



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

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**Kentucky Department for Medicaid Services
Acquired Brain Injury Waiver Renewal
Official Response to Formal Public Comments: Occupational and Speech Therapy
February 2022**

Between December 6, 2021, and January 9, 2022, the Department for Medicaid Services (DMS) received formal public comment regarding the renewal of Kentucky's Acquired Brain Injury (ABI) waiver. ABI is a 1915(c) Home and Community Based Services (HCBS) waiver that provides services to individuals aged 18 and older with an acquired brain injury.

Waiver Renewal and Public Comment Information

DMS must renew the waiver with the Centers for Medicare and Medicaid Services (CMS) to continue providing ABI waiver services. In the proposed ABI renewal, DMS updated the definitions of occupational therapy (OT) and speech therapy (ST) to clarify that both are Extended State Plan Services. This means ABI participants must first receive these services through the state Medicaid plan. If the state Medicaid plan denies the participant OT and ST, the services can be requested through the waiver.

DMS held the formal public comment period to allow stakeholders to provide feedback on updates proposed in the ABI renewal application. Of the 150 comments stakeholders submitted, more than 60% were related to OT and ST. Due to the number of submissions, DMS is issuing a separate response to most OT and ST-related comments. The response to all other comments is available at <https://bit.ly/kyABlpcResponse>.

Transition of Therapy Coverage from Waiver to State Medicaid Plan

Historically, DMS offered OT, ST, and physical therapy (PT) to waiver participants through its 1915(c) HCBS waiver programs. In 2014, Kentucky expanded the provider types for these services offered through the state Medicaid plan. This created a duplication of services between the state Medicaid plan and the 1915(c) HCBS waivers, which CMS does not allow. To comply with CMS requirements, Kentucky must transition these services out of all 1915(c) HCBS waivers. This transition process has occurred for most waivers, with the remaining applicable waivers to follow including ABI and ABI Long Term Care (ABI LTC).



In spring 2021, the American Rescue Plan Act (ARPA) became federal law. ARPA allocates extra funding to states for HCBS, known as the enhanced Federal Medical Assistance Percentage (FMAP). For a state to receive its full enhanced FMAP funding, it must comply with section 9817 of ARPA which requires, in part, that states “preserve covered HCBS, including the services themselves and the amount, duration, and scope of those services, in effect as of April 1, 2021.” CMS directed DMS that removing OT and ST from the ABI waiver at this time could violate this provision. To avoid the duplication of services and loss of enhanced FMAP funding, DMS is adopting CMS direction to offer OT and ST through the waiver as an extended state plan service.

After the ABI renewal takes effect, current waiver participants would need to transition to state plan OT and ST when their current waiver OT and ST prior authorization ends. Participants can receive up to twenty (20) state Medicaid plan OT and ST sessions without prior authorization. If a participant requires more than 20 sessions, the service provider should initiate the state Medicaid plan prior authorization process before their first 20 sessions are complete.

Response to Comments Regarding OT and ST

A majority of individuals who submitted comments regarding OT and ST said that when provided under the state Medicaid plan, these services are not intensive enough to rehabilitate and maintain individuals who have an acquired brain injury. Commenters say this is because state Medicaid plan OT and ST is not community-based, requires individuals to receive the services at a facility, and does not allow the number or length of sessions that ABI participants require.

A review of the Kentucky Administrative Regulation (KAR) definition of OT provided under both the state Medicaid plan and the waiver shows both versions of the service are meant to be rehabilitative. Additionally, the ABI KAR specifically states OT is not for maintenance or prevention of regression. The same applies to ST. The regulatory definitions of both waiver-paid and state Medicaid plan-paid OT and ST do not specify where services must be provided. Decisions about where OT and ST are provided should be person-centered based on the participant’s assessed needs, goals, and desired outcomes.

The definitions for OT and ST are available in the following regulations:

- Occupational Therapy – State Medicaid Plan: 907 KAR 8:010.
- Speech Therapy – State Medicaid Plan: 907 KAR 8:030.
- Occupational and Speech Therapy – ABI Waiver: 907 KAR 3:090.

In reviewing comments regarding the intensity of waiver-covered OT and ST versus state Medicaid plan-covered OT and ST, DMS noted it appears therapists routinely accompany participants in the community to complete activities of daily living or instrumental activities of daily living such as grocery shopping, apartment hunting, or learning to drive. It is important to note that while OT and ST strategies can be taught in the community, therapists should not be providing long-term assistance to participants in completing these activities. Once the therapist establishes the care plan, natural supports or non-clinical providers should observe the skills and strategies that need to be worked on as modeled by the therapist in order to help execute the plan. Conversely, natural supports and non-clinical service providers should be giving the therapist feedback so interventions can be adjusted as necessary to best support the participant. The goal of OT and ST is to return the participant to their highest possible level of functioning and should not be used as a substitute for 24-hour supervision, socialization, or community access.

DMS received several requests to edit the definition of waiver-covered OT and ST to say it involves cognitive brain injury retraining or that it can be habilitative or rehabilitative. Changing

service specifications requires amending the ABI KAR. DMS is not amending the 907 KAR 3:090 for this renewal. Kentucky's full 1915(c) HCBS waiver service menu will be reviewed as part of the state's Enhanced FMAP Spending Plan. Any updates to service specifications will be completed through a future KAR change accompanied by a waiver amendment. The public will have an opportunity to review and comment on future KAR and waiver amendments.

Several commenters requested a definition of "medically necessary." This is found in 907 KAR 3:130. The state Medicaid plan is authorized under 1905(a) of the Social Security Act, which requires services to be medically necessary. HCBS are authorized under 1915(c) of the Social Security Act as an alternative to institutionalization. If the state Medicaid plan denies a participant needed OT or ST services, the case manager or support broker should provide the denial letter when requesting services through the waiver. Participants who receive authorization for waiver-covered OT and ST after a state Medicaid plan denial can continue to receive OT and ST through the waiver even after the state Medicaid plan limits reset at the start of a new calendar year.

Stakeholders submitted comments on a number of other topics related to participants receiving OT and ST through the state Medicaid plan, including:

- The number and qualifications of state Medicaid plan OT and ST providers.
- How receiving state Medicaid plan OT and ST will affect continuity of care for participants.
- The ability of ABI participants to obtain OT and ST through the state Medicaid plan and receipt of denials due to having third-party insurance.

Waiver OT and ST providers have the option to enroll as state Medicaid plan providers. This will allow OT and ST providers under the waiver to continue to serve their ABI participants and will expand the number of state Medicaid plan OT and ST providers available to ABI participants. Providers can enroll in the state Medicaid plan online using the Kentucky Medicaid Partner Portal Application. Information is available at <https://chfs.ky.gov/agencies/dms/provider/Pages/providerenroll.aspx>. Providers who currently provide therapy services in both the HCBS waivers and the state plan (e.g. home health agencies) are already enrolled as state plan providers and no further action is needed.

To assure continuity of care, all providers who deliver services to a participant, regardless of whether it is covered through the waiver or the state Medicaid plan, should attend person-centered team meetings. Involvement in person-centered team meetings keeps all providers informed of the participant's assessed needs, goals, and desired outcomes and helps assure the participant receives the appropriate level of support. The case manager/support broker should be checking for new or changing service needs, including OT and ST, during monthly monitoring as outlined in D-2-a. of the ABI waiver application. If the participant's needs have changed, it is up to the case manager/support broker to work with the person-centered team to identify these needs and update the person-centered service plan (PCSP) accordingly – which may include changing OT and ST or initiating the service if it's not currently being used. An ABI participant should not be navigating this process on their own.

If an ABI participant has third-party coverage, the third-party is responsible to pay for a service before Medicaid covers it either through the state plan or the waiver. This is current policy as defined in federal regulations and would not change as a result of participants using state Medicaid plan OT and ST. Both Medicaid and the waiver are the "payer of last resort" for individuals with a liable third-party payer as outlined in Social Security Act § 1902(a)(25).

Providers submitted comments regarding the potential administrative and financial impact of OT and ST as extended state plan services. On the administrative side, providers said that state

Medicaid plan policy requires prior authorization which is burdensome and will create extra work. Currently, the prior authorization process through the state plan is as follows:

- Per the state Medicaid plan OT regulation 907 KAR 8:010 and ST regulation 907 KAR 8:030, participants can receive up to twenty (20) OT sessions and twenty (20) ST sessions per calendar year **without prior authorization**.
- Additional sessions require prior authorization **every ninety (90) days**.

When providing OT and ST through the waiver:

- A provider must receive a prior authorization before initiating services.
- Currently, a provider must receive a prior authorization every six months, however, upon the effective date of this renewal, prior authorizations for OT and ST will be required every ninety (90) days to align with other Medicaid and Medicare-paid rehabilitative services.

When an OT or ST provider delivers services to a waiver participant authorized under the state Medicaid plan, the providers must bill the state Medicaid plan. Providers commented that the state Medicaid plan reimburses these services at a lower rate and/or does not reimburse a majority of claims compared to the waiver. Providers indicated the lower reimbursement rate under the state Medicaid plan would result in lower profits compared to providing services through the waiver and could result in difficulty hiring or retaining skilled therapists. OT and ST covered by the waiver are billed differently than OT and ST covered by the state Medicaid plan, which makes it difficult to make a 1:1 comparison of rates. Reimbursement for state Medicaid plan OT and ST is outlined in the Occupational and Speech Therapy fee schedules available at <https://chfs.ky.gov/agencies/dms/Pages/feesrates.aspx>. The focus of service provision should be person-centered and based on the participant's assessed needs, goals, and desired outcomes. Without this focus, the PCSP is more about the services provided than the person receiving them.

Next Steps

After issuing this response, DMS will update the ABI waiver application as needed and will submit it to CMS for approval. Upon the effective date of the renewal ABI waiver, the transition of ABI participants to state plan OT and ST will begin. Again, ABI participants will transition once their prior authorization for waiver OT and ST ends. More details on this transition are forthcoming.