

# **Kentucky Cabinet for Health and Family Services**

## **Medicaid 1915(c) HCBS Case Management Service Authorization Frequently Asked Questions (FAQs) Policy Edition**



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# Kentucky 1915(c) HCBS Case Management Service Authorization FAQs

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## Section 1: Document Background

The Department for Medicaid Services (the Department), on behalf of the Cabinet for Health and Family Services (the Cabinet), is publishing this Frequently Asked Questions (FAQs) document to provide timely updates and responses to stakeholder questions about the Case Management-initiated service authorization policy that took effect on November 25, 2019. These questions were collected from the Service Authorization Webinar held on October 17, 2019, regional Service Authorization Question and Answer Sessions, and questions sent to the 1915(c) Waiver Help Desk. The Department has modified some questions from the originally submitted language to be as clear as possible and not share case-specific details.

We thank you for your continued interest in the 1915(c) HCBS waivers, case management and person-centered service planning redesign. We value your feedback and consider it an important part of the waiver redesign project.

If you have additional questions about case management and/or service authorization, please contact the 1915(c) Waiver Help Desk via email [1915cwaiverhelpdesk@ky.gov](mailto:1915cwaiverhelpdesk@ky.gov) or by phone at 844-784-5614.

If you have technical questions about the Medicaid Waiver Management Application (MWMA) or need help navigating the system, please call the MWMA Contact Center at 1-800-635-2570.

If you have comments or questions about 1915(c) waiver redesign, please email [medicaidpubliccomment@ky.gov](mailto:medicaidpubliccomment@ky.gov) or call (502) 564-7540.

## Section 2: Questions and Responses

Q1: Will the functional assessment tell a case manager the services and amounts to request?

Date Added/Revised: 11/26/19

**No.** The functional assessment alone is not a sole-source of information on an appropriate service or amount of services necessary to advance a participant's person-centered plan goals and service preferences. Case managers will use the information collected via each waiver's functional assessment tool to inform person-centered service plan (PCSP) development. Other documentation, such as observed needs not included in the functional assessment, and participant-expressed goals and preferences should also be used to inform PCSP development and the services included in it, along with the scope, amount, frequency and duration of services appropriate to advance person-centered plan goals and objectives.

A case manager is expected to review the participant's assessment information to gain understanding of his or her comprehensive health status and their functional and daily living needs. Services authorized in a PCSP should align with the participant's assessed needs, intensity of those needs, goals, and preferences.

Q2: What functional assessments are case managers reviewing to justify the services they authorized?

Date Added/Revised: 11/26/19

The functional assessments used in the 1915(c) waiver programs include:

- Acquired Brain Injury (ABI), Acquired Brain Injury Long-Term Care (ABI LTC), Michelle P. Waiver (MPW)
  - MAP-351
- Model II Waiver (MIIW)
  - MAP-351A
- Home and Community Based (HCB) Waiver
  - Kentucky Home Assessment Tool (K-HAT)
- Supports for Community Living (SCL) Waiver
  - Support Intensity Scale (SIS)

Q3: If additional services are needed but not supported in the functional assessment, where does the additional documentation go?

Date Added/Revised: 11/26/19

Case managers can add justifications for services not supported by the functional assessment to the service notes, by uploading a document, or by ensuring it is reflected in the participant's goals and objectives.

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Q4: Will the case manager need to request a new functional assessment if there is a major change in the participant's abilities to justify the modification?

Date Added/Revised: 12/20/19

**Yes**, this has not changed. Case managers should request a new functional assessment for participants if there is a major change in their functional abilities. Most of the time a lengthy hospitalization or rehabilitation stay will cause a participant to be dis-enrolled. As a result, they will receive a new functional assessment upon submission of a request to resume services. Case managers should provide documentation of any changes that would support a request for increased services.

Q5: Can the participant and their family sign the functional assessment?

Date Added/Revised: 11/26/19

**Yes**, participants and their families in the ABI, ABI LTC, Model II, MPW and SCL waivers may sign the functional assessment to help support the services recommended, however, their signature is not required. In the HCB waiver, participants or the participant's legal guardian and/or authorized representative are required to sign the functional assessment, which is the K-HAT.

Q6: In MPW, what is an assessment team? How should the assessors sign the MAP-351?

Date Added/Revised: 12/20/19

All assessments must be conducted by an assessment team. According to **907 KAR 1:835. Michelle P. Waiver Services and reimbursement Section 1.(6)(b)** an assessment team consists of:

1. *Two (2) registered nurses; or*
2. *One (1) registered nurse and one (1) of the following:*
  - a. *A social worker;*
  - b. *A certified psychologist with autonomous functioning;*
  - c. *A licensed psychological practitioner;*
  - d. *A licensed marriage and family therapist; or*
  - e. *A licensed professional clinical counselor.*

The assessors who sign the MAP-351 should identify their qualifications by listing their credentials after their name. Please see the memo sent to Community Mental Health Centers (CMHCs) regarding MPW assessments for more information:

<https://chfs.ky.gov/agencies/dms/ProviderLetters/cmhc1915cassessmemomemo.pdf>

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Q7: How should a case manager handle SCL allocations where the individual will not have a SIS until they have two respondents who have known them for 90 days?

Date Added/Revised: 11/26/19

Case managers should enter the PCSP requesting services based on the needs of the participant as identified by the case manager. The PCSP can be requested for 120 days. If an extension is needed, please contact the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID).

Q8: In HCB, there are cases where the K-HAT is not completed and approved prior to the LOC end date. Is this an instance where a case manager can backdate the PA up to 30 days?

Date Added/Revised: 12/20/19

Yes, this is an instance where a case manager can backdate the PA up to 30 days. Additionally, if a participant's K-HAT is not completed and approved prior to their LOC start date, the case manager should notify the Department by contacting the 1915(c) Waiver Help Desk.

Q9: When and how should the case manager check a participant's financial eligibility?

Date Added/Revised: 11/26/19

Medicaid eligibility is "month pure," meaning when a participant has eligibility at the beginning of the month they will keep it until the end of the month. Case managers should check eligibility at the beginning of the month or prior to providing a service.

Q10: How does a case manager know someone is at risk of losing their waiver services due to financial ineligibility?

Date Added/Revised: 11/26/19

Case managers will find a message in red on the MWMA individual summary screen telling them to call the Department for Community Based Services (DCBS). Participants have 90 days to have their eligibility corrected to a type of assistance (TOA) that supports waiver services. If they do not, they will be dis-enrolled from the waiver.

Q11: When a participant loses eligibility, can a case manager prevent them from being dis-enrolled?

Date Added/Revised: 11/26/19

Participants have 90 days to have their eligibility confirmed prior to dis-enrollment. If a participant is actively trying to get their Medicaid re-instated, please contact the 1915(c) Waiver Help Desk at 844-784-5614 or by emailing [1915cwaiverhelpdesk@ky.gov](mailto:1915cwaiverhelpdesk@ky.gov). The Department will review the situation and

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may cancel the program closure and provide additional time for the participant to regain eligibility.

**Q12: What happens when a participant loses Medicaid eligibility and is dis-enrolled from the waiver?**

Date Added/Revised: 11/26/19

Issued prior authorizations and level of care (LOC) will end on the date the participant loses financial eligibility. This process has not changed and will continue to work as it does today.

**Q13: What can be done if a participant is dis-enrolled from the waiver and it is not their fault?**

Date Added/Revised: 11/26/19

If the dis-enrollment is the result of a system or agency error, the Department will review these on a case-by-case basis and consider back-dating services to close any gaps. Please include the reason for the gap in your service comments.

**Q14: What if a participant is showing up as enrolled in a Managed Care Organization (MCO)?**

Date Added/Revised: 11/26/19

If a participant is listed as enrolled in an MCO, they do not have the TOA required to receive 1915(c) waiver services. The case manager or the participant/legal guardian/authorized representative should contact DCBS at 855-306-8959 and let them know the participant is on a long-term care waiver.

**Q15: Until the LOC process is changed, how long will it take the Department to do the review?**

Date Added/Revised: 11/26/19

The Department is targeting to keep the reviews within three (3) business days, but it may take longer at first as staff adjust to process changes and shifts in day-to-day volume.

**Q16: When a participant is having their annual recertification, should the PA start date also be their annual LOC start date?**

Date Added/Revised: 12/20/19

Yes, services cannot start prior to the LOC start date.

**Q17: Will a case manager know when a participant is denied LOC upon recertification?**

Date Added/Revised: 11/26/19

**Yes**, this information is available in MWMA.

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### Q18: How will the leap year affect re-certifications in 2020?

Date Added/Revised: 12/20/19

As long as the LOC and PCSP are done timely, participants will experience no gap in service. Approval of the new LOC and POC will begin the day after the current LOC end date. For example, if a participant's current LOC has an end date of 12/11/19, the new LOC will begin on 12/12/19. Since the LOC and POC are approved for a max of 365 days, the end date for the new LOC and POC is 12/10/20. In 2020, the start date for the new LOC and POC would be 12/11/20.

### Q19: What are SMART goals? Will case managers receive training about them?

Date Added/Revised: 11/26/19

Goals and objectives on a PCSP should be SMART:

- S tated Clearly: The goal or objective should be understandable to the participant and in his/her own words;
- M easurable: There should be markers of progress toward achieving a goal or objective that can be identified and quantified;
- A ttainable: The goal or objective should be broken into small and actionable steps. Barriers to achieving the goal or objective should be identified and a plan put in place to help mitigate those barriers;
- R elevant: The goal or objective should be important to the participant. Steps toward the goal or objective should help the participant develop and use available resources to achieve it; and
- T ime-Bound: There should be a defined period for when the participant is expected to achieve the goal or objective, keeping in mind that reaching the goal or objective can take time and several steps. There should also be an agreed upon schedule in place for checking progress.

Training for case managers is currently being developed with input from Cabinet staff and the Department's Case Management Advisory Subpanel. The Department will release more information about the training as it is finalized. Training is anticipated to occur this spring.

### Q20: What does it mean when the case manager receives a notification in their message center that a PCSP is "current"?

Date Added/Revised: 12/20/19

"Current" does not mean the PCSP is approved. When a case manager is notified that a PCSP is in a "current" status, he or she should review each service to confirm if they were approved, partially approved, or denied.

### Q21: Does a case management supervisor need to review every PCSP their case managers complete?

Date Added/Revised: 11/26/19

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While not required, case management supervisor review of PCSPs is considered a best practice standard and is encouraged as this new process goes live. If a case management supervisor reviews PCSPs, their review should focus on:

- Use of 1915(c) waiver or non-waiver services
- Frequency of services
- Amount of services
- Appropriateness of goals

More information about case management supervisor reviews of PCSPs can be found on page 16 of the Service Authorization Training Guide at

<https://chfs.ky.gov/agencies/dms/dca/Documents/serviceauthorizationtrainingguide.pdf>.

Q22: Will there be a designated team of staff who will be reviewing the PCSPs?

Date Added/Revised: 11/26/19

**Yes**, the Department will review PCSPs that include high-skill and/or high-cost services. The Department will also regularly review a random selection of PCSPs to monitor for quality and utilization management.

Q23: There are certain phrases Carewise looked for when approving a PCSP. Is this also the case for the new system?

Date Added/Revised: 12/20/19

**No**, the use of key phrases indicates a PCSP is written to the reader and is not person-centered. The Department will be looking at the person centeredness of PCSPs.

Q24: Will there still be *lack of information* (LOI) requests

Date Added/Revised: 11/26/19

**Yes**, if the Department receives a request with insufficient information. The participant and his or her legal guardian and/or authorized representative will also receive a letter. This letter will also be available in the participant's message center in MWMA. The case manager will receive a notification in their message center as well.

Q25: When a team member participates in the person-centered planning meeting via phone, how should his or her participation be acknowledged?

Date Added/Revised: 12/20/19

When a team member participates in person-centered planning via phone they are expected to be engaged in the process and provide input on the participant's goals, objectives, services and units requested. When these team members send an email to acknowledge their role in the process, it should discuss the specific ways the individual will help the participant with their goals and objectives. Emails that simply state "I will be happy to support the participant" or "I will continue to support the participant" are not acceptable.

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**Q26: The Service Authorization Training Webinar and Guide states the MAP-350 no longer needs to be uploaded to MWMA. Does it still need to be reviewed and signed by the participant and/or legal guardian annually?**

Date Added/Revised: 11/26/19

**No**, the MAP-350 is no longer required for all six waivers starting November 25, 2019. Case managers are now asked the following yes or no questions in MWMA verifying that they educated participants on freedom of choice:

- “The Individual/Legal Representative has been given a choice between institutional and waiver services and has been given a choice between eligible waivers and providers.”
- “The Individual understands that under the waiver programs, they may request services from any Medicaid provider qualified to provide the service and that a listing of currently enrolled Medicaid providers may be obtained from Medicaid Services.”

Case managers will not be cited during an audit for not having the MAP-350 as auditors are being trained on the new waiver expectations.

**Q27: Will there be new forms that participants need to sign?**

Date Added/Revised: 11/26/19

**No**, participants do not need to sign any new forms at this time. Participants still need to sign team meeting documents attesting that they are facilitating the meeting and sign their PCSP to demonstrate that they understand the contents.

**Q28: Can case managers alter the team meeting sign-in sheet?**

Date Added/Revised: 11/26/19

Case managers may alter the team meeting sign-in sheet, as long as it still captures the date of the meeting, a list of attendees, a signature from each attendee, and their role on the team or relationship to the participant. The Department will share an example of a sign-in sheet one of our providers has created.

**Q29: What happens if a participant's service needs change?**

Date Added/Revised: 11/26/19

Case managers should modify the PCSP when service needs change, documenting the nature of the change and what is driving the change in the case notes. The case record should include justification and/or documentation as to why the services needs have changed. If the participant is dis-enrolled and a resume services task is requested, MWMA will generate a new assessment task.

**Q30: What happens when a participant needs emergency waiver services?**

Date Added/Revised: 11/26/19

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There should be a team meeting between the case manager, participant, and the provider(s) who will be providing the service(s). The participant's legal guardian and/or authorized representative should be aware of the meeting and participate if possible. If the legal guardian/authorized representative does not respond to requests to attend a service planning meeting, case managers should document that in the case notes.

**Q31: Do case managers need all person-centered planning team signatures for a PCSP modification?**

Date Added/Revised: 11/26/19

**No**, signatures are only required for the parties involved in requesting the modification. The only exception is modification of behavioral services which requires all team members to sign, including service providers. Alternative documentation, such as phone calls, etc., will still be acceptable.

**Q32: If a person receives multiple services from one provider, does a representative from each discipline need to be present for the team meeting? For example, if a participant is updating a goal related to occupational therapy can a representative from that provider share the update with the OT?**

Date Added/Revised: 12/20/19

As long as the individual representing the provider agency can answer questions, give updates related to multiple disciplines and provide feedback that helps to establish goals, it can be a single representative of the provider. All members of the person-centered team need to fill out the sign-in sheet completely, including their agency name, to document which representative attended.

**Q33: How will attendant care workers know the goals and objectives that the participant is working toward?**

Date Added/Revised: 12/20/19

There is no change to how the goals, objectives, and documentation are captured. Case managers will continue to document the participant's goals and objectives. There is also no change to how the case manager distributes the PCSP to parties involved in providing care to the participant. All direct service providers should be informed of specific goals and objectives for the service being provided.

**Q34: Do Behavior Support Plans need to be uploaded?**

Date Added/Revised: 12/20/19

**Yes**, the most recent behavior support plan should be uploaded to MWMA. Behavior supports are intended to fade over time. Behavior Support Plans should include an update on the participant's progress that explains why units decreased, increased or stayed the same. The Department will not approve this service for a full year in order to track each participant's progress.

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Q35: When a participant is hiring an immediately family member as a PDS employee in HCB or SCL, what forms need to be included in MWMA?

Date Added/Revised: 12/20/19

Case managers should upload the approval letter the participant received regarding their request to hire an immediate family member.

Q36: Does the ABI waiver contain a support broker service separate from case management?

Date Added/Revised: 12/20/19

**Yes**, the Department has revised the service authorization crosswalks to include support broker as a service. The crosswalks are available on the Department's DCA website at <https://chfs.ky.gov/agencies/dms/dca/Pages/default.aspx>.

Q37: The case management limitation for ABI is defined as one unit per month, with one unit of service defined as one month. Do case managers still need to conduct two monthly visits?

Date Added/Revised: 12/20/19

**Yes**, case managers still need to conduct two visits per month. There have been no changes made to the current case management definition, limitation, or requirement of two monthly visits. Please continue to reference the ABI regulations: 907 KAR 3:090 and 907 KAR 3:100. The case management limitation for ABI will change once the amended waiver application is effective. For further information, please reference the amended waiver application here: <https://chfs.ky.gov/agencies/dms/dca/Documents/amendedabiwaiver.pdf>. Any changes to ABI case management services will also be reflected the ABI Regulations.

Q38: How do case managers bill the case management service in HCB and MPW?

Date Added/Revised: 11/26/19

For MPW, case managers should use the date of their face-to-face meeting with a participant as the date of service. There should be documentation supporting this. Bill the number of units indicated on your prior authorization.

For HCB, case managers should request one unit and it will reimburse at the max or lesser of billed charges. Instead of requiring you to bill multiple units each month, you can bill one unit and receive up to the full reimbursement.

Q39: What is the case management reimbursement limitation for traditional case management and support broker (participant-directed) in MPW?

Date Added/Revised: 12/20/19

The case management reimbursement is one unit per month at \$200.00 and the support broker

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reimbursement is one unit per month at \$265.00.

**Q40: Why is the support broker service not listed in the SCL service authorization crosswalk?**

Date Added/Revised: 12/20/19

The SCL regulation does not list support broker as a separate service. All case management and support broker services for SCL should be billed under case management (T2022). Case managers should review the Service Authorization Crosswalks for information on support brokers. The crosswalks are available on the Department's DCA website at <https://chfs.ky.gov/agencies/dms/dca/Pages/default.aspx>.

**Q41: Will the waivers contain an exceptional unit option for case management? Some clients tend to switch providers more frequently and require a much larger amount of time invested by the case manager.**

Date Added/Revised: 11/26/19

The Department will not offer an exceptional unit for case management services at this time. The Department may consider a tiered payment structure for case management services during future phases of redesign, when more data is available to objectively consider this need and develop a tiered, acuity based payment methodology for case management services. Exceptional supports will continue to be available for applicable services on the SCL waiver. For the exceptional supports process in SCL, please see [Provider Letter #A-49](#).

**Q42: The Department recently proposed updated rates for case management services across waivers. Will these rates and the service authorization policy update take effect at the same time?**

Date Added/Revised: 12/20/19

**No**, rates are not changing during the service authorization implementation process. The updated rates are part of proposed changes to appendices C, I and J of the amended 1915(c) HCBS waiver applications. The Department accepted official public comment on updates to those appendices between November 8, 2019, and December 10, 2019. The proposed rates can be viewed in the amended waivers and in the "What Does This Mean to Me?" documents available on the Department's DCA website at <https://chfs.ky.gov/agencies/dms/dca/Pages/default.aspx>.

**Q43: How should a case manager enter Financial Management Services for ABI, ABI LTC, and MPW?**

Date Added/Revised: 11/26/19

T2040 Financial Management for ABI, ABI-LTC and MPW will no longer be added as a separate service line within the PCSP; therefore, there will also be no separate prior authorization for this service. The Financial Management Agency is selected upon adding any PDS service on the "Service Details" screen of the PCSP.

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Q44: Is respite approved for a calendar year?

Date Added/Revised: 12/20/19

**Yes**, respite will stay on the calendar year. Respite should follow the current waiver-related KARs until the amended 1915(c) HCBS waiver applications and updated KARs are approved and implemented.

Q45: Can E1399 supplies, such as gloves and wipes, be requested through the waivers? Are creams and ointments such as Desitin, Sween cream, calmoseptine, A&D ointment, etc. be covered under the ABI, ABI LTC, HCB, MPW and SCL waivers?

Date Added/Revised: 12/20/19

**Yes**, wipes and gloves can be requested through the ABI, ABI LTC, HCB, MPW and SCL waiver programs. Creams and ointments are may be covered under the waiver if they are medically justified.

Q46: In MPW, who can receive Goods and Services? Is it only for participants using PDS?

Date Added/Revised: 11/26/19

Currently, Goods and Services is only a PDS service in MPW.

Q47: Should Occupational, Speech, and Physical Therapy services be requested through the state Medicaid program for MPW participants?

Date Added/Revised: 11/26/19

Occupational, Speech, and Physical Therapy services for MPW participants under the age of 21 should be requested through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. For more about EPSDT, visit <https://chfs.ky.gov/agencies/dms/dpgo/dcmb/Pages/epsdt-screenings.aspx>.

Occupational, Speech, and Physical Therapy services for MPW participants older than 21 can still be requested through the waiver. In the amended 1915(c) HCBS waivers, the Department is proposing to transition these services to the state Medicaid program for MPW participants older than 21, however, this change will not take effect until the amended waivers have been approved by the Centers for Medicare and Medicaid Services (CMS). The Department does not anticipate this to happen until mid-2020.

Q48: Will minors on MPW be required to continue to order supplies through EPSDT?

Date Added/Revised: 12/20/19

**Yes**, children's supplies must go through EPSDT, but the Department will work with participants if they are unable to find an EPSDT provider to deliver services and may make an exception. When requesting children's supplies through MPW, the Department expects case managers to provide

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denials from three durable medical equipment (DME) companies and the names of the individual they spoke to at the company.

**Q49: Due to the change in how children under 21 can access services through the waiver, what Community Living Supports (CLS), Attendant Care and Personal Care (PC) tasks are covered on the EPSDT program in our state?**

Date Added/Revised: 12/20/19

Attendant care and CLS services are not offered under the Medicaid State Plan. To access attendant care or CLS services through the waivers for participants under the age of 21, case managers need to provide documentation justifying the request for service.

Personal care services are offered under the Medicaid State Plan and must be accessed first. If a case manager cannot find providers willing to provide personal care through Home Health, personal care services may be accessed under the waiver.

The services provided to a participant under the age of 21 through the EPSDT benefit allows individuals under the age of 21 to receive all medically necessary services through Kentucky's State Medicaid program. The EPSDT benefit covers services that are medically necessary for a participant under the age of 21 but are not covered under the waiver. For example, under the waiver DME does not cover nutritional supplements such as PediaSure or Boost unless they are a participant's sole source of nutrition. Utilizing the EPSDT benefit, some nutritional product can be covered and paid for through DME even if they are not a participant's sole source of nutrition. All service requests are reviewed on a case-by-case basis. Information about EPSDT is located on the Department website here: <https://chfs.ky.gov/agencies/dms/dpqo/dcmb/Pages/epsdt-screenings.aspx>.

**Q50: What information does a case manager need to include when requesting Supported Employment for a participant?**

Date Added/Revised: 12/20/19

Supported Employment is intended to fade over time. When requesting this service, case managers should include documentation as to why units have stayed the same, decreased or increased. The Department will not approve this service for a full year in order to track each participant's progress.

**Q51: Can a participant receive personal care in the morning / evening at their residence in addition to attending adult day care?**

Date Added/Revised: 12/20/19

**Yes**, participants can receive personal care in the morning / evening to assist the participant with personal needs, while also attending adult day services. Services delivered must align with defined service limitations and the two services cannot be provided at the same time.

**Q52: Will there be changes to exceptional supports on the SCL waiver?**

Date Added/Revised: 11/26/19

**No**, currently there are no changes to exceptional supports. The exceptional supports process for the

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SCL waiver can be found in provider letter #A-49

(<https://chfs.ky.gov/agencies/dms/dca/iddcsb/Documents/sclproviderlettera49.pdf>).

**Q53: How can case managers assist participants in finding non-waiver resources to support their needs?**

Date Added/Revised: 11/26/19

Waiver participants can receive services available through Kentucky's state Medicaid program. For more information on services available through the state Medicaid program, call (502) 564-6890.

The Department's Division of Community Alternatives (DCA) also keeps a list of community resources on its website at <https://chfs.ky.gov/agencies/dms/dca/Documents/resourcelisting.pdf>.

**Q54: It is a challenge to help clients understand their Freedom of Choice when provider options don't exist or when providers try to call the shots. What does the Department recommend in this situation?**

Date Added/Revised: 11/26/19

Freedom of choice must be made available to participants and is a federal requirement that case managers must uphold and integrate into options counseling. The Department recognizes that not all areas of the state have multiple service provider options for a participant.

The 1915(c) Waiver Help Desk is available to case managers to report if they believe a service provider is attempting to exert undue influence on the level of services included in a PCSP. This will allow the Department to provide technical assistance and help ensure conflict-free PCSP development, as required by state and federal regulation.

The 1915(c) Waiver Help Desk can be reached at [1915cwaiverhelpdesk@ky.gov](mailto:1915cwaiverhelpdesk@ky.gov) or by calling 844-784-5614.

**Q55: Having case managers authorize services puts them at risk with providers and participants. They must advocate for their participant, but sometimes receive pressure from providers to request the maximum number of services. How do case managers avoid getting caught between the participant and provider?**

Date Added/Revised: 11/26/19

It is the position of the Department that a provider should not dictate the number of hours provided to fulfill a PCSP nor who provides services to a participant. Participants have freedom of choice in selecting providers, with the exception of observing rules for conflict-free case management that disallow receipt of case management and direct services from the same provider. Services should be based on assessed need, as well as the participant's goals, objectives, and preferences. While a service provider should have input as part of the person-centered planning team, services should not be based on how many hours a provider wants, nor should participants be told they must receive all services from the same provider. If a case manager is struggling to resolve a disagreement among parties or believes that providers are exerting undue influence, then they should contact the 1915(c) Waiver Help Desk for technical assistance or alert the Department for further review and resolution.

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**Q56: What if there is a disagreement among the participant, a case manager and/or the identified service provider about the recommended services to be authorized in a PCSP?**

Date Added/Revised: 11/26/19

The case manager is ultimately responsible to authorize the services in MWMA and is expected to exercise professional judgment in objectively explaining the level of services considered appropriate, discussing the disagreement with all parties to consider any additional factors that should be considered and entering the authorized level of services into MWMA.

If there is still disagreement with the level of services authorized by the case manager, there is a grievance process in place for disagreements between the case manager and a service provider, the participant and the case manager, or the participant and a service provider. This process allows participants and providers to share their grievance or concern with the Department so an objective third party can review decisions resulting in a disagreement, consider all perspectives and make a final determination.

**Q57: If a participant or guardian wants 40 hours, but their plan says they only need 30 hours, how do case managers handle this situation?**

Date Added/Revised: 11/26/19

Case managers should document a PCSP that reflects the appropriate level of services based on a participant's assessed and identified needs.

In this instance, the case manager should review the functional assessment information and the contents of the PCSP with the participant and providers. The Department encourages that case managers have a practical discussion with the person-centered planning team to help all parties understand how needed hours are calculated based on the estimated time it would take to complete the components of the PCSP and the scope of services the participant needs. A case manager should also educate a participant and/or their legal guardian/authorized representative that over-stating need for services is considered an act of Medicaid fraud, and that waste and misuse of services can result in negative consequences.

If a participant continues to disagree, he or she may appeal the service authorization through the grievance, reconsideration and appeals process.

**Q58: What happens if the case manager requests, for example, 25 hours, but the representative and employee want more hours and refuse to sign the PCSP?**

Date Added/Revised: 11/26/19

The participant should be informed that services cannot be provided without their signature, but that signing the PCSP does not preclude them from filing a grievance over the case manager's determination about the level of services authorized. The representative and employee should document their disagreement on the sign-in sheet and sign it. Case managers should document this and upload the notes into the system.

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**Q59: How many units of services will a participant receive during the appeal process? For example, if the case management team believes that 20 hours is appropriate, but the participant wants 40 hours.**

Date Added/Revised: 11/26/19

During an appeals process, the participant will receive the same number of units that they were receiving prior to the decision resulting in appeal. If the service in question is a new service being added to the PCSP, the participant will receive the lower amount of service units authorized by the case manager until the appeal is decided, and a finalized number of services has been authorized. The Department will not be recouping during the appeals process and will send out a letter before the process begins. The Department plans to conduct additional trainings for providers to inform case managers of service delivery standards and person-centered planning when an appeal occurs and is under review.

**Q60: How does a participant or provider ask for a reconsideration, file a grievance, or appeal a service authorization decision they disagree with? What is the process for filing a grievance or appeal?**

Date Added/Revised: 12/20/19

Instructions for requesting a reconsideration or filing an appeal are included in all adverse action notices that the Department sends to the participant. Case managers also receive a copy of adverse action notices in MWMA.

Grievances can be filed by calling the 1915(c) Waiver Help Desk at 844-784-5614 or by emailing [1915cwaiverhelpdesk@ky.gov](mailto:1915cwaiverhelpdesk@ky.gov).

**Q61: There have been instances when service requests were entered and warranted, but it took months to find an appropriate caregiver. Will that cause an issue?**

Date Added/Revised: 11/26/19

Technically, if a participant is not receiving any services, they should be discharged from the waiver after 60 days. A case manager should document challenges identifying a service provider and contact the Department via the 1915(c) Waiver Help Desk by emailing [1915cwaiverhelpdesk@ky.gov](mailto:1915cwaiverhelpdesk@ky.gov) or by calling 844-784-5614 for further assistance.

**Q62: What happens if a case manager requests inappropriate services?**

Date Added/Revised: 12/20/19

Any recoupment issued will be connected to the provider delivering the service in question. If the Department identifies that a case manager requested inappropriate services, we will provide technical assistance and reserve the right to issue corrective action. Justification for services should be documented if they are not supported by the functional assessment. Service notes should support the amount of services provided. Knowingly misrepresenting the level of need or services in the PCSP is considered an act of Medicaid fraud.

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### Q63: Will case managers be responsible for the cost effectiveness of PCSPs?

Date Added/Revised: 11/26/19

**Yes**, monitoring cost-effectiveness of services is not a new role or responsibility. According to the current waiver-related Kentucky Administrative Regulations (KARs) case managers are responsible to monitor implementation of a PCSP for cost-effectiveness on a monthly basis. Case managers are encouraged to review a participant's documented needs in the functional assessment and determine how best to meet those needs, including looking at appropriate services in the state Medicaid program and engaging community resources.

### Q64: Since case managers are now approving services and managing allocating funds, are they also liable for fraudulent activities?

Date Added/Revised: 12/20/19

Case managers have always been responsible for assuring that participant needs are appropriately addressed with the authorized services. According to the current waiver-related Kentucky Administrative Regulations (KARs) case managers are responsible to monitor "the quality of services, safety of services, and cost effectiveness of services being provided to a participant in order to ensure that implementation of the participant's PCSP is successful and done so in a way that is efficient regarding the participant's financial assets and benefits" on a monthly basis.

Case managers are not being asked to investigate fraud but are asked to be responsible for assuring the participant's needs align with the services authorized. The Department understands that additional training will continue to be required and is in the process of developing additional person-centered planning and case management related trainings to continue to support the case managers.

Case managers are responsible to report any fraud they identify. Knowingly misrepresenting the level of need or services in the PCSP is considered an act of Medicaid fraud.

### Q65: How is a case manager supposed to detect Medicaid fraud, waste, or abuse?

Date Added/Revised: 11/26/19

Considering and monitoring cost-effectiveness of services, ensuring waiver services are appropriate to each participant's assessed and documented needs, and engaging state Medicaid program services and community resources can help reduce instances of fraud, waste and abuse. Any time the case manager suspects Medicaid fraud, waste, and abuse they should report it to the Office of the Inspector General (OIG) by calling 1-800-372-2970.

### Q66: In the Service Authorization Training, the Department lists "Billing for services when the participant is in an alternate care setting or out of state" as an example of fraud, waste, and abuse. According to a Department letter issued in October 2018, billing for services out of state is an acceptable practice. Can you clarify?

Date Added/Revised: 11/26/19

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The guidance issued via provider letter on October 25, 2018 (<https://chfs.ky.gov/agencies/dms/ProviderLetters/pdstravelupdate.pdf>) pertains to instances where a waiver participant living in Kentucky travels out of state for a temporary period of time, such as visits to family or trips to attractions. The situation would be considered fraud if the participant is receiving services while residing outside of the state.

### Q67: How will billing reviews be conducted?

Date Added/Revised: 11/26/19

The Department is working on standardizing billing review processes across all waivers. Proposed changes include performing desk-level billing reviews since the information is available in MWMA.

### Q68: Will there be any changes to the annual monitoring process?

Date Added/Revised: 12/20/19

The Department is in the process of standardizing annual quality and certification monitoring tools as part of 1915(c) waiver redesign. The Department understands the service authorization process is a shift in practice that has a learning curve for all involved and is approaching this change in a collaborative way to make sure the Department drives positive, successful change. The Department's emphasis will be on education, technical assistance and transparent communication with case management providers, as opposed to citing and recouping for services authorized. The Department reserves the right to recoup for regulatory violations, such as not meeting documentation requirements.

### Q69: If technical assistance is given, will there be a recoupment?

Date Added/Revised: 11/26/19

While the Department will initially focus on technical assistance to help support the shift to case management-initiated service authorization, the Department reserves the right to issue recoupment for willful and intentional violations of state or federal regulation and will continue to uphold and enforce program rules and requirements.

### Q70: Did the Case Management Advisory Subpanel consider this updated service authorization policy?

Date Added/Revised: 11/26/19

**Yes**, the Department's Case Management Advisory Subpanel provided input on updates to service authorization. The subpanel's meeting minutes are available at <https://chfs.ky.gov/agencies/dms/dca/Documents/hcbsapandsubpanelinfodoc.pdf>.

### Q71: What communication has been provided to participants about this service authorization policy update?

Date Added/Revised: 11/26/19

The Department issued a letter for participants on November 22, 2019. The letter is available via the

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following link <https://chfs.ky.gov/agencies/dms/dca/Documents/serviceauthforparticipants.pdf>.

**Q72: Is there training on the updated service authorization policy available for direct service providers?**

Date Added/Revised: 11/26/19

Direct service providers can take the same training offered to case managers. The Service Authorization Training and Service Authorization Training Guide is available on the Department's Division of Community Alternatives webpage at <https://chfs.ky.gov/agencies/dms/dca/Pages/default.aspx>.

**Q73: How did the Department determine the location and dates of the regional Q & A sessions?**

Date Added/Revised: 12/20/19

The Department held six Q & A sessions across five different locations within the Commonwealth, making every effort to hold sessions in various regions. The Department recognizes that some case managers were unable to participate due to scheduling conflicts and / or locations selected. The Department has opened the 1915(c) Waiver Help Desk to provide additional support, and continues to receive questions in other formats, such as via email. The help desk can be reached at 844--784-5614 or by emailing or [1915cwaiverhelpdesk@ky.gov](mailto:1915cwaiverhelpdesk@ky.gov).

**Q74: When will the Service Authorization Standard Operating Procedure (SOP) and Service Authorization Crosswalks be released?**

Date Added/Revised: 11/26/19

The Department released the Service Authorization SOP and the Service Authorization Crosswalks on November 19, 2019. They are available on the Department's DCA website at <https://chfs.ky.gov/agencies/dms/dca/Pages/default.aspx>.

**Q75: Where can case managers find the Department's Fee and Rate Schedules?**

Date Added/Revised: 12/20/19

Case managers can find the Department's Fee and Rate Schedule on the Department of Medicaid Services website at the link here: <https://chfs.ky.gov/agencies/dms/Pages/feesrates.aspx>. A link to this page is also available on the Department's DCA website at <https://chfs.ky.gov/agencies/dms/dca/Pages/default.aspx>.

**Q76: What is the difference between the 1915(c) Waiver Help Desk and the MWMA Contact Center?**

Date Added/Revised: 12/20/19

Case managers should contact the 1915(c) Waiver Help Desk when they have questions about the 1915(c) HCBS waivers. This includes, but is not limited to, questions or problems with a specific case,

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or questions related to waiver policy. The 1915(c) Waiver Help Desk can be reached at 844-784-5614 or [1915cwaiverhelpdesk@ky.gov](mailto:1915cwaiverhelpdesk@ky.gov)

Case managers should call the MWMA Contact Center when they have questions about MWMA. This includes, but is not limited to, system errors or technical issues, help with navigation, training and TRIS, or issues with denied claims, eligibility or other errors. The MWMA Contact Center can be reached at 1-800-635-2570 or [medicaidpartnerportal.info@ky.gov](mailto:medicaidpartnerportal.info@ky.gov).