



Service Authorization Training Guide

**Kentucky 1915(c) Home and Community Based Waiver
Services**

Education for Case Managers

Welcome to the Service Authorization Training Guide

Welcome to the 1915(c) Home and Community Based Services Case Management Service Authorization training, brought to you by the Kentucky Cabinet for Health & Family Services' Department for Medicaid Services, which will be referenced as 'DMS' throughout the remainder of this training guide.

Kentucky's service authorization process was developed in collaboration with DMS, the Department for Aging and Independent Living (DAIL) and the Department for Behavioral Health Developmental and Intellectual Disabilities (DBHDID), as well as other stakeholders, including participants, caregivers, case managers, and 1915(c) waiver service providers. In response to stakeholder feedback, the Cabinet decided to move from the medical model of authorization, which used a quality improvement organization, or QIO called Carewise, to issue "prior authorizations" similar to the standard practice for medical procedures like surgeries or specialized treatments, to a person-centered approach with individualized plans and services.

This training guide is part of a larger effort to address case management as well as the new approach to authorizing 1915(c) waiver services. The training guide will help you understand case managers' roles and responsibilities in authorizing waiver services included in a person-centered service plan, how changes to the Medicaid Waiver Management Application (MWMA) will function in order to authorize services, and the intended outcomes of these changes. DMS's goal is for you to be more informed on the service authorization process.

Please note that this training manual will be updated once the amended waivers are approved and implemented in mid-2020.

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ACRONYMS

ABI	Acquired Brain Injury Waiver
ABI-LTC	Acquired Brain Injury Long-Term Care Waiver
ADL	Activities of Daily Living
CHFS	Cabinet for Health and Family Services
CM	Case Manager
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
DAIL	Department for Aging and Independent Living
DBHDID	Department for Behavioral Health, Developmental and Intellectual Disabilities
DMS	Department for Medicaid Services
HCB	Home and Community Based Waiver
HCBS	Home and Community Based Services
IADL	Instrumental Activities of Daily Living
KAR	Kentucky Administrative Regulation
K-HAT	Kentucky Home Assessment Tool
MMIS	Medicaid Management Information System
MPW	Michelle P Waiver
MWMA	Medicaid Waiver Management Application
NCAPPS	National Center on Advancing Person-Centered Practices and Systems
OIG	Office of the Inspector General
PCSP	Person-Centered Service Plan
PDS	Participant Directed Service
POC	Plan of Care
SCL	Supports for Community Living Waiver
SIS	Supports Intensity Scale
SOP	Standard Operating Procedure

SECTION I: SERVICE AUTHORIZATION COURSE OBJECTIVES

About the Service Authorization Course

Service Authorization is a required course for all Kentucky 1915(c) Home and Community Based Services (HCBS) waivers' case managers (CMs). This course is expected to take approximately two (2) hours to complete.

Service Authorization Course Objectives

As a result of completing this course, case managers will be prepared to:

1. Understand the difference between *prior authorization* and *service authorization*
2. Discuss with the participant how the assessed level of need directly determines the appropriate level of services
3. Use the Service Authorization Crosswalk tool to help participants select the best service-blend to meet the participant's assessed needs, strengths, preferences, identified goals, and desired outcomes
4. Transparently communicate to the participant how the participant's goals, objectives, and level of care informs the level of services
5. Identify and report fraud, waste, and abuse

This course will also review some of the following critical tools:

1. **Service Authorization Crosswalk Tool**: This tool will be used by case managers to define each 1915(c) waiver service and provide guidance on appropriate use, limitations, and other requirements for service authorization across all waivers. Case managers should use this reference document as they engage with the participant during the person-centered service plan (PCSP) planning process to ensure resources are allocated appropriately. The crosswalk defines:
 - a. Service name, summary, and definition
 - b. Applicable 1915(c) waiver(s)
 - c. Service limitations
 - d. Services requiring Cabinet-level review
 - e. Services with risk of duplication
 - f. Service indicators
2. **Medicaid Waiver Management Application (MWMA) Quick Reference Guide**: Used to provide step by step guidance to case managers on identifying what information must be submitted into MWMA to complete a service authorization.
3. **Service Authorization Standard Operating Procedure (SOP)**: Used to provide formal step by step guidance to case managers on the authorization process.
4. **Service Authorization Presentation**: Used to provide service authorization objectives in a web-based training module for better understanding of this model of practice.

5. **Service Authorization Post Test:** Used to ensure an understanding of the expectations and process and is required to meet DMS training benchmarks. Case managers must achieve an 80% pass rate.

Case managers can access the above critical tools via the DMS-Division of Community Alternatives website.

SECTION II: SERVICE AUTHORIZATION OVERVIEW

Service Authorization Purpose

The Kentucky Cabinet for Health and Family Services (the Cabinet) defines the purpose statement for service authorization to help guide the service authorization process and roles accordingly:

“Person centered thinking is foundational to the development of the PCSP and service authorization. Without it, a plan is more about services than the person. At the same time, **we must responsibly distribute limited resources in a way that promotes equitable access to services for all...**”

- Cabinet for Health and Family Services Purpose Statement, 12/2018

Service authorization provides safeguards so that services are:

1. Based on participant needs, goals, and desired outcomes
2. Prioritized and accessible to promote participant choice
3. Customized to the individual (service, amount, delivery method, setting)
4. Timely (Duration between PCSP and initial service delivery is reduced)
5. Continuous (Participant wait times and gaps in service are reduced)

Medical vs. Social Models of Service Review

The Cabinet changed the name of the 1915(c) waiver’s authorization function from *prior authorization* to *service authorization* to reflect the understanding that home and community based services needed by a participant are driven by more than just clinical or medical needs and require a holistic review that considers other social and community factors. Services to help participants with their goals should contribute to growth within holistic dimensions such as a participant’s social, environmental, physical, financial, cultural, and behavioral needs.

The goal of service authorization is to address the participant’s assessed needs and consider which services could advance the participant’s person-centered goals. While some services are reviewed based on their clinical appropriateness, the Cabinet recognizes that not all support needs are medical in nature. [The National Center on Advancing Person-Centered Practices and Systems \(NCAPPS\)](#) maintains a public facing website containing multiple resources explaining the importance of person-centered thinking, person-centered planning, and the social model of care. As case managers review these resources, it should be noted that in the Cabinet’s updated approach to waiver services, the term *service authorization* is specific to Kentucky’s model of person-centered practice.

Another distinction between *prior authorization* and *service authorization* is the entity conducting the authorization function. *Prior authorization* is typically performed by an independent third-party with a

focus on medical criteria. *Service authorization* will be performed by the participant's case manager, who has firsthand knowledge of the participant's individualized needs, goals, and objectives.

Case Manager Service Authorization Roles and Responsibilities

Case managers are required to submit service authorizations according to the standards outlined in the Service Authorization Standard Operating Procedure (SOP). 1915(c) HCBS waiver service providers will not receive payment if they administer services that were initiated before the services are authorized by the case manager or Cabinet-level reviewer. Any services authorized are only valid during the period that the participant is actively enrolled in waiver-supportive Medicaid services and determined to meet the 1915(c) waiver eligibility criteria. Any disenrollment from the 1915(c) waiver or from Medicaid terminates all previously authorized services, effective the date of the disenrollment.

Case managers are responsible for entering service authorization information into MWMA and completing the service authorization process to receive a prior authorization number. It should be noted that although prior authorization is changing to service authorization, the authorization number in MWMA will still be referred to as a prior authorization number. Case managers must indicate an ongoing necessity for the waiver services and ensure services correspond to assessed need, goals, and desired outcomes as documented in the participant's functional assessment.

When authorizing services, case managers must:

1. Review the participant's functional assessment results (i.e. SIS / K-HAT / MAP-351), as well as the participant's strengths, preferences, identified goals, and desired outcomes to gain initial understanding of baseline needs and expectations before initiating the PCSP planning process. The type of service and its scope, amount, and duration should correspond to the needs identified in the participant's functional assessment.
2. Inform and educate the participant and / or their representatives to facilitate understanding of how the participant's assessed level of need influences the level of services that can be authorized. Case managers must transparently inform the participant if a requested service or the scope, amount, and duration of service cannot be authorized based on the assessed needs of the participant.
3. Inform participants and / or their representatives about the right to file a grievance or formally appeal any service authorization determination should they disagree with the authorized level of service determined by the case manager. Participants maintain the right to appeal a service authorization determination even after they have signed that they understand the contents of their PCSP.
4. Document the authorized service(s) in MWMA.
5. Enter the scope, amount, and duration for the service within MWMA.
NOTE: MWMA will calculate total units and / or dollars. Upon authorization, MWMA will display a prior authorization number interfaced from the Medicaid Management Information System (MMIS).
6. Enter the units (or financial value as indicated) according to the amount being authorized.

- a. Check to ensure service and units are aligned with service indicators, found in the Service Authorization Crosswalk Tool, and remain within service authorization limitations.
 - b. Ensure the information entered into MWMA is accurate before submission.
7. Upload any document reflecting involvement of the person-centered planning team in developing the PCSP.
8. Complete any revisions to the plan as requested by the participant, Department for Medicaid Services (DMS) or its designee (for services requiring Cabinet-level review).

SECTION III: APPLYING SERVICE AUTHORIZATION TO THE PERSON-CENTERED PLANNING PROCESS

Analyzing the Functional Assessment

Case managers will develop the PCSP with members of the participant’s person-centered planning team, which typically includes:

- The participant
- The participant’s guardian, authorized representative, Participant Directed Services (PDS) representative, or selected natural supports
- The case manager
- 1915(c) waiver service providers
- Any other person the participant wishes to include

Understanding the participant’s needs, strengths, preferences, identified goals, and desired outcomes related to community-based living allows case managers to develop service authorizations to assist the participant in meeting the established goals. The case manager is expected to utilize information from the participant’s functional assessment, as well as additional information provided by the participant and the person-centered service planning team.

Each waiver uses different functional assessment tools to determine the appropriate level of service for participants. Table 1 displays each functional assessment tool by waiver:

Table 1: Functional Assessment Tools by Waiver

1915(c) Waiver	Functional Assessment Tool	Assessor
Acquired Brain Injury Waiver	MAP-351	Case Manager
Acquired Brain Injury-Long Term Care Waiver	MAP-351	Case Manager
Home and Community Based Waiver	K-HAT	Independent Assessors

Michelle P. Waiver	MAP-351	CMHCs
Model II Waiver	MAP-351A	Provider Agency
Supports for Community Living Waiver	SIS	DBHDID

As stated in Section II, case managers are required to review and consider the needs identified in the participant’s functional assessment to support authorizing services. Tips on analyzing the functional assessment described below are designed to set minimum expectations for case managers.

Case managers must analyze the participant’s functional assessment with an in-depth review of all sections and additional supporting information. Case managers must analyze the assessment thoroughly, identifying any conflicting information in the documentation which requires clarification. Case managers should ask the following critical questions, among others, when evaluating the different sections of the assessment:

- Do the stated needs match up with the findings in the functional assessment? If not, why?
- Does information in one section directly contradict information in another? If so, resolve the discrepancy with the assessor and/or participant before engaging in service planning.
- Can waiver services address the entirety of the stated needs? If not, what other resources are available to address the unmet needs?
- Are there any barriers to service delivery? What resources are needed to reduce or eliminate the barriers?

Each participant’s circumstances are unique, and case managers should approach each functional assessment without preconceptions as to the needs and services. Additionally, while the functional assessment is a major contributor to the service planning process, it should not be used as the only source of information to guide the service plan. Case managers should understand the participant’s goals, preferences, and objectives, as well as review historical case notes to gain information and insight into the service needs. If the participant’s selected services are not supported by the functional assessment, the case manager must explain the reason for the service selection in the PCSP and corresponding documentation in MWMA.

After the case manager completes a thorough examination of the available information, the case manager will begin PCSP development with the person-centered service planning team. Case managers must use all the information to inform the development of the PCSP.

Educating Participants, Guardians, Authorized Representatives, and Participant Direct Services (PDS) Representatives

Education is one of the most important parts of the case manager’s role. Informed and educated participants, legal guardians, authorized representatives, and PDS representatives are more engaged in the person-centered planning process, allowing the case manager to focus on service

coordination. The case manager should work to develop trust and educate the participant by providing accurate, timely information on services via options counseling. Medicaid policies and procedures are highly complex. It may be necessary to repeat information or provide information in different ways to support the participant's individual communication needs and information retention. It is important to remember to use plain language and avoid clinical or complex terms and acronyms when talking to participants and natural supports.

Setting Expectations

Case managers should set expectations with the participant and their person-centered planning team at the first contact. Many participants are underinformed or misinformed about Medicaid services and how participants may request services. Case managers who set expectations early in the process are most successful in delivering the level of service and support expected by participants.

Case managers should strive toward developing a rapport with the participant and keep lines of communication open throughout both the development of the PCSP and the ongoing monitoring of the 1915(c) waiver services. Case managers should use their professional training, patience, and empathy to assist the participant in understanding the information. Case managers should also develop and maintain the participant's trust by only making commitments which they know they can keep. Case managers should always be free to say, "I don't know," or "Let me get back to you."

Documentation and Training Materials

Case managers should provide the participant with informational materials and resources to supplement in-person conversations. Case managers must review the informational materials and check for thorough understanding during the conversations. The case management agency should use informational materials developed by Cabinet departments that allow participants to understand Medicaid waiver policies and procedures.

Options Counseling and Education

How Options Counseling Can Guide Service Authorization

Objective options counseling and participant education provide information on available service options that could meet the needs, advance goals, and engage participants in the person-centered service planning process. Most participants possess support needs in excess of the waiver services available. Effective options counseling identifies additional services and engages the participant in using additional resources to address unmet needs. Case managers should use community resources, such as the local Aging and Disability Resource Center, Community Mental Health Centers, and other information and referral resources to identify additional options available to the participant.

Case managers provide options counseling as part of participant education. As mentioned previously, participant education should begin early, and the case manager should reinforce participant education as often as required. Case managers inform the participant that waiver services may not meet all their support needs during the service planning process. Case managers use options counseling as they discuss the service mix; the full spectrum of resources available to the participant drives the service planning process.

During the options counseling process, the case manager explores goals the participant wishes to accomplish during the duration of the service plan. A clear understanding of the goals, and the service needs associated with those goals, can assist the case manager and participant in

developing the service plan. Case managers can assist with goal development by identifying specific goals with measurable outcomes for the participant to consider. After the participant describes their goals, the case manager assists with the application of services to support those goals.

Case managers who include the participant, natural supports, and providers early in the planning process reduce the likelihood of opposition later in the process. Some participants, natural supports, and providers will express opposition, regardless of the level of inclusion and information provided. Case managers must identify the root cause of the opposition with effective, active listening skills. Many participants express opposition to portions of the care plan that are beyond the case manager's control. When opposition of this type occurs, the case manager must use probing questions to better understand the source of the opposition. These include:

- What makes you say (repeat opposition statement)?
- Why is (opposition statement) important to you?
- Who else could assist you with (the reason for opposition)?

Case managers must listen carefully to the responses and look for key statements that can provide insight into the root cause behind the opposition. Often, participants express themselves readily, but may be unclear in their own reasons for opposition.

When participants express opposition to policies and procedures, including service descriptions and limitations, case managers should reiterate that policies and procedures are beyond the case manager's control. After restating the clear limits of the policies and procedures, case managers should work with the participant to identify other methods to address the key factors behind the opposition. The case manager should never end the exploration of the participant's opposition without considering further options.

At times, participants express opposition to the amount of a service or the service blends. To address this type of opposition, the case manager returns to the functional assessment. The assessment identifies which ADLs and IADLs warrant services and supports. Case managers should always reference the participant's functional assessment results when discussing service amounts and the service mix.

If participant opposition to the authorized services cannot be addressed using education and conversation, the participant may wish to exercise their right to appeal the service plan. Case managers must support this process as they would any other request for appeal. Refer to Section V of this training guide and 907 KAR 1:563 for the appeals process.

SECTION IV: SERVICE DEFINITIONS AND OFFERINGS

Introduction to the Service Authorization Crosswalk

The service authorization crosswalk ("the crosswalk") provides case managers with an overview of the 1915(c) waiver service offerings available to participants. The crosswalk defines each 1915(c) waiver service and provides guidance on appropriate use, limitations, and other requirements for service authorization across all 1915(c) waiver services. In addition, DMS identified service indicators, which can be used to aid case managers in discussing and identifying the appropriate

services based on the participant’s assessed needs, as well as the participant’s strengths, preferences, identified goals, and desired outcomes.

The crosswalk contains the service definition and limitations for each service as indicated in the 1915(c) waiver applications and the Kentucky Administrative Regulations (KARs), both found on the [Division of Community Alternatives website](#). There will be four crosswalks, grouped by waiver as listed below:

1. ABI and ABI-LTC Service Authorization Crosswalk
2. HCB Service Authorization Crosswalk
3. MPW / SCL Service Authorization Crosswalk
4. Model II Service Authorization Crosswalk

For each 1915(c) waiver service, the crosswalk will contain eight (8) elements. These elements, along with a description of each element, can be found below in Table 2.

Table 2: Crosswalk Elements and Descriptions

Element	Description
<i>Service</i>	Name of the service
<i>Applicable 1915(c) Waivers</i>	A list of all 1915(c) waivers the service applies to
<i>Summary at a Glance</i>	A brief description of the service and limits
<i>Definition</i>	The service as defined in the 1915(c) home and community-based services waiver specific KAR
<i>Limitations</i>	Any limits associated with the service, such as volume limits, conflicts with other services, variation based upon a specific waiver
<i>Duplication of Service Risk</i>	Limitations on this service where it cannot be billed concurrently with another service
<i>DMS Review/Approval</i>	Indication that the service requires approval by DMS or its designee prior to service delivery
<i>Service Indicators</i>	Examples of rationale that support use of the service

Using the Service Authorization Crosswalk

Upon review of the participant’s functional assessment, the case manager can reference the crosswalk to help identify all 1915(c) waiver service offerings. The case manager is required to support the participant in selecting the service(s) that align with the participant’s assessed needs, strengths, preferences, identified goals, and desired outcomes, while remaining within the established service limitation. Each 1915(c) waiver program offers several service options and the

crosswalk provides the case manager with a snapshot of each service. The crosswalk serves as a tool for the case manager to compare services, review service indicators, determine services at risk of duplication with another service or program, and identify services requiring a Cabinet-level review and approval prior to service delivery.

Case managers will review the available services and respective definitions to advance an appropriate balance of services. Within the crosswalk, each service has a list of service indicators. The service indicators provide case managers with targeted questions and prompts to consider as the case manager educates and supports the participant and their person-centered planning team on the service options.

The crosswalk identifies instances of “duplication of service risk”. This means that the 1915(c) waiver service may be duplicative of another service, such as a service received through the Medicaid state plan, another 1915(c) waiver service, and / or a community resource. Case managers need to be mindful that Medicaid is considered the payer of last resort. Any service that can be reimbursed and / or provided through the state plan, including but not limited to certain pieces of durable medical equipment or therapies available via *Early and Periodic Screening, Diagnosis and Treatment* (EPSDT) services for participants under age 21, should be obtained through the Medicaid state plan, before obtaining like services via the 1915(c) waiver.

SECTION V: MANAGING PARTICIPANT OBJECTIONS

Common Objections

Case managers are in the best position to understand the participant’s needs since they actively engage with participants in their community and have the most “on the ground knowledge” of the participant’s functional, social, environmental, and behavioral needs. Historically, when case managers received push-back about volume or level of service, they have been able to point to a third-party as the objective decision-maker. Thus, some case managers may have less experience or comfort level with conversations about appropriate services based upon the participant’s functional assessment and the need to support an effective use of resources.

Below are some scenarios provided by case managers that describe common types of objections experienced when working with participants. Case managers will need to be prepared to address the types of objections listed. Gathering talking points and setting an agenda prior to meeting with the participant can help the case manager respond to the participant’s concerns.

1. Legally responsible individuals or household members who are employed as the participant’s direct service provider and have a financial interest in the amount of waiver service hours allocated to deliver services.

Scenario:

During several meetings at the participant’s school, Mary, the participant’s mother and also the participant’s direct service provider, kept telling the school that she had to pay for behavioral supports for her daughter. After the case manager investigated, it was discovered that Mary’s hours as the participant’s direct service provider had decreased from 40 hours to 38 hours per week, with the remaining 2 hours given to behavioral support services. Mary interpreted this as she was now paying for these services since hours were not allocated to her.

Potential communication option

- a. Explain the findings of the functional assessment to the participant, legal guardian, authorized representative, and the PDS representative, and how the needs identified in the functional assessment necessitate authorized waiver services.
 - b. Discuss Mary's role as the participant's legally responsible representative in helping to oversee the most effective PCSP for the participant versus her role as the participant's direct service provider.
2. Participants are concerned that if they do not use all 40-hours of 1915(c) waiver services per week that the waiver allows, they will "lose" their 1915(c) waiver slot.

Scenario:

George believes he is entitled to a full 40-hours of services per week because that is the maximum number of service hours allowed on his waiver, but the amount of in-home support he needs based on his functional needs and person-centered goals is closer to 25 hours per week, which is what his case manager is able to authorize. George has complained about receiving 25 hours per week instead of 40 hours per week to numerous individuals that he interacts with, as he is worried that he needs to 'use it or lose it' if he does not need all 40 hours of services.

Potential communication options

- a. The best way to address this scenario begins with participant engagement during the PCSP planning process. During the PCSP development process, the case manager should educate the participant about the waiver program, how services are determined, and how Medicaid is the payer of last resort. Reference this conversation when this situation arises.
 - b. Let George know you understand his frustration and explain without being upset, appropriate use of in-home services and funds. Give examples of what is appropriate and explain how you are reflecting the hours needed based on the scope of services needed.
 - c. Educate George on DMS's appeals and grievance process and inform him that he has the right to appeal changes to his service plan that he does not agree with. Inquire as to whether or not George requires assistance with filing his appeal. The case manager can refer to the grievances and appeals process as summarized in this section of the service authorization training guide and via 907 KAR 1:563.
3. Providers perceive the case manager as 'playing favorites.'

Scenario

During a planning meeting Michelle, a case manager, notices that one of the service providers (Provider A) has made more than one remark about another service provider (Provider B) receiving authorization for more hours / units than Provider B should be receiving. At one point, Provider A told Michelle that she should seek education, so she understands the importance of Provider A's particular treatment modality and the need for Provider A to receive additional hours / units than Provider B.

Potential communication options

- a. Acknowledge Provider A's concerns and reflect that their perspective has been heard and that you appreciate their input. Remind all members of the person-centered service planning team that the arbiter of authorizing the type, scope, amount and duration of services is between the participant and the case manager. Make a quick observation within the person-centered planning meeting to the effect that you are aware of Provider A's disagreement with the distribution of the participant's service hours. Invite the provider to discuss following the meeting and firmly but respectfully direct meeting participants to continue with the meeting agenda.
- b. It is always better to discuss inappropriate behavior in private. Following the meeting or at an agreed upon time, point out to Provider A how you have arrived at the blend of or amount of services based upon the functional assessment and other relevant information gleaned during the PCSP meeting. Using the functional assessment to determine needs is your guide to appropriate services. Ask the provider to address communications respectfully within the meeting and in all professional interactions.

Objective Communication

Communicating effectively in difficult situations requires several skills. Below are some pointers for remaining objective in dealing with difficult situations.

1. **Seek to understand:** Case managers should take the time they need to truly understand the situation and participant or person-centered team member's perspective before responding. To ensure understanding, confirm your understanding through re-stating feedback. For example, *"To make sure I understand, you're saying you're upset because you think you'll need to pay for 2 hours of services."*
2. **Be objective:** Case managers should be assertive in managing the objections of participants. Assertiveness is neither a passive nor aggressive response. It means remaining confident and objective in decisions while acknowledging the disagreeing party and sharing where you disagree and how information influences the ultimate outcome.
3. **Avoid defensiveness:** Case managers should avoid quick responses that demonstrate irritation, frustration, or feeling defensive. Greet another's escalated tone with calmness and professionalism, at all times.
4. **Restate goals:** The goal of waiver services is to provide participants with a needed service based upon the functional assessment and other relevant information, including the participant's needs, strengths, preferences, identified goals, and desired outcomes, providing what is needed to advance a participant's person-centered goals. The previous section covered information about how to determine appropriate services as part of the PCSP meeting. Restating goals helps focus the PCSP team on the purpose of waiver services.
5. **Reference regulations, policy and other supports:** Guidelines within the Service Authorization Crosswalk can help immensely. The regulatory and policy supports are your objective 'back up' when resistance is met. The KARs, waiver documentation and the Cabinet for Health and Family Services (CHFS) Department for Medicaid Services (DMS) Case Manager (CM) 1915(c) Waiver Help Desk can also be supports to case managers in difficult situations.

Grievances and Appeals

If there are disagreements related to authorized services a good first course of action is to try to resolve the issue through communication and working to understand the underlying issues. Case managers must be able to communicate the rationale of decisions about the type, scope, amount and duration of services that can be authorized.

If a disagreement about authorized services cannot be resolved, the participant, guardian, authorized representative, or PDS representative has a right to request an administrative hearing in accordance with 907 KAR 1:563.

A case manager may need to support the participant and their natural supports in identifying the point of entry to file a grievance or appeal about a service authorization decision that you made.

If the participant would like to file a complaint / grievance, the participant, guardian, or authorized representative (if applicable) can contact DMS via email, mail, or Cabinet for Health and Family Services, Department for Medicaid Services, Case Manager 1915(c) Waiver Help Desk at 844-784-5614.

In the event an adverse action is taken, the participant can file for reconsideration / appeal of the decision. This includes a reduction in 1915(c) waiver service, denial of a 1915(c) waiver service, disagreement with case manager's approved hours and / or Cabinet only approves a portion of the requested services.

While the reconsideration / appeal process is taking place, the case manager will submit service information into MWMA based on the participant's needs identified in the functional assessment. A reconsideration / appeal can be submitted and if the decision is overturned, the 1915(c) waiver service will be backdated to the originally requested start date.

Participants or their representatives must submit a request for an administrative hearing in writing within 30 days of the adverse event / issue to:

Department for Medicaid Services, Division of Program Quality and Outcomes
275 E Main Street 6W-B
Frankfort, KY 40621

If the participant is already receiving Medicaid payments or services, a request for a hearing must be postmarked or received within 10 calendar days of the notice of adverse action to continue receiving payments until date of the Cabinet's Final Order.

SECTION VI: ROLE OF THE CASE MANAGEMENT SUPERVISOR

Process for Properly Documenting Authorized Services and Rationale

In preparation to transition the function of service authorization to case managers, case management service providers are strongly encouraged to provide supervisory review of PCSPs submitted by their case managers to monitor utilization and ensure proper allocation of services. Supervisory review is also intended to identify staff training needs and offer additional protection against the risk of fraud, waste, abuse, and adverse monitoring finds.

Case management supervisor review will ensure PCSPs are aligned with participant goals and needs identified in the functional assessment and other participant specific information. Specifically, supervisory review of PCSPs will focus on:

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

The case management supervisor will confirm that the participant's needs are met through a combination of 1915(c) waiver services as well as non-waiver services. Non-waiver services include, but are not limited to natural supports, Medicaid state plan services, and community resources. If case management supervisors find that a PCSP does not align with participant goals and needs identified in the functional assessment and other participant specific information, they will request a revision to the PCSP via MWMA. Case managers will receive automated tasks to address supervisor comments and may resubmit the PCSP. While not required, case management supervisor review of PCSPs is considered a best practice standard and is strongly encouraged.

SECTION VII: CABINET FOR HEALTH AND FAMILY SERVICES AUTHORIZATION PROCESS

In transitioning the service authorization function, the Cabinet will review high-cost or skilled services. Services that require Cabinet-level review must be approved by the Cabinet prior to service delivery.

Services that Require DMS or its Designee Approval

Select 1915(c) waiver services that require skilled care or significant resources will be subject to Cabinet-level review for PCSPs to be authorized. Cabinet-level review requirements for service authorization differ between 1915(c) waivers. Table 3 indicates services that will require Cabinet-level review by waiver:

Table 3: 1915(c) Waiver Services Requiring Cabinet-Level Review*

Waiver Service Name	Services Requiring Secondary Review					
	ABI	ABI-LTC	HCB	MPW	SCL	Model II
Behavior Supports				X		
Behavioral Services	X	X				
Consultative Clinical and Therapeutic Services					X	
Counseling	X	X				
Environmental Accessibility Adaptation Services				X	X	
Environmental and Minor Home Adaptation	X	X	X			
Goods and Services	X	X	X	X	X	
Group Counseling	X	X				
Nursing Supports		X				
Occupational Therapy	X	X		X		
Person Centered Coach					X	
Physical Therapy		X		X		
Positive Behavior Supports					X	
Skilled Services by a Licensed Practical Nurse (LPN)						X
Skilled Services by a Registered Nurse (RN)						X
Skilled Services by a Respiratory Therapist (RT)						X
Specialized Medical Equipment	X	X				
Specialized Medical Equipment and Supplies					X	
Specialized Respite			X			
Speech Therapy	X	X		X		
Supported Employment	X	X		X	X	
Vehicle Adaptation					X	

***Note: This table reflects current services in each waiver**

While other 1915(c) waiver services may not be subject to Cabinet-level review and may be authorized by case managers, all PCSPs are subject to random review from the Cabinet as well as supervisory review from case management supervisors.

Process for Cabinet-Level Review

Once the case manager submits a service that requires Cabinet review into the POC module of MWMA, the Cabinet will receive an MWMA task to complete the review. The Cabinet will review both the functional assessment and the PCSP as part of the review process. The Cabinet will determine whether the requested service will be approved or denied based on the participant’s goals and needs identified in the functional assessment and documentation. The Cabinet reviewer will also confirm the PCSP has been signed by the participant, guardian, authorized representative (if applicable), PDS representative (if applicable), the case manager, and by each individual who will be involved in implementing the PCSP. The Cabinet reviewer will also confirm that the required documentation has been entered and / or uploaded into MWMA as required. Case managers will receive an MWMA notification indicating the Cabinet’s decision, and a prior authorization number will be issued if the service is approved. If the Cabinet requires additional information, the case manager will receive a task within MWMA and the task will contain the additional information request.

When the case manager receives the notification from MWMA that the PCSP is current, it is the responsibility of the case manager to enter into the PCSP to determine if the PCSP and corresponding services were approved, denied, and / or to confirm

It is a best practice for the case manager to review the PCSP upon notification that the PCSP is 'current'. The case manager is responsible to review the service status and confirm that all approved services were approved at the requested units.

Exceptional Supports Review

The exceptional supports review process as established in [Provider Letter # A-49, Attachment B](#) (March 1, 2017) remains unchanged at this time. Case managers providing support to SCL waiver participants will continue to follow the established exceptional supports review process. PCSPs that require an exceptional supports review will only undergo the existing review process conducted by the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID). For more information on exceptional supports review, case managers can access [trainings](#) conducted by DBHDID on SCL waiver regulations.

SECTION VIII: MWMA AND SERVICE AUTHORIZATIONS

MWMA Overview

Case managers will continue to use MWMA to document the participant's PCSP. Case managers will enter the plan and service details into the plan of care (POC) module in MWMA, including goals / objectives, 1915(c) waiver service details, non-waiver service details and uploading all required documents. When entering the 1915(c) waiver service details, case managers will continue to enter the service type, frequency, and scope into the POC module.

MWMA will continue to require that all POC module fields be completed and all required documentation be uploaded when the case manager submits the PCSP. If a functional error is displayed, the case manager must address the error and resubmit the PCSP. Once all services are in the 'approved' status, including services requiring Cabinet-level review, MWMA will interface with the Medicaid Management Information System (MMIS) and a prior authorization number will be generated. There may be instances in which MMIS returns an error message. If this occurs, the error will include instructions for the case manager to follow to resolve the error. In the event the case manager continues to receive an error message and / or is unable to resolve the error, contact information for the appropriate help desk will be provided in the error message. The case manager should contact the appropriate help desk as soon as possible to prevent delays in 1915(c) waiver services delivery.

The 1915(c) waiver service can start upon approval in MWMA. It is the responsibility of the servicing provider to ensure the member has financial eligibility on the date the service is provided.

Cabinet-Level Review in MWMA

If the service requires Cabinet-level review, MWMA will send a task to the Cabinet highlighting that a review of services is required. Upon receipt of the task, the Cabinet reviewer will complete their review. The reviewer will review the functional assessment to confirm that services align with the needs identified in the PCSP. The reviewer will also ensure that all necessary paperwork is completed appropriately. If the reviewer requires additional information, the task feature within MWMA will generate a notification and correspondence alerting the case manager of the requested information.

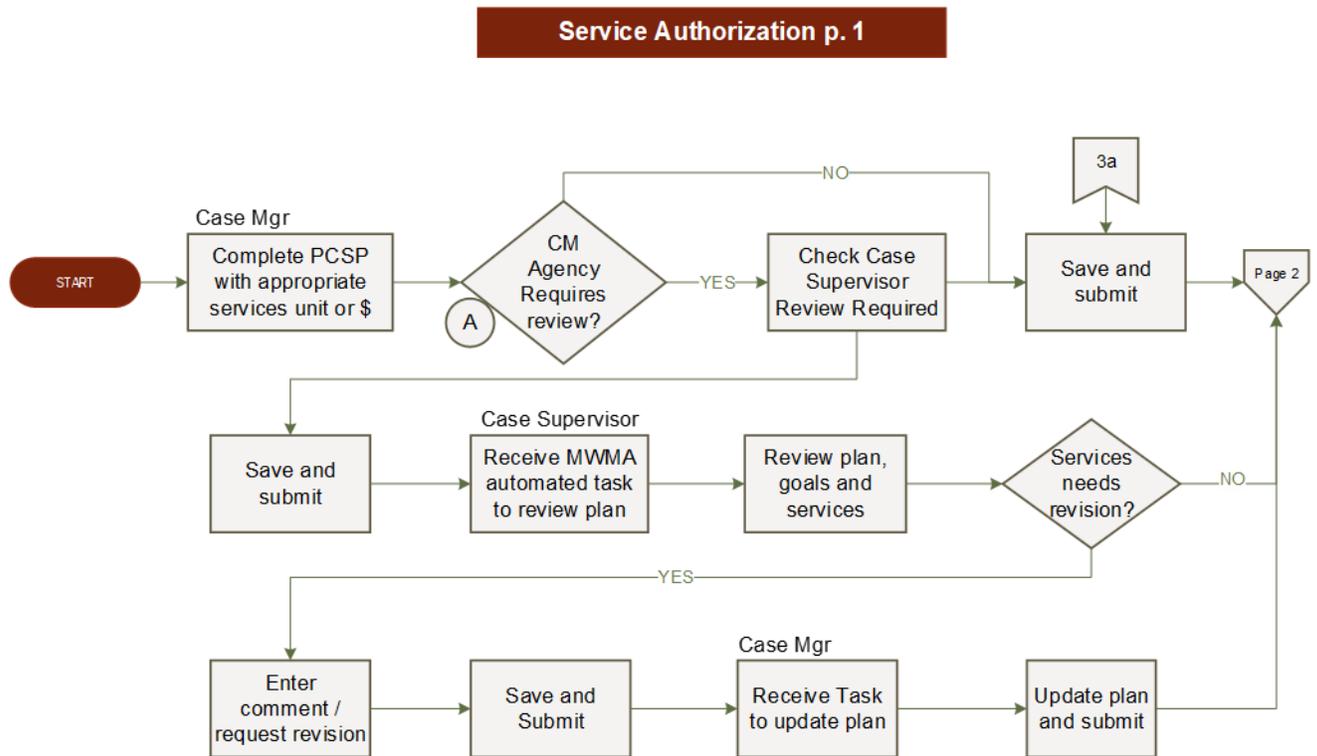
MWMA will interface with MMIS after the service is approved and a prior authorization number will be issued. There may be instances in which MMIS returns an error message. If this occurs, the

error will include instructions for the case manager to follow to resolve the error. For PCSPs that contain a combination of both services that can be approved by the case manager and services requiring a Cabinet-level review, all services must be in an approved status before the prior authorization number(s) will be generated.

It is important to note that PSCP approval, including the issuance of a prior authorization number, must be completed prior to the participant starting services.

Figures 1-3 represent the MWMA service authorization process flow. Please refer to the *MWMA Prior Authorization Quick Reference Guide* for additional MWMA instruction.

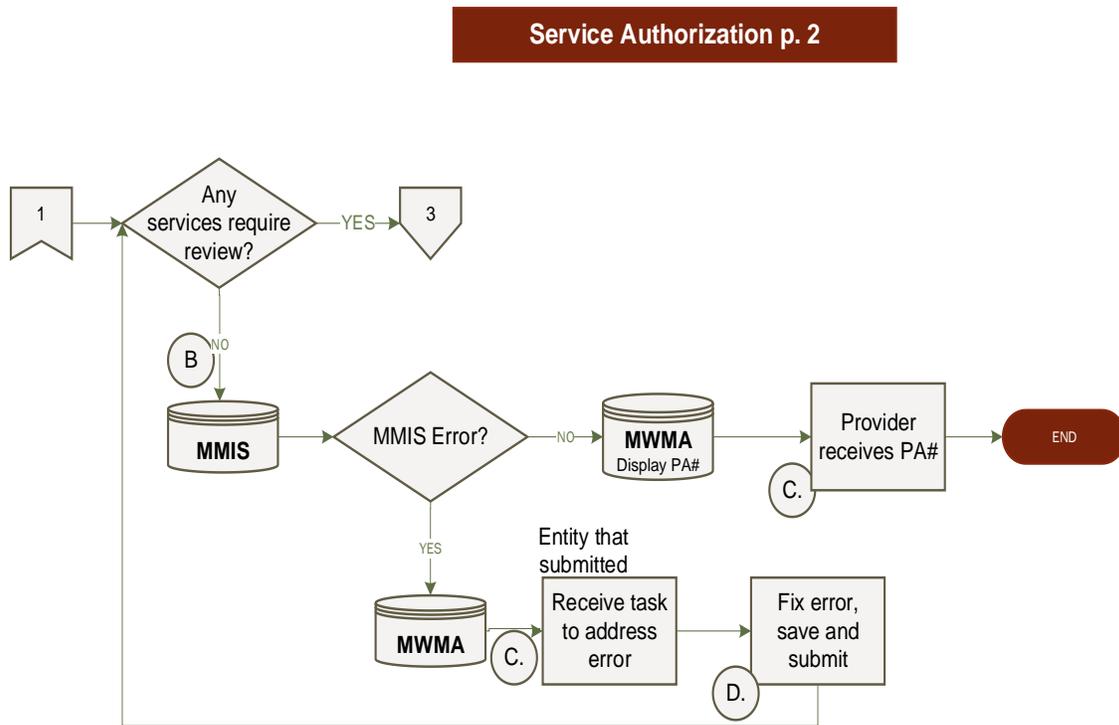
Figure 1: Service Authorization Process Flow p.1



Footnotes:

A. Case management provider agencies are encouraged to have the Case Supervisors review the PCSP. Refer to Section IV of the Service Authorization Training Guide.

Figure 2: Service Authorization Process Flow p.2



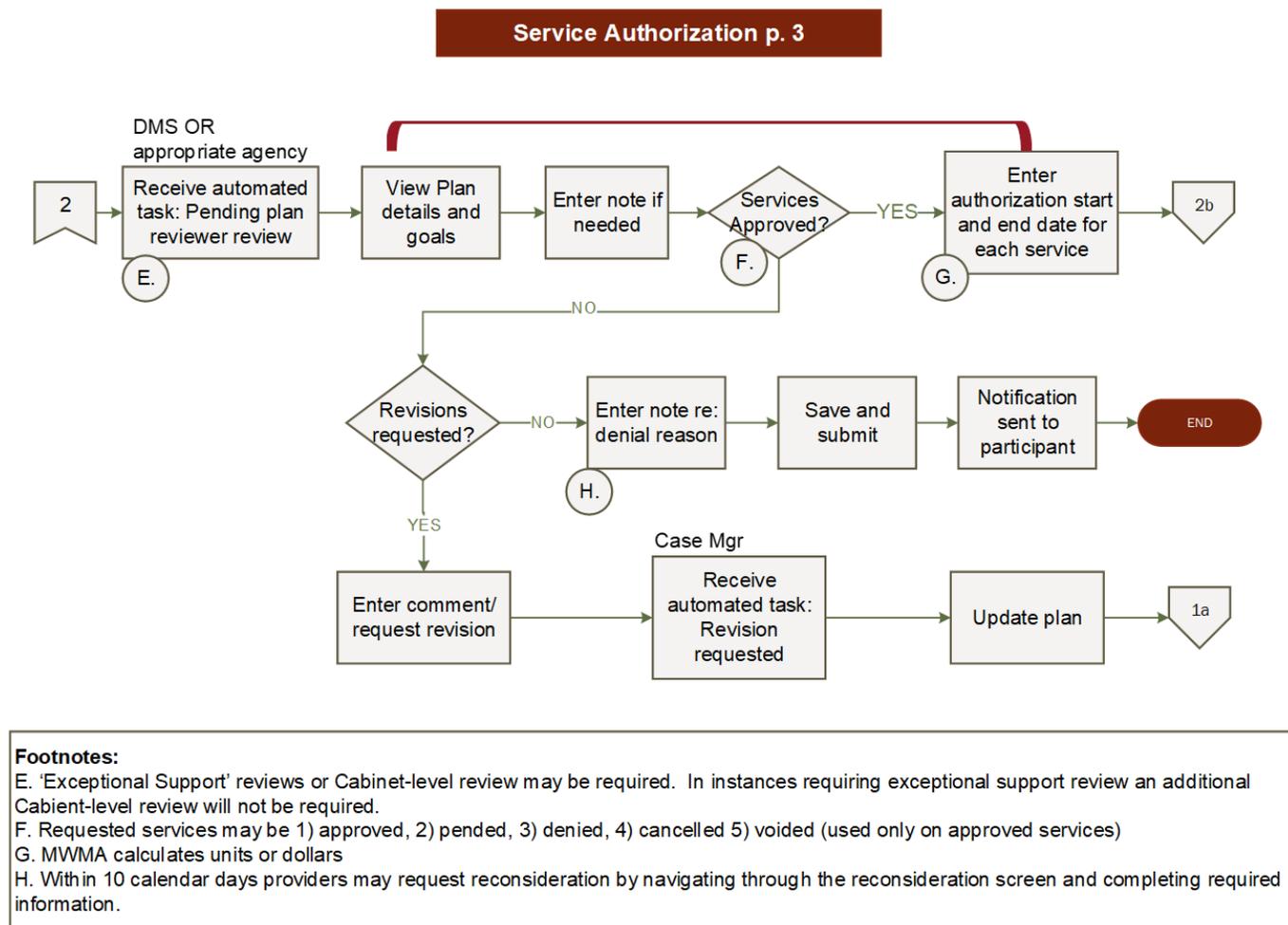
Footnotes:

B. Services not requiring a Cabinet-level of review are automatically marked as approved.

C. MMIS returns a prior authorization number OR an error (i.e., piece of data is missing or incorrect date); 1) a technical error would cause no prior authorization number to be generated 2) a functional error would cause an error for that particular service authorization request (MWMA will require all field completion prior to submittal).

D. Some errors require technical intervention.

Figure 3: Service Authorization Process Flow p.3



Footnotes:
 E. 'Exceptional Support' reviews or Cabinet-level review may be required. In instances requiring exceptional support review an additional Cabinet-level review will not be required.
 F. Requested services may be 1) approved, 2) pended, 3) denied, 4) cancelled 5) voided (used only on approved services)
 G. MWMA calculates units or dollars
 H. Within 10 calendar days providers may request reconsideration by navigating through the reconsideration screen and completing required information.

Service Authorization Notifications and Correspondences

MWMA will contain additional service-related correspondences. The participant, impacted 1915(c) waiver service provider, and case manager will each receive a copy of all correspondences. A directory of MWMA correspondences will be available in a future MWMA quick reference guide.

Document Upload Requirement Update

Case managers will no longer be required to upload the MAP-350 form into the POC module within MWMA effective 11/25/2019.

SECTION IX: THE CASE MANAGER'S ROLE IN ADDRESSING FRAUD, WASTE, AND ABUSE

What is Fraud, Waste, and Abuse?

DMS works in conjunction with the Cabinet's Office of the Inspector General (OIG) to combat fraud, waste, and abuse in Medicaid. DMS actively refers any suspicious or questionable activity identified by staff or reported by an outside source to the OIG for thorough and timely review.

The Centers for Medicare & Medicaid Services (CMS) [defines](#) fraud, waste, and abuse in the following manner:

1. **Fraud** - A knowing misrepresentation of the truth or concealment of a material fact to induce another to act to his or her detriment. Includes any intentional or deliberate act to deprive another of property or money by guile, deception, or other unfair means.

Example: Knowingly submitting claims for services that were not rendered.

2. **Waste** - Overutilization, underutilization, or misuse of resources. Waste typically is not an intentional act.

Example: Costs incurred when an individual is receiving more units or hours of service than needed, e.g., when an individual's health improves but their intensity of supports remains the same.

3. **Abuse** - Provider practices that are inconsistent with sound fiscal, business, or medical practice, and results in unnecessary cost to the Medicaid program or payment for services that are not medically necessary or fail to meet professionally recognized health care standards.

Example: A provider bills for services during an individual's sub-acute rehabilitation stay. This is abuse because the provider should have been aware of the rules, which specify that services cannot be billed during an institutional stay.

Fraud, waste, and abuse can lead to increased program costs and diminished program integrity within home and community-based services. It can also result in ineffective use of limited state resources, which could ultimately result in some programs becoming limited.

Fraud, waste and abuse may occur in many ways, including:

- Identity theft
- Billing for unnecessary services or items
- Billing for services when the participant is in an alternate care setting or out of the state
- Upcoding, or billing for services at a higher level of complexity than the actual service
- Billing for noncovered services or items
- Billing for services or items not rendered
- Kickbacks, or rewarding sources of new business; and
- Beneficiary fraud including card sharing, provider shopping, and misrepresenting one's circumstances to obtain coverage

Detecting and Preventing Fraud, Waste, and Abuse

Case managers can detect and prevent fraud, waste and abuse by:

- Educating the participant, guardian, authorized representative, PDS representative, and any other relevant parties about program requirements and procedures
- Using the service crosswalk and other Cabinet-prepared tools and supports to assist in the person-centered planning process
- Reviewing the service utilization with the participant and comparing the current plan to corresponding service authorizations and upholding authorization rationale, deferring to an appeal when the participant disagrees
- Responding in a timely fashion to changes in need or care settings, and monitoring the implementation of changes in the PCSP for effectiveness
- Conducting the required face-to-face visit(s) in accordance with the specific 1915(c) waiver regulation with the participant and seeking input from the participant's planning team
- Thoroughly documenting the monthly summary note in MWMA
- Having an awareness of, and access to, waiver applications, state regulations and policies
- Participating in compliance trainings

Case managers that knowingly authorize levels of service that exceed the level of the participant's demonstrated need could face potential corrective action measures.

How to Report Fraud, Waste, and Abuse

Recipients, providers and the general public (including those in the Passport Managed Care region) may report suspected fraud, waste and abuse by contacting the KY Cabinet for Health and Family Services (CHFS) Office of the Inspector General (OIG) either by phone or mail.

You may call **(800) 372-2970** weekdays from 8:00 a.m. to 4:30 p.m. EST, or you may mail any fraud and abuse issues to:

Cabinet for Health and Family Services

Office of the Inspector General

Division of Audits and Investigations

275 East Main Street, 5 E-D

Frankfort, Kentucky 40621

A person reporting suspected fraud and abuse is not required to give his / her name. Any information provided is kept confidential.

SECTION X: CLOSING

The Kentucky Cabinet for Health and Family Services is shifting the way it conducts authorization for 1915(c) waiver services. Specifically, the Cabinet is moving from a medical model prior authorization approach to a holistic, person-centered service authorization process led by case

managers. Under the new service authorization process, case managers will continue to manage participants' person-centered service plans to align with participants' goals, objectives, and needs identified in the functional assessment. Additionally, the Cabinet will conduct reviews of certain skilled and resource-intensive services for alignment with participants' goals, objectives, and needs.

Thank you for reading the Service Authorization Training Guide. The Cabinet values case managers for their contributions to the overall quality improvement and delivery of the 1915(c) waiver programs. For additional assistance on service authorization, the Cabinet will be operating the Cabinet for Health and Family Services (CHFS) Department for Medicaid Services (DMS) Case Manager (CM) 1915(c) Waiver Help Desk. The help desk can be reached at 844-784-5614 beginning on 11/25/2019 at 8:00am EST.