1915(c) Home and Community Based Services (HCBS) Waiver Redesign:

Service Authorization Training for Case Managers

Commonwealth of Kentucky
Cabinet for Health and Family Services
November 2019

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SERVICE AUTHORIZATION COURSE OBJECTIVES

Section I

Service Authorization Course Objectives

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

Understand the difference between *prior authorization* and *service authorization*

Discuss with the participant how the assessed level of need directly determines the appropriate level of services

Use the Service Authorization Crosswalk to identify 1915(c) waiver service names, definitions, and limitations

Transparently communicate to the participant how their goals, objectives, and level of care informs the level of services

Identify and report fraud, waste, and abuse

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Service Authorization Course Objectives

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

Service Authorization Crosswalk – This tool will be used by case managers as a reference document during the Person Centered Service Plan (PCSP) process to ensure service information is easily accessible to assist with considering service requests

Medicaid Waiver Management Application (MWMA) Quick Reference Guide – Used to identify what information must be submitted in MWMA to complete a service authorization

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Service Authorization Course Objectives
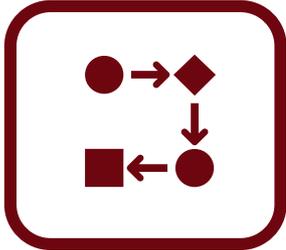
Service Authorization Standard Operating Procedure – Used to provide step by step guidance for the authorization process for case managers
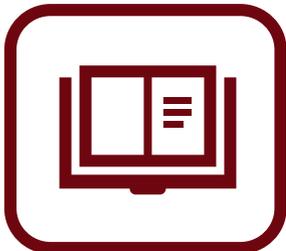
Service Authorization Guide - Used to provide service authorization objectives for better understanding of this model of practice
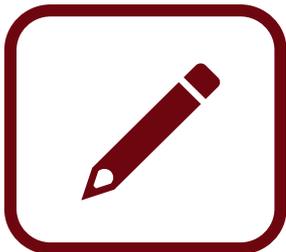
Service Authorization Post Test – Used to ensure an understanding of the expectations and process, and is required to meet Department for Medicaid Services (DMS) training benchmarks

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SERVICE AUTHORIZATION OVERVIEW

Section II

Service Authorization Purpose Statement

"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:

Based on participant needs, goals, and desired outcomes	Prioritized and accessible to promote participant choice	Customized to the individual (service, amount, delivery method, setting)

Timely (duration between PCSP and initial service delivery is reduced)	Continuous (participant wait times and gaps in service are reduced)

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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**.

- 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.

- *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.**

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Case Manager Roles and Responsibilities

When authorizing services, case managers must:

Review Documented Information

- Review participant's functional assessment (i.e. SIS / K-HAT / MAP-351) results, 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.

Consider Documented Needs vs. Participant Requests

- Consider participant's requested service, amount, scope, and duration of services, compared to the participant's documented needs, identified goals, and desired outcomes.
- Identify when participant's service request may be excessive based on the documented needs and explain what the case manager is objectively able to authorize in the PCSP.

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Case Manager Roles and Responsibilities

When authorizing services, case managers must:

Offer a Rationale for the Person-Centered Service Plan Authorized

- Provide information to participant / representative on how the level of need indicated in the assessment influences service authorization

Maintain Participants' Right to Disagree with Level of Services Authorized

- Provide information to participant / representative on grievance and appeals process to ensure participant receives all needed services

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Case Manager Roles and Responsibilities

Document necessary information in MWMA

✓ Assign an appropriate service in MWMA that has been determined to meet defined PCSP goal(s);

✓ Enter the frequency and appropriate start and end dates for the service within MWMA;

✓ Enter the units (or financial value as indicated) according to the amount being authorized;

✓ Upload any document reflecting involvement of the person-centered planning team in developing the PCSP;

✓ Ensure the information entered into MWMA is accurate before submission;

✓ Complete any revisions to the PCSP as requested by the participant, DMS, or its designee (for services requiring Cabinet-level review).

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APPLYING SERVICE AUTHORIZATION TO THE PERSON-CENTERED PLANNING PROCESS

Section III

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Analyzing the Functional Assessment

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

1915(c) waiver service providers

His or her representative or selected natural supports

The Participant

The Case Manager

Any other person the participant wishes to include
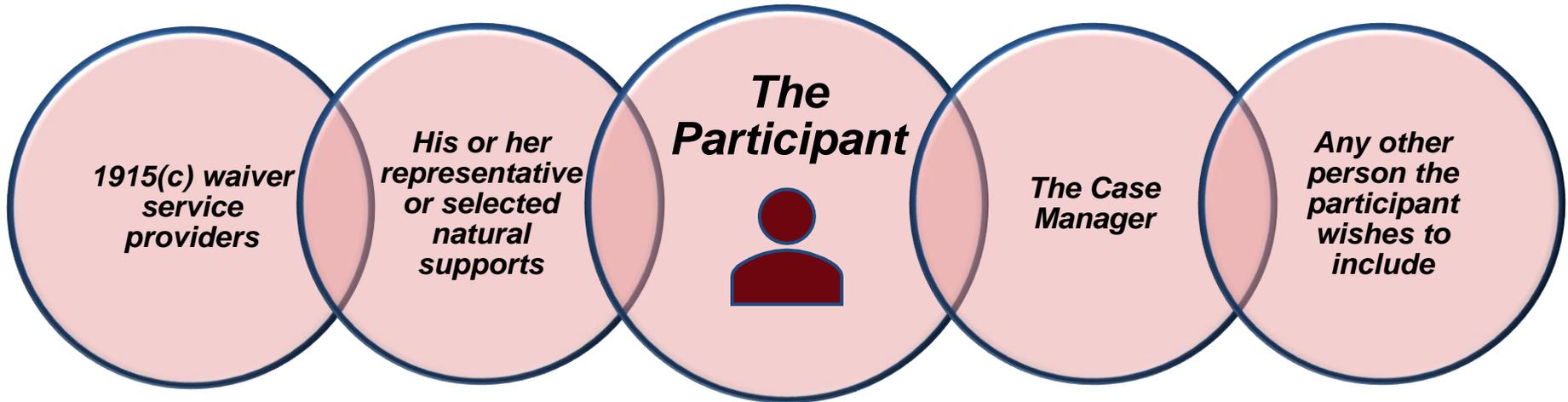
Analyzing the Functional Assessment

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

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Analyzing the Functional Assessment

Case managers are required to use the results of the participant's functional assessment to assist in service authorization.

Case managers must analyze the participant's functional assessment with an in-depth review, identifying any conflicting information in the document which requires clarification.

Each participant's circumstances are unique, and case managers should approach each functional assessment without preconceptions as to the needs and services.

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.

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Analyzing the Functional Assessment

Case managers should ask the following critical questions, among others, when evaluating the different sections of the assessment:

Do the stated needs align with what you have observed when working with the participant? 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?

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Analyzing the Functional Assessment

Additional functions of analyzing the functional assessment include:

Educating the Person-Centered Planning Team	Informed and educated participants, legal guardians, authorized representatives, and Participant Directed Services (PDS) representatives are engaged in the person-centered planning process and allow the case manager to focus on service coordination.
Setting Expectations	Case managers who set expectations early in the process can expect reduced confusion and opposition. Case managers should also develop and maintain the participant's trust by only making commitments which they know they can keep.
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.
Addressing Opposition to Defined Services	Case managers who include the participant, natural supports, and providers early in the planning process promote collaboration and cooperation. Case managers must identify the root cause of the opposition with effective, active listening skills.

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Analyzing the Functional Assessment

How Options Counseling Can Guide Service Authorization

- Objective **options counseling** and participant education provides information on available service options that could meet needs, advance goals, and engage participants in the person-centered service planning process.

- 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* and Community Mental Health Centers (CMHCs) to identify additional options available to the participant beyond waiver services.

- During the options counseling process, the case manager identifies goals the participant wishes to achieve via the service plan.

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SERVICE DEFINITIONS AND OFFERINGS

Section IV

Service Authorization Crosswalk

*The **crosswalk** defines each waiver service and determines limitations, efficiencies, and other requirements for service authorization **across all waivers** to provide a summary of current authorization protocols.*

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

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Service Authorization Crosswalk - *Example*

Service Name	Respite
Applicable Waivers	**ABI, ABI-LTC**
Summary at a Glance	**Short-term care due to absence or need for relief of a primary caregiver**
Definition	**Respite care service is defined as short term care which is provided to a waiver recipient due to absence or need for relief of the primary caregiver, or provided to an individual who is unable to care for himself during transition from a residential facility. Respite care services must be provided at a level to appropriately and safely meet the medical needs of the waiver recipient. Respite is considered an essential service to assist the recipient and family to prevent institutionalization. The Case Manager or Community Guide shall be responsible for assisting individuals to access other supports or supports available through other available funding streams if their needs exceed the limit.**
Limitations	**ABI: Be limited to 336 hours (1,344 fifteen (15) minute units) per one (1) year authorized person-centered service plan unless an individual's non-paid caregiver is unable to provide care due to a death in the family, serious illness or hospitalization.** **ABI-LTC: Reimbursement for respite care services shall be limited to no more than 5760 fifteen minute units per recipient per calendar year unless an individual's non-paid caregiver is unable to provide care due to a death in the family, serious illness or hospitalization.**
Duplication of service risk	**Yes**
Requires DMS/designee review prior to service delivery	**No**

Service Indicators	**o Provide necessary relief to allow caregivers to take care of personal matters or engage in tasks for other members of the household.**
	
	o Signs/evidence of family/caregiver burnout, including but not limited to:
	  - Caregiver lack of self-care
	  - Increased agitation between caregiver and participant
	
	o Caregiver is responsible for 24 hour care of participant

Note: This language is extracted from current KARs and is subject to change.

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Using the Service Authorization Crosswalk

Support participant in selecting services that align with the assessed needs, strengths, preferences, identified goals, and desired outcomes

Identify 1915(c) waiver services at risk of service duplication

Identify services requiring Cabinet-level review and approval prior to service delivery

Utilize service indicators as prompts to consider when educating participant on 1915(c) service options

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Using the Service Authorization Crosswalk - *Duplication of Service Risk*

The crosswalk highlights 1915(c) services that may be duplicative of services available through:

- Another 1915(c) waiver service
- Medicaid state plan services
- Community resources

Services that can be reimbursed and / or provided through the state plan **should be obtained through the Medicaid state plan before obtaining the item / service via the 1915(c) waiver**, including but not limited to:

- Durable Medical Equipment
- Therapies available via Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for participants under age 21
- Additional Medicaid state plan services can be accessed via the DMS website

MANAGING PARTICIPANT OBJECTIONS

Section V

Objective Communication

> *Case managers will make an objective judgment call on the amount, scope, and duration of 1915(c) services that are appropriate to advance the participant's needs and desired goals.*
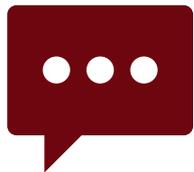
- Case managers will communicate and educate the participant and providers on the rationale used to develop the proposed 1915(c) waiver service blend

- Participants and providers may not agree with the case manager's judgment call, and additional communication and education may need to occur

- Case managers will modify or maintain the proposed amount, scope, and duration of services based on any additional information received from the participant

Effective Communication

Seek to Understand

Take the time to understand the participant's perspective

Be Objective

Remain objective in decisions while acknowledging the disagreeing party

Avoid Defensiveness

Remain calm and professional at all times

Restate Goals

Reaffirm participant's needs, strengths, preferences, identified goals, and desired outcomes

Reference Regulations, Policy & Other Supports

Utilize Kentucky Administrative Regulations (KARs), the Service Authorization Crosswalk, and waiver documentation to support decisions

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Grievances and Appeals

When a participant disagrees with the level of services that can be reasonably authorized, the case manager will support the participant by:

- Attempting to resolve the issue through communication and working to understand the underlying issues

- Communicating the rationale of decisions about the type, scope, amount, and duration of services that can be authorized

- Supporting the participant if they need assistance in identifying the point of entry to file a grievance / appeal

If a disagreement about authorized services cannot be resolved, the participant / authorized representative or guardian has a right to request an administrative hearing.

How to Submit a Grievance or Appeal

Participants or their representatives can contact DMS via email, mail, or the 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.

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How to Submit a Grievance or Appeal

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 East Main Street, 6 W-B

Frankfort, Kentucky 40621

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ROLE OF THE CASE MANAGEMENT SUPERVISOR

Section VI

Case Management Supervisor Role

Case Management Service Providers are strongly encouraged to provide supervisory review of PCSPs submitted by their case managers.
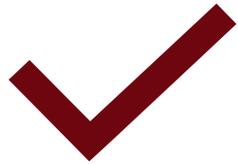
- If reviewed, the case management supervisor will confirm that the participant's needs are met through a combination of 1915(c) waiver services as well as non-waiver services. Non-waiver services may include natural supports, Medicaid state plan services, and community resources.

- Case management supervisors will review frequency of services, amount of services, and appropriateness of goals within supervisory review to ensure PCSPs align with participant goals and assessed needs.

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Case Management Supervisor Role

Case Management Service Providers are strongly encouraged to provide supervisory review of PCSPs submitted by their case managers.

- If case management supervisors find that a PCSP does not align with participant goals and needs identified in the functional assessment, they will request a revision to the PCSP via MWMA.

- Supervisory review is considered by the Cabinet to be a best practice standard to ensure service appropriateness, help providers identify staff training needs, and protect against risk of fraud, waste, abuse, and adverse monitoring findings.

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CABINET FOR HEALTH AND FAMILY SERVICES AUTHORIZATION PROCESS

Section VII

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Cabinet-Level Review and Authorization

The Cabinet will **review high-cost or skilled services**. Services must be approved by the Cabinet prior to service delivery.

| Case manager submits service type, frequency, and scope into Plan of Care (POC) module of MWMA | → | Cabinet receives MWMA task alerting that the POC requires review of services | → | Cabinet reviews POC and enters decision into MWMA | → | Case manager receives MWMA notification indicating if service is approved, denied, or if additional information is needed | → | Upon Cabinet-level approval, a prior authorization number will be issued |

* Upon Cabinet-level approval of 1915(c) waiver services, the service authorization will generate a 'prior authorization number'

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Cabinet-Level Review and Authorization

The Cabinet will:

- Review both the functional assessment and the PCSP to determine whether the requested service will be approved or denied based on the participant's goals and needs

- Confirm the PCSP has been signed by the participant, guardian or authorized representative (if applicable), the PDS representative (if applicable), the case manager, and by each individual who will be involved in implementing the PCSP

- Confirm that the required documentation has been entered and / or uploaded into MWMA

- Conduct ongoing random reviews of PCSPs to monitor quality and utilization management

1915(c) Waiver Services Requiring Cabinet-Level Review and Authorization

Waiver Service Name	Services Requiring Cabinet-Level Review					
	ABI	ABI-LTC	HCB	MPW	SCL	Model II
Behavior Supports				X		
Behavioral Services*	X	X				
Consultative Clinical and Therapeutic Services					X	
Counseling / Group Counseling**	X	X				
Environmental and Minor Home Adaptation***	X	X	X	X	X	
Goods and Services (above $500)	X	X	X	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 and Supplies****	X	X			X	
Specialized Respite			X			
Speech Therapy	X	X		X		
Supported Employment	X	X		X	X	
Vehicle Adaptation					X	

This table reflects current services in each waiver.

* "Behavioral Services" may also include "Behavioral Programming".
** "Counseling / Group Counseling" may also include "Individual Counseling".
*** "Environmental and Minor Home Adaptation" may also include "Environmental Accessibility", "Environmental Modification", or "Environmental and Home Modifications".
**** "Specialized Medical Equipment and Supplies" may also include "Specialized Medical Equipment".

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Exceptional Supports Review

The exceptional supports review process as established in Provider Letter # A-49, Attachment B remains unchanged.

Case managers providing support to SCL waiver participants will continue to follow the same review process.

MWMA AND SERVICE AUTHORIZATIONS

Section VIII

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MWMA Transition Timeline

To prepare for service authorization changes, MWMA will adhere to the following transition timeline:

Cabinet is requesting **routine PCSP updates be completed** *prior* **to 11/15/19**

MWMA will be in **maintenance mode** from 11/22/19-11/25/19
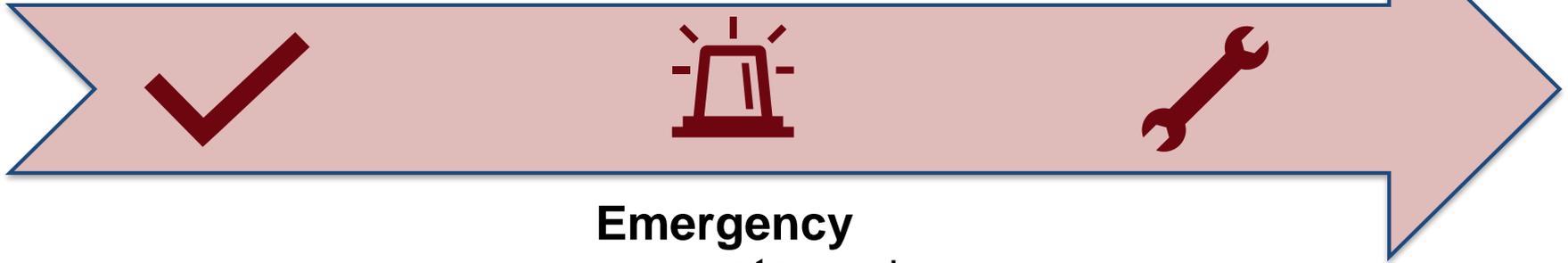
Emergency requests can be submitted between 11/16/19-11/22/19

Changes to Medicaid Waiver Management Application (MWMA)

MWMA **updates** will be **deployed on 11/22/2019** and the system will be **available to case managers on 11/25/2019.**

Case managers will continue to enter the service type, frequency, and scope into the plan of care (POC) module within MWMA.

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.

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Changes to Medicaid Waiver Management Application (MWMA)

If the service authorization transaction is not successful, MMIS will return an **error message**. Case managers will receive error resolution instructions within the error message, along with a help desk contact number.

Case managers will **no longer be required** to upload a **MAP-350 form**.

Additional **service-related correspondence letters** have been added to MWMA.

Case managers will receive **MWMA specific job aids and quick reference guides** prior to 11/25/19.

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

Section IX

What is Fraud, Waste, and Abuse?

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.

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

Abuse - Provider practices that are inconsistent with sound fiscal, business, or medical practice, and result 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.

Reference: US DHHS Centers for Medicare & Medicaid Services. (July 2016). Fraud, Waste, and Abuse Toolkit, Health Care Fraud and Program Integrity: An Overview for Providers. from https://www.kcmn.us/docs/FamilyServices/Minutes/2017_Agenda-Minutes/Medicaid%20Health%20Care%20Fraud%20Program%20Overview.pdf

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What is Fraud, Waste, and Abuse?

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 Medicaid business

- Beneficiary fraud including card sharing, provider shopping, and misrepresenting one's circumstances to obtain coverage

Reference: US DHHS Centers for Medicare & Medicaid Services. (July 2016). Fraud, Waste, and Abuse Toolkit, Health Care Fraud and Program Integrity: An Overview for Providers. from https://www.kcmn.us/docs/FamilyServices/Minutes/2017_Agenda-Minutes/Medicaid%20Health%20Care%20Fraud%20Program%20Overview.pdf

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What is Fraud, Waste, and Abuse?

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.

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Detecting Fraud, Waste, and Abuse

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

Educating the participant, guardian, authorized representative, and PDS representative (if applicable) 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

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Detecting Fraud, Waste, and Abuse

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

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

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How to Report Fraud, Waste, and Abuse

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.

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CLOSING

Section X

Closing

- Please share information learned today with your colleagues
- Link to Training Quiz: https://forms.gle/PXMsCKe4N6KRrtKt8
- You may contact the *Cabinet for Health and Family Services (CHFS) Department for Medicaid Services (DMS) Case Manager (CM) 1915(c) Waiver Help Desk* at **844-784-5614** with questions. The help desk will be live starting on 11/25/2019 at 8:00am EST

Thank you for completing the Service Authorization Training Module!