that are more than a year old will not be reimbursable.

Recommendation: The TAC recommends that DMS require the MCOs to issue provider numbers within 120 days of receiving a completed provider application.

Nursing TAC  
Recommendations Presented to MAC  
November 20, 2014

**Summary of Agenda Items:**

1. MCO Refund Requests

Many practices are receiving notices from the Medicaid MCOs requesting refunds for over payments. These requests arise after the MCOs audit their records and determine that overpayments have been made on regular visits or that the provider has been paid for more than two (2) level four/five visits. Some of the refund requests are for significant amounts. Practices run on a very tight budget and these unexpected requests for refunds could, in some instances, be enough to cause the practice to close. No one wins when that happens- not patients, not providers and not Medicaid.

It is almost impossible for providers to determine if they are being overpaid. The MCOs set their rates and the EOBs reflect the rate that the MCO has paid to the provider. The provider does not know that the rate recorded on the EOB is incorrect. Secondly, it is not possible for providers to determine if a patient has had more than two level four/five visits in a year.

2. Limitation on Level 4/5 Visits

Kentucky struggles to meet health standards (United Health Foundation, 2012). This is especially true with regard to chronic, complex health problems such as diabetes (41<sup>st</sup>), cardiovascular disease (43<sup>rd</sup>), premature death (44<sup>th</sup>), obesity (40<sup>th</sup>), and smoking (50<sup>th</sup>). Patients who have chronic problems require more attention and higher levels of scrutiny at health care visits. Kentucky providers are expected to provide evidence-based care and meet nationally accepted standards of care, or they will be penalized by the Physician Quality Reporting System (PQRS) if standards are not met. The Center for Medicaid and Medicare Services (CMS) has established national standards for level of care, documentation, and reimbursement for all patient visits. These standards are based on extent of history, physical examination, diagnosis, treatment and overall complexity of the visit. As previously noted, many people in Kentucky suffer from diabetes, heart disease, COPD and obesity. Providing appropriate care for these individuals is a Level 4 visit. While providers are required legally and ethically to provide the appropriate level of care to the patient and document that care, the situation created by this limitation continually forces providers to down code visits. The down coding results inaccurate data on patient visits.

### 3. Physical Exams

Currently, Medicaid and the MCOs limit participants to one physical exam per year. Many people require more than one physical exam per year. This is particularly true for children who are required to receive school physicals and six months later may be required to receive a sports physical. Additionally, there are children who are placed in foster care who require a physical exam each time they are placed in a new home. There are a myriad of other reasons that a person may require more than one physical exam in a year's time. The requirements for some of the exams are different, so it is not a matter of providing a "one size fits all" exam.

Further, if the person has had a physical exam performed and billed by another provider, and the second provider is not aware of previous exam, the second provider's claim will be denied.

It was interesting to note that Anthem, in a recent DMS publication that compared the services of the MCOs, listed "Free annual sports physicals for members 6-18". This advertisement is encouraging parents to bring their child in for a sports physical, for which the provider may not be reimbursed.

### 4. Annual APRN License Renewal

Each year APRNs are required to renew their professional license. Nursing licenses expire on October 31 of each year. Medicaid requires APRNs to mail in notification of their license renewal via the postal service. If the notification is not received by DMS by November 1 of each year, the APRN is considered to have a lapsed license and therefore Medicaid patient prescriptions are denied at the pharmacy and payment claims are not accepted. Clearly, there are problems with this system. It is a huge waste of paper; 2000+ extra pieces of mail coming in to DMS in the month of October has to cause some sort of extra work and handling by staff; and mail can get lost. APRNs worry if their medication prescriptions will be accepted at the pharmacy on November 1, for there is no way to verify prior to that date if the license verification was received at the Medicaid offices.

### 5. Reimbursement

Kentucky is one of only four states that reimburse APRNs at 75% of the physician rate. The majority of states pay at 100%. If Medicare is the metric and pays at 100%, then private insurance pays 110-120% and Medicaid pays physicians at 73%. A 75% reimbursement rate for APRNs translates to 54.75% of the Medicare rate.

In order for APRNs to participate in Medicaid, the reimbursement rate must improve. Currently, APRNs receive about \$23.00 for a Level 2 visit, \$33.00 for a Level 3 visit, and about \$50.00 for a Level 4 visit (which are

limited to 2 per year). These fees are not sufficient to cover the overhead costs of running a practice.

The physician Medicaid rate of 73% is also a low national rate, and hasn't budged since 1993 (Jasper & Hunt, 2012). The Primary Care Medicaid Rate Increase, which applies only to physicians, will provide a temporary bump in payment in order to attract primary care physicians to Medicaid but will stop in 2015. In order to avoid a bait and switch fee system that leads to provider withdrawal and care disruption, Kentucky should consider adjusting the Medicaid physician reimbursement rate higher than the currently low 73% rate.

Low reimbursement levels have multiple bad effects—providers limit Medicaid patient caseloads, providers choose not to participate in Medicaid at all, or systems compensate by having providers just see more and more patients. Certainly it is part of the explanation for the fact that 63% of the primary care need is met in rural settings in Kentucky and that only 22% of primary care provider physicians accept Medicaid (Deloitte, 2012).

Lack of participation limits patient access. Lack of access to care leads to poor health outcomes and increasing health care costs. We are talking about increased hospitalizations, readmissions and use of the emergency room, which are significantly more expensive than outpatient visits.

## **Recommendations**

1. MCO Refund Requests
  - a. On the repayment of refunds, the TAC request that the payback period match the look back period; that payments retained by payers from future remits be equal to the total percentage of claims paid during the look back; and that payments not be withheld at 100% until fully refunded. This would aid with practice cash flows and not jeopardize the providers' ability to continue services.
  - b. The TAC requests that there be more transparency on rates paid to providers, with providers receiving a list of the reimbursement that the MCO is paying to that provider. MCOs should be required to honor the reimbursement rate noted on the EOBs sent to providers. The MCOs should not be permitted to decide two (2) years later that the fee paid and posted on the EOB was incorrect.

2. Limitation on Level 4/5 visits
  - a. The TAC requests a legal justification from DMs for limiting level four/five visits to two visits per patient per year, while at the same time requiring providers to meet nationally accepted standards in the provision of care.
  - b. If the limitation is to remain in place, the TAC requests real time notification from DMS or the MCOs that the patient has exceeded the two (2) visit limitation.
  - c. Does the two (2) level 4/5 visit restriction apply to any level 4/5 visits the patient may have had with any provider, or is it per patient, per provider, per year?
  
3. Limitation to one (1) annual physical per year
  - a. The TAC requests a report of claims denied for well child annual visits because an exam was already done.
  - b. Is the limitation per calendar year or is it a rolling date?
  - c. The TAC requests a minimum of two (2) physical exams per year be permitted
  - d. The TAC requests that providers be notified in real time if a patient has met their limitation on physical exams for the year.
  
4. APRN License Verification

The TAC requests that DMS reduce paper waste and improve utilization of staff time by accepting a single electronic file from the Kentucky Board of Nursing, within 30 days of the deadline for licensure renewal, that lists all APRNs who have renewed their license each year. TAC requests that DMS not automatically drop APRNs from Medicaid on November 1, but extend that deadline to November 30.
  
5. Reimbursement

The TAC requests that DMS and the MCOs provide improved reimbursement for APRNs at 90 % of the physician rate and increase the physician rate to 90% of the Medicare rate.

Respectfully submitted,

Elizabeth Partin DNP, APRN  
Chair

## **Report from the Kentucky Pharmacists Association on the Pharmacy Technical Advisory Committee (PTAC)**

### **Appointees to the Pharmacy TAC by the Kentucky Pharmacists Association:**

Jeff Arnold	Med Care Pharmacy Florence (LTC Pharmacist)
Cindy Gray	Diamond Pharmacy Services (340B Pharmacist)
Christopher Betz	Norton Audubon Hospital/Sullivan University College of Pharmacy (Health Systems Pharmacist)
Suzi Francis	Kroger Pharmacy (Community Pharmacist, Chain)
Robert Warford	EFill Rx Pharmacy (Community Pharmacist, Independent)

In cooperation with DMS staff, all PTAC members have been provided with copies of the following Orientation Materials:

- KRS Chapter 61, Open Meeting of Public Agencies
- Reporting relationship to the Advisory Council for Medical Assistance/Medicaid Advisory Committee (MAC)
- Advance Notification to DMS for public notice (boards and committees)
- 205.540 Advisory Council for Medical Assistance -- Membership -- Expenses-- Meetings -- Qualifications of members.
- 205.550 Subjects on which council advises.
- 205.590 Technical advisory committees.

The first PTAC Meeting has been set for Friday, February 20, 2015 at the Kentucky Pharmacists Association, 1228 U.S. 127 South, Frankfort, KY from 9:30 a.m. until 11:30 a.m. Notification of the meeting will be posted by DMS staff on the CHFS web site. All interested parties are welcome to attend, and representatives from each MCO are strongly encouraged to participate.

Respectfully submitted,

Robert S. Oakley, President, Kentucky Pharmacists Association  
Robert McFalls, Executive Director, Kentucky Pharmacists Association

## **Recommendations to the MAC**

Prepared by the Primary Care Technical Advisory Committee

Presented on January 22, 2015

The Primary Care Technical Advisory Committee met at 10:00 AM on Thursday, January 8, 2015.

A majority of TAC members were present along with DMS staff. Additionally, representatives from each of the MCOs were present for the discussion. Agenda items included:

- The automated wrap payment from 7/1/14 forward.
- Wrap payment reconciliation from 11/1/11 – 6/30/14.
- Creation of a joint workgroup to address issues related to the reconciliation process.
- DMS's response to recommendations accepted by the MAC.

Shortly after we reported to the MAC in November, the first phase of reconciliation for claims with dates of service from 11/1/11 – 6/30/14 began. Letters were sent to providers with claims data for that period. For the majority of these clinics, their spreadsheets include hundreds of thousands of lines of data. The letter required a 60-day turnaround for the reconciliation process to be completed in order to determine whether money is owed to the provider or must be repaid to DMS. As you can imagine, these spreadsheets are daunting and, upon closer inspection, are missing thousands – and sometimes tens of thousands – of claims for medical, dental and behavioral health visits. Because the spreadsheet does not include many patient identifiers, practices are required to manually search for each claim, which is extremely time intensive. After starting the process, one large practice estimated that it would require re-allocating a number of staff away from their regular duties and working around the clock to complete the process within the 60-day timeframe. For large practices this is a huge burden, but for small practices, it's simply impossible.

When this was initially addressed with DMS, we were told that providers could request an extension, which many have done. However, DMS is currently only granting 30-day extensions. In many cases, this is still not enough time to complete the process. We raised this issue again at the TAC meeting on January 8<sup>th</sup> and were told by DMS that they would consider granting additional extensions.

There have also been two very positive developments this month that have the potential to lead to a greatly improved and more streamlined reconciliation process. The first is that each MCO as well as Avesis have agreed to work with these clinics to address missing data. One MCO in particular has agreed to share claims data directly with practices in order to complete the missing fields. This has been tested with one clinic and was very successful, however, it took four weeks for this MCO to run the report and get the data file to this clinic. With this in mind, we believe it is critical that DMS grant additional extensions to any clinics with a substantial amount of missing data. The second positive development is that DMS agreed to meet with us this past Tuesday to review the spreadsheet and determine which elements were absolutely

essential for this process, which would eliminate most of the data points that our members are currently having to search for and enter manually. It was a very productive meeting and led to a better understanding of the reconciliation process from both sides. While this does not solve the issue of missing claims data, it is a big step in making the process more efficient and will greatly reduce the burden on providers.

As we've reported since September, the TAC has been asking DMS to convene workgroups with providers and MCOs to proactively identify issues with the process and work to address them from all sides. While DMS has not agreed to initiate these meetings, they have since accepted the TAC's invitation for a meeting we set up with one of the MCOs to address the issue of missing data. This meeting is scheduled for next week and we should be able to report on our progress at the next MAC meeting.

It is our understanding that there will be a final reconciliation process starting as soon as March. At this time we do not have much information about what this process will entail or require of providers. We expect there will continue to be challenges and issues that must be addressed between providers, DMS and the MCOs and hope that we can continue working together to address them.

One final issue that we want to raise before the MAC is the process for recommendations accepted by the MAC. It's our understanding that recommendations accepted by the MAC and made to DMS should receive a response within 30 days. However, the response to our September recommendations was dated November 19<sup>th</sup> and wasn't posted online until December 8<sup>th</sup>. We think it would be extremely beneficial for all TACs to receive these responses once they are completed and within the required 30-day timeframe. This will allow us to prepare for our next TAC meeting and use the time more effectively.

**Because a quorum was not present at the November MAC meeting, the Primary Care TAC would like to re-submit the following recommendation generated from our November 6<sup>th</sup> TAC for the MAC's consideration:**

1. The Primary Care TAC recommends that DMS include additional identifiers on EOBs – such as: MCO Member ID, claim number, subscriber number and patient name – in order to allow clinics to reconcile payments more efficiently.

**In addition, we submit the following recommendations from the January 8<sup>th</sup> TAC meeting:**

1. In light of the fact that the reconciliation process for 11/1/11 – 6/30/14 includes a tremendous amount of paid claims data and requires a very manual process to complete the spreadsheet developed by DMS, we recommend that DMS adopt and disseminate a revised spreadsheet including only the essential data elements we selected together on January 20<sup>th</sup> to reduce the burden on providers.

**These elements include:**

1. Patient First and Last Name
2. Billing Provider (Clinic) NPI
3. Billing Provider (Clinic) Medicaid ID
4. Rendering Provider Medicaid ID
5. MCO Name
6. Patient MCO ID
7. Date of Service
8. Procedure (E&M) Code
9. MCO Paid Amount
10. MCO Paid Date
11. Primary Payor Amount (Commercial Carriers), if any.

**In addition the following two elements will be required for Medicare Cross-over claims:**

1. Medicare Co-Insurance Amount
  2. Medicare Deductible Amount
- 
2. In light of the magnitude of this process, including the lack of adequate claims data provided by DMS and given that we are dealing with both the wrap payment and the Medicare dual eligible issue, the Primary Care TAC recommends that DMS provide additional extensions beyond the initial 30 days to allow providers sufficient time to complete the process. While we would like to have it completed quickly, we feel it is much more important to accomplish the reconciliation in the correct and equitable manner for all parties, DMS, the clinics and the MCOs. It is after all a partnership.
  3. Our final recommendation concerns the process for responding to recommendations made by the TAC through the MAC. We realize responses must be publicly posted, but there is no notification that responses have been provided to the group who made the recommendations. The Primary Care TAC recommends that each TAC be sent a copy of the responses to their recommendations directly and within the required 30-day timeframe.





Non-Crossover Fields	Crossover Fields	Field Description	Expected Returns
Billing Provider NPI	Billing Provider NPI	RHC/FQHC National Provider ID	10 characters - numeric
Billing Provider Taxonomy	Billing Provider Taxonomy	RHC/FQHC Taxonomy Number	10 characters - combination of alphabetic/numeric
Billing Provider Medicaid ID	Billing Provider Medicaid ID	Medicaid provider number for RHC/FQHC	8 or 10 characters - numeric
Provider Tax ID	Provider Tax ID	RHC/FQHC Tax ID Number	9 characters - numeric
Rendering Provider NPI	Rendering Provider NPI	National Provider ID of provider performing the service	10 characters - numeric
Rendering Provider Taxonomy	Rendering Provider Taxonomy	Taxonomy of provider performing the service	10 characters - combination of alphabetic/numeric
Rendering Provider Medicaid ID	Rendering Provider Medicaid ID	Medicaid provider number for provider performing service	Numeric
Member First Name	Member First Name	First name of Medicaid recipient/patient	Unlimited characters - alphabetic
Member Last Name	Member Last Name	Last name of Medicaid recipient/patient	Unlimited characters - alphabetic
Member ID	Member ID	Medicaid number for Medicaid recipient/patient	10 characters - numeric
MCO Billed	MCO Billed	Name of MCO billed for the service	Unlimited characters - alphabetic
Date Submitted to MCO	Date Submitted to MCO	Date claim submitted to MCO for reimbursement	Numeric (for example XX/XX/XXXX)
Date of Service (DOS)	Date of Service (DOS)	Date service rendered	Numeric (for example XX/XX/XXXX)
MCO Claim Number (ICN)	MCO Claim Number (ICN)	Internal Control Number assigned to claim by DMS	13 characters - numeric
Claim Detail Line Number	Claim Detail Line Number	Detail line number of a claim record	Numeric
Procedure Code	Procedure Code	CPT code billed for service performed	5 characters - numeric (may have additional alphabetic characters)
	Medicare Coinsurance Amount	Amount of Medicare coinsurance applicable to claim	Dollar value - numeric
	Medicare Deductible Amount	Amount of Medicare deductible applicable to claim	Dollar value - numeric
Date Payment Received from MCO	Date Payment Received from MCO	Date payment received from MCO for service	Numeric (for example XX/XX/XXXX)
MCO Paid Amount	MCO Paid Amount	Amount paid by MCO for service	Dollar value - numeric
Other Primary Insurance Paid Amount	Other Primary Insurance Paid Amount	Amount paid by non-Medicare third party for service	Dollar value - numeric

## **Recommendations to the MAC**

Prepared by the Primary Care Technical Advisory Committee

Presented on November 20th, 2014

The Primary Care Technical Advisory Committee met at 10:00 AM on Thursday, November 6th, 2014. A majority of TAC members were present, along with DMS staff. Additionally, four of the five MCOs were present for the discussion. Agenda items included:

- The automated wrap payment.
- Wrap payment reconciliation back to 11/1/11, including the reconciliation spreadsheet, timeline, Kentucky Spirit claims, and the claims resubmission process.
- Dual eligible payments to RHCs and FQHCs.
- EOB data received by clinics.
- Billing for 99211 nursing visits.
- Past recommendations accepted by the MAC.

Since September, significant progress has been made in addressing the automated wrap payment process. KPCA facilitated the scheduling of meetings between primary care providers, MCOs and DMS, which assisted all parties in identifying and resolving issues that were hindering the submission and processing of clean claims. As part of this process, DMS has asked providers to complete reconciliation spreadsheets for the months of July and August. This has been an incredibly time consuming task, but should improve the automated system moving forward.

Primary care providers have also been waiting for DMS to begin the wrap payment reconciliation process for dates of service going back to November 1, 2011 through June 30, 2014. We have been told that providers will begin receiving data on paid claims starting the end of November and will be asked to complete a similar reconciliation spreadsheet to identify any claims that are due a wrap payment. As part of this process, we discussed with DMS staff how to handle the reconciliation of Kentucky Spirit claims and the re-submission process for claims that were incorrectly denied or reimbursed.

The issue of dual eligible payments was also discussed. While CMS has determined that these payments are the State's responsibility, reconciliation has still not occurred. The primary concern raised by providers is that some claims that should be processed as \$0 pay by the MCO in order to receive a wrap payment from DMS have instead been denied. DMS requested that KPCA raise this issue with the MCOs at our monthly operational meetings.

One final issue that we want to raise before the MAC is the status of recommendations accepted by the MAC. We are concerned that formal recommendations made by the TAC and

accepted by the MAC are not being addressed or followed-up by DMS. We would appreciate clarification on this process.

The following recommendations were accepted by the MAC in September and have not been addressed by DMS to our knowledge:

1. The Primary Care TAC requests that DMS recognize and approach these issues in partnership with the providers and MCOs and work together on a commonly shared problem affecting over 180 clinics across the State.
2. The Primary Care TAC requests there be joint meetings between DMS, the MCOs and the affected parties to work on the resolution of the wrap and outstanding issues related to payment for Medicare/Medicaid dual eligible claims.
3. The Primary Care TAC requests that DMS deal with the resolution of the issue with Kentucky Spirit since there is a formal court ruling involving the contract DMS held with Kentucky Spirit and the State and it does not appear the providers can intervene, even on their own behalf.
4. The Primary Care TAC recommends that a working group including the TAC, DMS and the MCOs be established to sample, test and resolve the reconciliation process (all claims prior to June 30, 2014) to assure all data is being captured, to avoid misunderstandings by any party and to avoid confusion, as well as duplication of effort which will only result in extending the length of time needed to resolve the matter.
5. The Primary Care TAC recommends that for the dual eligible claims, DMS instruct the MCOs to transmit a \$0 paid amount instead of a denial when the claim is processed to DMS.

**Finally, the Primary Care TAC submits the following recommendations to the MAC:**

1. The Primary Care TAC recommends that DMS include additional identifiers on EOBs – such as: MCO Member ID, claim number, subscriber number and patient name – in order to allow clinics to reconcile payments more efficiently.
2. The Primary Care TAC recommends that DMS add a legend to the reconciliation spreadsheet to provide clear definitions for the column headers to ensure accuracy when completing the spreadsheet.
3. The Primary Care TAC recommends DMS extend the current timeline for providers to complete the wrap payment reconciliation process from 30 days to 60 days to allow clinics more time to review their data.



**CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES**

**Steven L. Beshear**  
Governor

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**Audrey Tayse Haynes**  
Secretary

**Lawrence Kissner**  
Commissioner

January 20, 2015

TO: Dr. Beth Ennis, Chair, Therapy Technical Advisory Committee (TAC)

RE: Update to Informal Response Issued July 2, 2014;  
Response to September 25, 2014 Therapy TAC Recommendations

Dear Dr. Ennis:

The following response is provided to answer specific questions posed by the Therapy TAC for the purpose of ensuring our members have access to care.

1) Why is there a 30 day recert on the 20 visit benefit?

Per 907 KAR 8:020E Independent physical therapy service coverage provisions and requirements, there is an annual limit of twenty (20) physical therapy visits per recipient per calendar year except where additional visits are determined to be medically necessary by either DMS or the recipient's Managed Care Organization (MCO). Providers should not need to recertify after 30 days in order to continue providing therapy services to Medicaid recipients. We are researching the issue, but it would be helpful if providers who are experiencing this problem could submit specific cases to DMS. We can then research each incident on a case-by-case basis to determine why the problem exists. Please have providers submit these to Erin Hoben at [erin.hoben@ky.gov](mailto:erin.hoben@ky.gov).

**Update:** We have not received any specific examples. Please submit any specific cases to Erin Hoben at [erin.hoben@ky.gov](mailto:erin.hoben@ky.gov) at DMS for us to research each incident on a case-by-case basis to determine why the problem exists.

2) For children on waiver, is there some way to streamline the recert process or flag with an alert, so children don't get moved to MCO? Or a work group to address this as it seems to be happening even if not in a recert timeframe.

DMS is happy to set up a meeting with representatives of providers who are experiencing this issue. DMS asks that providers be prepared with specific instances so we may be able to research each on a case-by-case basis. To set up a meeting, please contact Erin Hoben at [erin.hoben@ky.gov](mailto:erin.hoben@ky.gov).

**Update:** We have not received any specific examples, nor have we been contacted to set up a meeting. Please submit any specific cases to Erin Hoben at [erin.hoben@ky.gov](mailto:erin.hoben@ky.gov) at DMS for us to research each incident on a case-by-case basis to determine why the problem exists.

3) Has the OT hospital restriction been removed from the new regulations?

Yes. Under 907 KAR 8:010. Independent occupational therapy service coverage provisions and requirements, occupational therapy visits may now be provided by independent occupational therapists currently enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672.

Recommendations Presented at the September 25, 2014 MAC Meeting:

1) Is the authorization for 20 visits or for 30 days? Cabinet responded in an email that it was 20 visits, but carewise still says 30 days and no one has provided any solution.

Please see response to #1 above.

2) Concerns regarding Therapist/Assistant differential – no way to know when facilities are billing who provided the service, and people are concerned about being accused of fraud.

Currently, there is no process in place to identify whether a therapist or assistant provided services on the claim. We are currently updating our billing manual and systems to allow for this to be done and will issue a provider letter when the change is implemented.

Erin Hoben  
Chief Policy Advisor  
Office of the Commissioner  
Department for Medicaid Services

cc: Lawrence Kissner, Commissioner, Department for Medicaid Services  
Neville Wise, Deputy Commissioner, Department for Medicaid Services  
Lisa Lee, Deputy Commissioner, Department for Medicaid Services  
Dr. Langefeld, Medical Director, Department for Medicaid Services  
Barbara Epperson, Internal Policy Analyst IV, Department for Medicaid Services  
Dr. Beth Partin, Chair, Medicaid Advisory Committee



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**Audrey Tayse Haynes**  
Secretary

**Lawrence Kissner**  
Commissioner

July 2, 2014

TO: Dr. Beth Ennis, Chair, Therapy Technical Advisory Committee

RE: Response to Therapy Technical Advisory Committee (TAC) Testimony  
Presented at 5/22/2014 MAC Meeting

Dear Dr. Ennis:

We are writing to address testimony presented at the MAC meeting on May 22, 2014. We would first like to remind the MAC that because quorum was not met at the meeting, Department for Medicaid Services (DMS) will not be issuing any formal responses. Typically if a quorum is not set by the initiating legislation, the by-laws of a committee, etc. would set the quorum. The initiating legislation for the MAC does not address the issue of quorum or voting. Per corporate law and tradition, a quorum will default to be the majority of members in absence of it being defined by Articles of Incorporation or by-laws. See e.g. KRS 271A.7-250. The quorum, by definition, is the number of persons required for a body to transact business. Because there is no quorum set in statute for the MAC, the quorum required to transact business is the majority of the MAC members. There was not a majority at the May 22, 2014 MAC meeting.

In order for the Department for Medicaid Services (DMS) to issue a formal response to recommendations brought forth by the any Technical Advisory Committee, we ask that the MAC comply with quorum requirements.

The following response is provided to answer specific questions posed by the Therapy TAC for the purpose of ensuring our members have access to care.

1) Why is there a 30 day recert on the 20 visit benefit?

Per 907 KAR 8:020E Independent physical therapy service coverage provisions and requirements, there is an annual limit of twenty (20) physical therapy visits per

recipient per calendar year except where additional visits are determined to be medically necessary by either DMS or the recipient's Managed Care Organization (MCO). Providers should not need to recertify after 30 days in order to continue providing therapy services to Medicaid recipients. We are researching the issue, but it would be helpful if providers who are experiencing this problem could submit specific cases to DMS. We can then research each incident on a case-by-case basis to determine why the problem exists. Please have providers submit these to Erin Hoben at [erin.hoben@ky.gov](mailto:erin.hoben@ky.gov).

- 2) For children on waiver, is there some way to streamline the recert process or flag with an alert, so children don't get moved to MCO? Or a work group to address this as it seems to be happening even if not in a recert timeframe.

DMS is happy to set up a meeting with representatives of providers who are experiencing this issue. DMS asks that providers be prepared with specific instances so we may be able to research each on a case-by-case basis. To set up a meeting, please contact Erin Hoben at [erin.hoben@ky.gov](mailto:erin.hoben@ky.gov).

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Erin Hoben  
Chief Policy Advisor  
Commissioner's Office  
Department for Medicaid Services

cc: Lawrence Kissner, Commissioner, Department for Medicaid Services  
Neville Wise, Deputy Commissioner, Department for Medicaid Services  
Lisa Lee, Deputy Commissioner, Department for Medicaid Services  
Dr. Langefeld, Medical Director, Department for Medicaid Services  
Barbara Epperson, Internal Policy Analyst IV, Department for Medicaid Services  
Dr. Beth Partin, Chair, Medicaid Advisory Committee

## Therapy TAC

### **MAC RECOMMENDATIONS**

**Presented to MAC May, 2014**

**Approved by MAC on September 2014**

1. Is the authorization for 20 visits or for 30 days? Cabinet responded in an email that it was 20 visits, but carewise still says 30 days and no one has provided any solution.
2. For children on waiver, is there some way to streamline the recert process or flag with an alert, so children don't get moved to MCO? Or a work group to address this as it seems to be happening even if not in a recert timeframe.
3. Has the OT hospital restriction been removed from the new regulations?
4. Concerns regarding Therapist/Assistant differential – no way to know when facilities are billing who provided the service, and people are concerned about being accused of fraud.

## Therapy TAC

### **MAC RECOMMENDATIONS**

**Presented to MAC on Jan. 22, 2015**

1. Shift in EPSDT billing which is to occur in June – do you use provider type 45 and switch to CPT code billing or use specific therapy provider types? Providers would like the cabinet to recognize the significant impact of the rate shift on facilities.