Kentucky Department of
Our Children,
Our Commonwealth
Education

State Maintenance of Financial Support under the IDEA

State Inter Agency Council (SIAC)

Meeting

July 27, 2016

Chris Thacker
Disability Administrator
Human Development Institute – University of Kentucky

Individuals with Disabilities Education Act (IDEA)

- Provides states and local school districts federal funds under Part B of the Act to assist states in paying for the excess cost of providing special education and related services to children with disabilities ages 3 through 21.
- Allocates separate funds for preschool children with disabilities ages 3 through 5.
- Approximately 99,000 children and youth with disabilities in Kentucky as of the December 1, 2015 Child Count.
- For the 2016-2017 School Year IDEA allocated approximately $160 million for ages 3 through 21 and an additional $10 million for children ages 3 through 5.
- Around 88% is allocated to local school districts and another 6% to regional special education cooperatives.

What is State Maintenance of Financial Support (MFS) under IDEA?

- 34 CFR 300.163

  A State must not reduce the amount of State financial support for special education and related services for children with disabilities, or otherwise made available because of the excess costs of educating those children, below the amount of that support for the preceding fiscal year.

What is State Maintenance of Financial Support (MFS) under IDEA?

- What does ***State*** Financial Support Mean?

  The question has been asked whether this provision specifically means the support for special education and related services provided by the State educational agency (SEA) or whether, in computing its maintenance of financial support for special education and related services, the SEA must include support provided by other State agencies, such as a State Department of Health or a State Vocational Rehabilitation Agency.

  --OSEP Memorandum 10-5: Dec 2, 2009

What is State Maintenance of Financial Support (MFS) under IDEA?

- What does ***State*** Financial Support Mean?
  - *Under section 602(31) of the IDEA and 34 CFR 300.40 of the Part B implementing regulations, "State" is defined as each of the 50 States (as well as DC, PR and the outlying areas.)*
  - *Under section 602(32) and 34 CFR 300.41, "State Educational Agency" (SEA) is defined as the State Board of Education or other agency primarily responsible for the supervision of public elementary and secondary schools.*

--OSEP Memorandum 10-5: Dec 2, 2009

What is State Maintenance of Financial Support (MFS) under IDEA?

- What does ***State*** Financial Support Mean?
  - The reference to "State financial support" in 34 CFR §300.l63 is not limited to only the financial support provided to or through the SEA, but encompasses the financial support of *all* State agencies that *provide or pay* for special education and related services, as those terms are defined under the IDEA, to children with disabilities.

--OSEP Memorandum 10-5: Dec 2, 2009

What is State Maintenance of Financial Support (MFS) under IDEA?

- What does ***State*** Financial Support Mean?
  - Because 34 CFR 300.163(a) requires that a *State* not reduce its financial support from year to year for special education and related services, a State must include in its calculation of financial support under 34 CFR 300.163(a), *any* financial support for special education and related services provided by *any* State agency.

--OSEP Memorandum 10-5: Dec 2, 2009

What are examples of financial support by other agencies?

- **Payment by the State Vocational Rehabilitation Agency from State funds for job coaching services to youth with disabilities pursuant to an individualized education program (IEP)**
- **If the State Department of Health provides psychological counseling or other mental health services to children with disabilities pursuant to their IEPs, the cost of such services would also be included**

--OSEP Memorandum 10-5: Dec 2, 2009

What is the standard for State MFS?

- The standard for meeting State MFS is the amount of State financial support provided (made available) for special education and related services from year to year, regardless of the amount actually expended.

  --OSEP Memorandum 10-5: Dec 2, 2009

What is the penalty for failing to meet the State MFS requirement?

- If a State fails to maintain the required level of financial support for special education and related services, under 34 CFR 300.163(b), the Secretary of Education reduces the allocation of funds under section 611 of the IDEA for any fiscal year following the fiscal year in which the State fails to comply with the requirement of 34 CFR 300.163(a) by the same amount by which the State fails to meet the requirement.

--OSEP Memorandum 10-5: Dec 2, 2009

What does KDE need from the State agencies represented in SIAC?

KDE is requesting that State agencies which provide or make services available to meet the IEP needs of children and youth with disabilities do the following:

1. Provide the name of an agency contact for this work
2. On an annual basis, review services or funds made available by the agency that may be used to provide special education or related services to children with disabilities.
3. Determine the monetary value or dollar amount of the funds or services made available whether used for that purpose or not.
4. Provide this dollar amount to the KDE annually by April 1.

Questions about State MFS

1. Should this amount include funds and services made available from non-State funds?
2. If State funds for these types of services are used as matching funds for other Federal Grants will this impact the ability of the agency to use the funds for that purpose?
3. What if the agency cannot determine an exact amount for funds and services made available?
4. If funds or services are made available for this purpose but are not used, are they included in the amount reported to KDE?
5. Other questions?

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KENTUCKY

Cabinet for Health and Family Services
Department for Medicaid Services

Kentucky Medicaid

Medical Necessity and Appeals

State Interagency Council for Services To Children with Emotional Disabilities

July 27, 2016

Veronica Judy Cecil, JD
Deputy Commissioner

Medicaid at a Glance

KENTUCKY
Cabinet for Health and Family Services

- 1.3 Million Members
- $10 Billion Budget
- Managed Care Delivery System except for 1915(c) Waivers and Long Term Care

BEHAVIORAL HEALTH SERVICES

Rehabilitation Services

KENTUCKY
Cabinet for Health and Family Services

Screening
Assessment
Psychological Testing
Crisis Intervention
Mobile Crisis
Residential Crisis Stabilization
Day Treatment (Kids only)
Peer Support
Parent/Family Peer Support
Intensive Outpatient Program
Individual Outpatient Therapy
Group Outpatient Therapy
Family Outpatient Therapy

Collateral Outpatient Therapy (Kids only)
Partial Hospitalization
Service Planning (MH only)
Residential Services for Substance Use Disorders
Screening, Brief Intervention and Referral to Treatment (SU only)
Assertive Community Treatment (MH only)
Comprehensive Community Support Services (MH only)
Therapeutic Rehabilitation Program (MH only)

EPSDT Benefit applies when a service is medically necessary and not covered or is limited by the Medicaid State Plan.

BEHAVIORAL HEALTH PROVIDER TYPES

Provider Network Expansion

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Cabinet for Health and Family Services

Behavioral Health Services

Prior to January 1, 2014	After January 1, 2014
Community Mental Health Center (CMHC)	CMHC Licensed Practitioner Licensed Organization Provider Group

Behavioral Health Providers

KENTUCKY
Cabinet for Health and Family Services

New individual and group provider types specific to Medicaid covered Behavioral Health Services include:

Individual Provider Types

- Licensed Clinical Social Worker (LCSW)
- Licensed Psychologist (LP)
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Psychological Practitioner (LPP)
  - Certified Psychologists with Autonomous Functioning
- Licensed Professional Art Therapist
- Licensed Behavior Analyst
- Licensed Clinical Alcohol and Drug Counselor (LCADC)**

**Enrollment to begin August 1, 2016 but limited to certain licensed organizations until CMS and regulation approval for independent practice

Behavioral Health Providers

KENTUCKY
Cabinet for Health and Family Services

Providers who can perform services under supervision of a Medicaid-enrolled licensed practitioner:

- Licensed Professional Counselor Associate
- Marriage and Family Therapist Associate
- Certified Social Worker – Master's Level
- Licensed Psychological Associate
- Licensed Professional Art Therapist Associate
- Licensed Assistant Behavioral Analyst
- Licensed Clinical Alcohol and Drug Counselor Associate**

**Limited to certain licensed organizations until CMS and regulation approval for LCADC independent practice

Behavioral Health Providers

KENTUCKY
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Non-licensed professionals, including:

- Targeted Case Managers
  - Individual, provider group and licensed organization
- Community Support Associates
  - Licensed organization
- Peer Support Specialists
  - Provider group and licensed organization
- Certified Alcohol and Drug Counselors
  - Licensed organization

Behavioral Health Providers

KENTUCKY
Cabinet for Health and Family Services

Group Provider Types

- Behavioral Health Multi-Specialty Group (MSG)

Licensed Organizations

- Behavioral Health Services Organization (BHSO)
- Residential Crisis Stabilization Unit
- Outpatient Services
  - Psychiatric Residential Treatment Center
  - Psychiatric Hospital
  - Chemical Dependency Treatment Center*

* Enrollment to begin August 1st

Medical Necessity

What is Medical Necessity?

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Cabinet for Health and Family Services

Defined in Managed Care Organization (MCO) contracts as:

- covered services which are medically necessary as defined under 907 KAR 3:130;
- meet national standards, if applicable; and
- provided in accordance with 42 CFR § 440.230, including children's services pursuant to 42 U.S.C. 1396d(r).

Court ordered services are not covered.

MCO Medical Necessity

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MCO may choose either Interqual or Milliman

Must use ASAM (American Society of Addiction Medicine) for substance abuse

For behavioral health, if Interqual or Milliman doesn't apply the following are to be used:

- LOCUS for adults
- CASII or CANS for children
- ECSII for young children

Medical Necessity

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Cabinet for Health and Family Services

Role of the Provider

- The provider who orders the service must **document** completely in order to demonstrate medical necessity.
- Provider is responsible for submitting prior authorization requests, if applicable.
- The member and provider may request an appeal with the MCO if a service is denied in whole or in part.

Appeals

Current MCO Member Appeal Process

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- Member is denied a service in whole or in part.
- Member has 30 days to file an appeal with the MCO's internal appeal process as required by federal and state law and regulation.
  - 907 KAR 17:010 Section 4
- MCO either upholds or overturns decision within 30 days.
- Member has 45 days to request a State Fair Hearing by sending a letter to the Department for Medicaid Services.
  - 907 KAR 17:010 Section 5

907 KAR 17:010

Current MCO Provider Appeal Process

KENTUCKY
Cabinet for Health and Family Services

- Provider renders a service and submits a clean claim for payment to the MCO.
- Provider claim is adjudicated and is either paid or denied in whole or in part.
- Provider files an appeal with the MCO's internal appeal process as required by federal and state law and regulation.
- MCO either upholds or overturns decision.
- Provider contract may have a provision for arbitration or mediation.
- Upon exhaustion of internal appeal, Provider may appeal to circuit court as a contract dispute.*

*Senate Bill 20 changed appeal process to permit external independent review

QUESTIONS

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aetna®

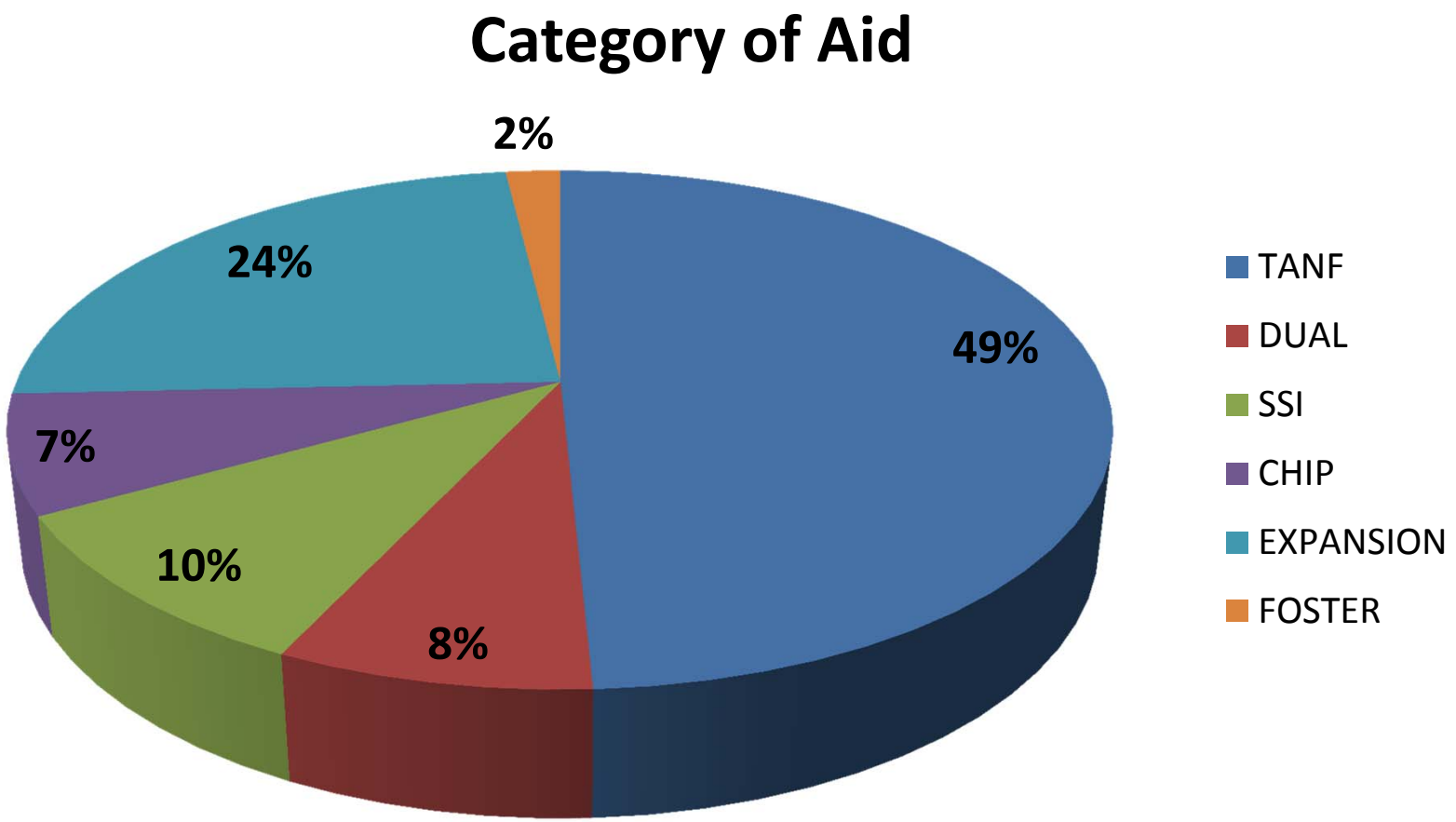
AETNA BETTER HEALTH® OF KENTUCKY

State Interagency Council (SIAC)

July 27, 2016

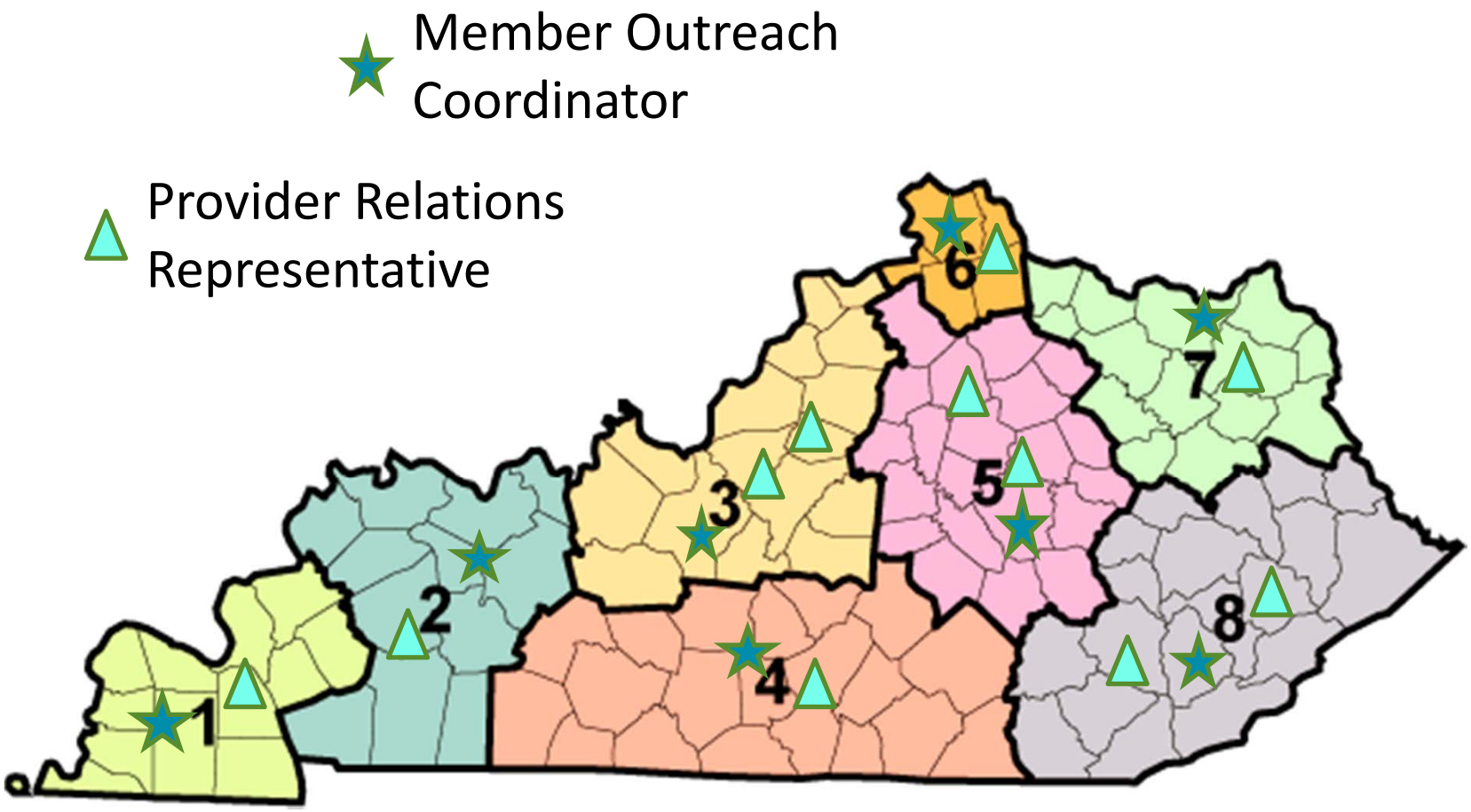
Kimberlee Richardson, LPCC
Director, Behavioral Health

Over 276,000 members



*276,806 members as of June 2016.
Membership varies monthly.

Provider Relations and Member Outreach



Community Outreach

- System of Care Academy
- KY School of Alcohol & Other Drug Studies
- LIAC, RIAC, & SIAC participation
- AOC & DJJ Diversion
- Anti-Bullying Curriculum
- Diabetes Nutrition Classes
- Chronic Disease Self-Management Program
- Homeless Population Outreach
- Education and support for Pregnant Women, New Moms and their children

Quality Initiatives

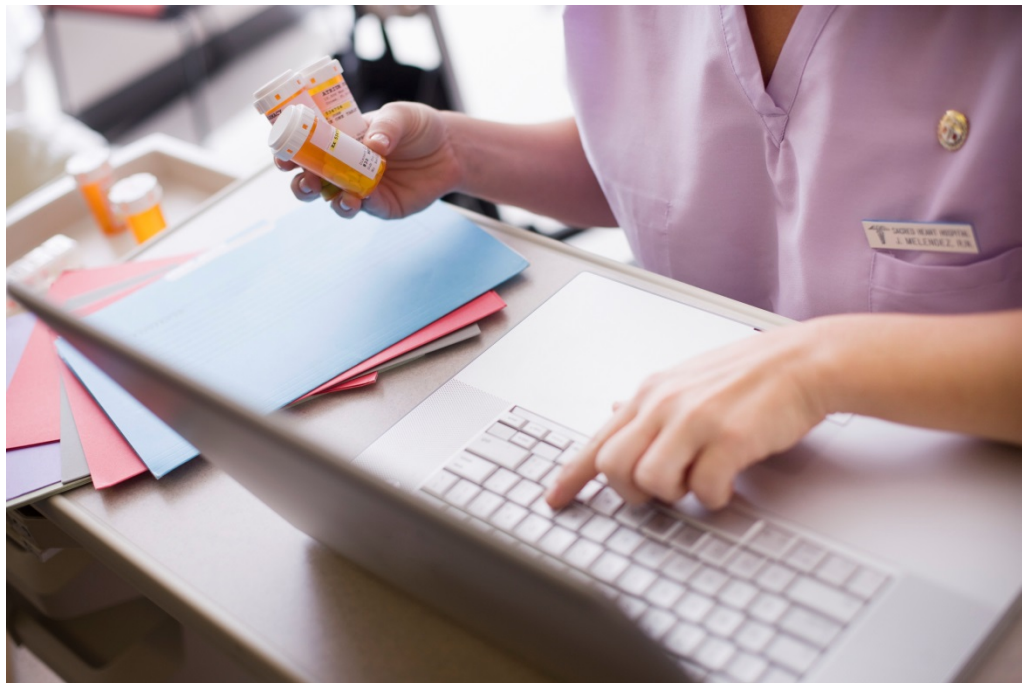
Performance Improvement Projects

Antipsychotic Medication Utilization in Children

Attention Deficit Hyperactivity Disorder

Comprehensive Diabetes Care

Major Depression



Focus Study Activities

Dental Initiative

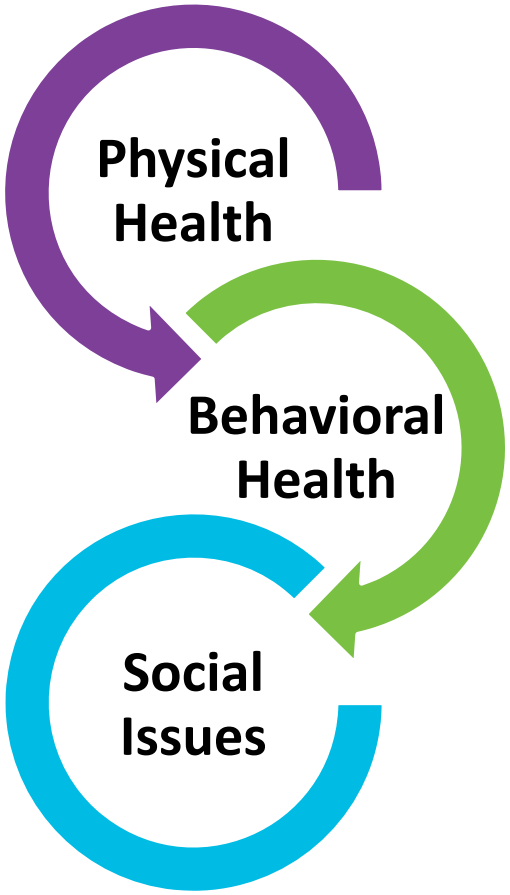
Physical, Behavioral and Social Integration

Fully integrated care encompassing physical health, behavioral health and social economic status of members

Strong provider partnerships and alliances with community based organizations

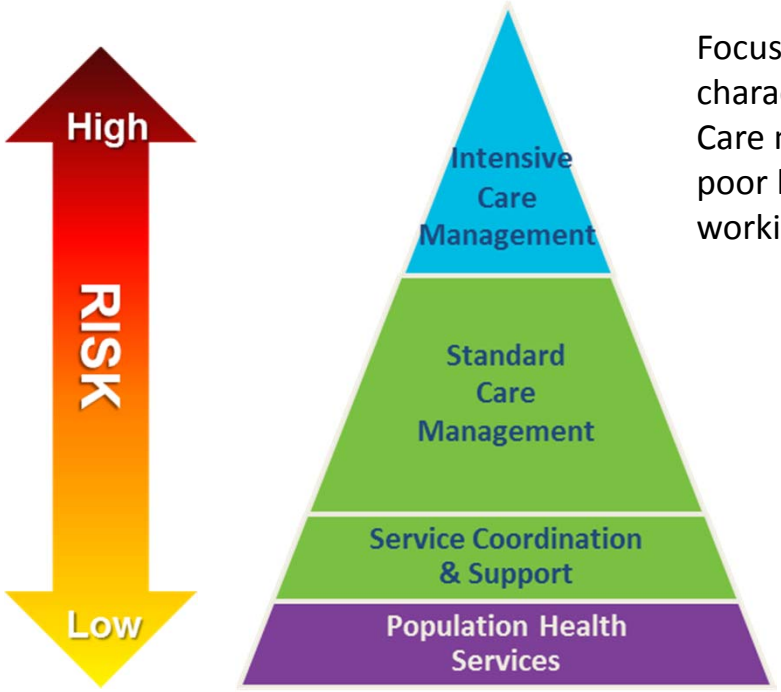
Interdisciplinary care teams that include the member and family

Leveraging technology to ensure care team has a view of the whole person



Integrated Case Management

Member centered approach & focus on community relationships integrating physical health, behavioral health and social economic status of members



Focuses on high-risk, vulnerable members characterized by bio-psycho-social complexity. Care managers address the root causes that drive poor health, within the context of a longer term working relationship with the member.

Focuses on members with a lower complexity profile with less risk for future utilization but with an immediate presenting issue

Low risk populations

Prior Authorization Process

Many Behavioral Health services DO NOT require authorization when provided by in-network practitioners

- **Screening/Assessment**
- **Individual/Group/Family Therapy**
- **Peer Support**
- **Targeted Case Management**

For services that DO require authorization:

https://www.aetnabetterhealth.com/kentucky/providers/

Questions?

Anthem BlueCross BlueShield

Medicaid

Presentation to the:

State Inter-Agency Council (SIAC)

July 27, 2016

Agenda

- Overview
- Medicaid Membership
- Provider Network
- Community Outreach
- Value Added Benefits
- Early and Periodic Screening, Diagnostic & Treatment
- Care Coordination
- BH Authorization Process
- Case Management/Disease Management
- Care on Call 24 Hour Nurse Line
- Emergency Room Utilization
- Quality Outcomes
- Performance Improvement Projects
- Appeals and Grievances
- Key Contact Information

Overview

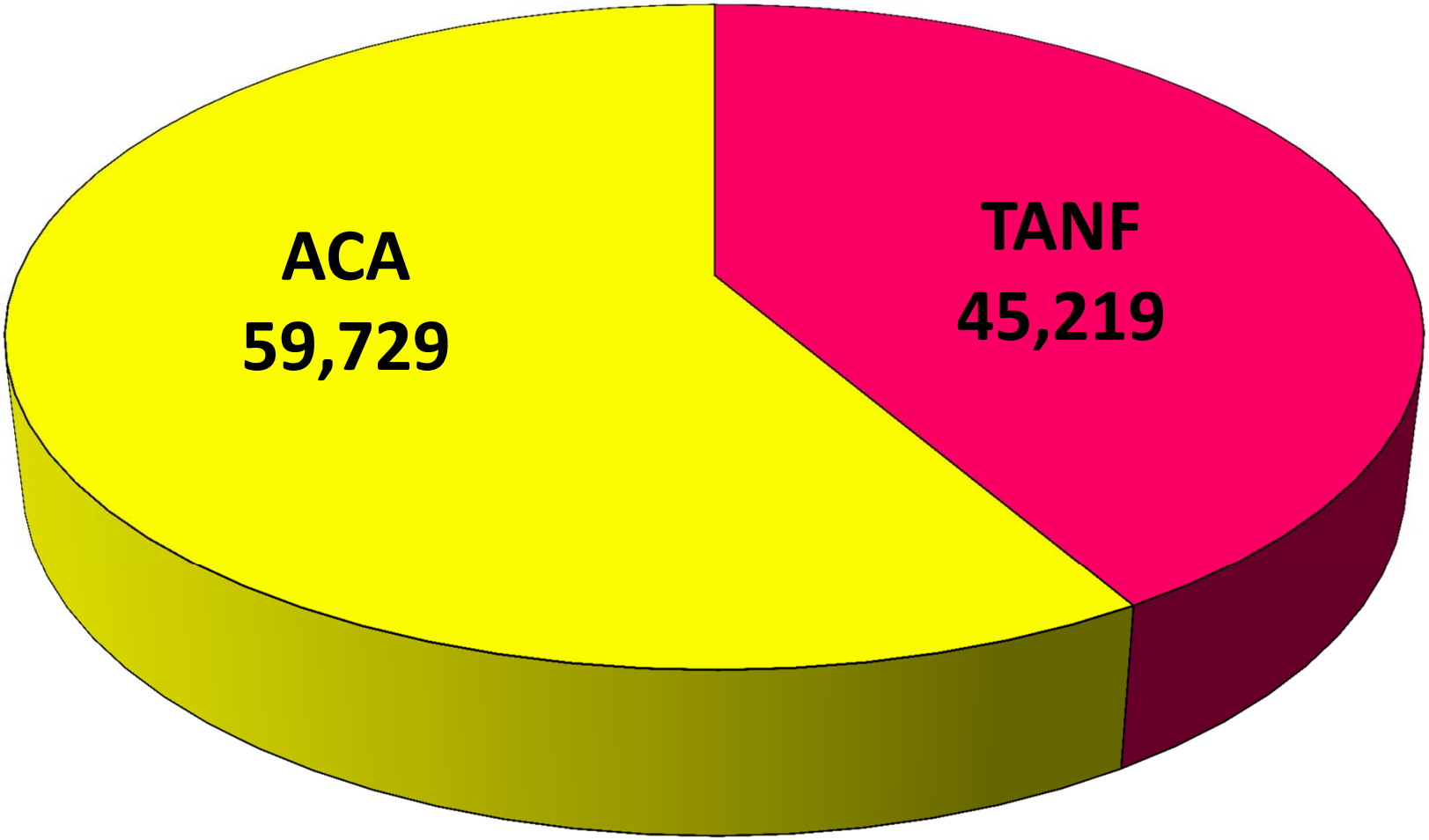
Anthem BlueCross BlueShield Medicaid

ABOUT US

- **Anthem Blue Cross and Blue Shield serves more than 100,000 Medicaid beneficiaries in Kentucky.**
- **We began serving Kentucky's Medicaid program in 2014, but Anthem has provided health insurance benefits and services in the commonwealth for over 75 years.**
- **Every day, members of the Anthem team can be found in Kentucky communities listening to members, interacting with providers and partnering with community-based organizations.**

Anthem BlueCross BlueShield Medicaid

Medicaid Membership



- **104,948 members as of July 11, 2016**

Anthem BlueCross BlueShield Medicaid

Provider Network

- The Medicaid provider network was established based on the Anthem commercial network We have a very comprehensive, statewide network that includes over 20,000 providers:

Hospitals - 106

Specialist – 14,162

Dental - 579

Pharmacy – 1,226

PCP – 3,624

Behavioral Health – 2,268

Vision - 784

- Easy To Do Business With…
  - ✓ Our call center receives over 10,000 calls per month from Kentucky providers.
  - ✓ 400 claims per month are reprocessed *while the provider is on the phone.*
  - ✓ Our provider website received 8,831 visits in April 2016 and has over 1,000 active Kentucky users.
    - o Activities include checking eligibility, reviewing claim status, and submitting claims.
    - o All web services also available on mobile devices!

Anthem BlueCross BlueShield Medicaid

Provider Relations Regions

Anthem BlueCross BlueShield

Medicaid

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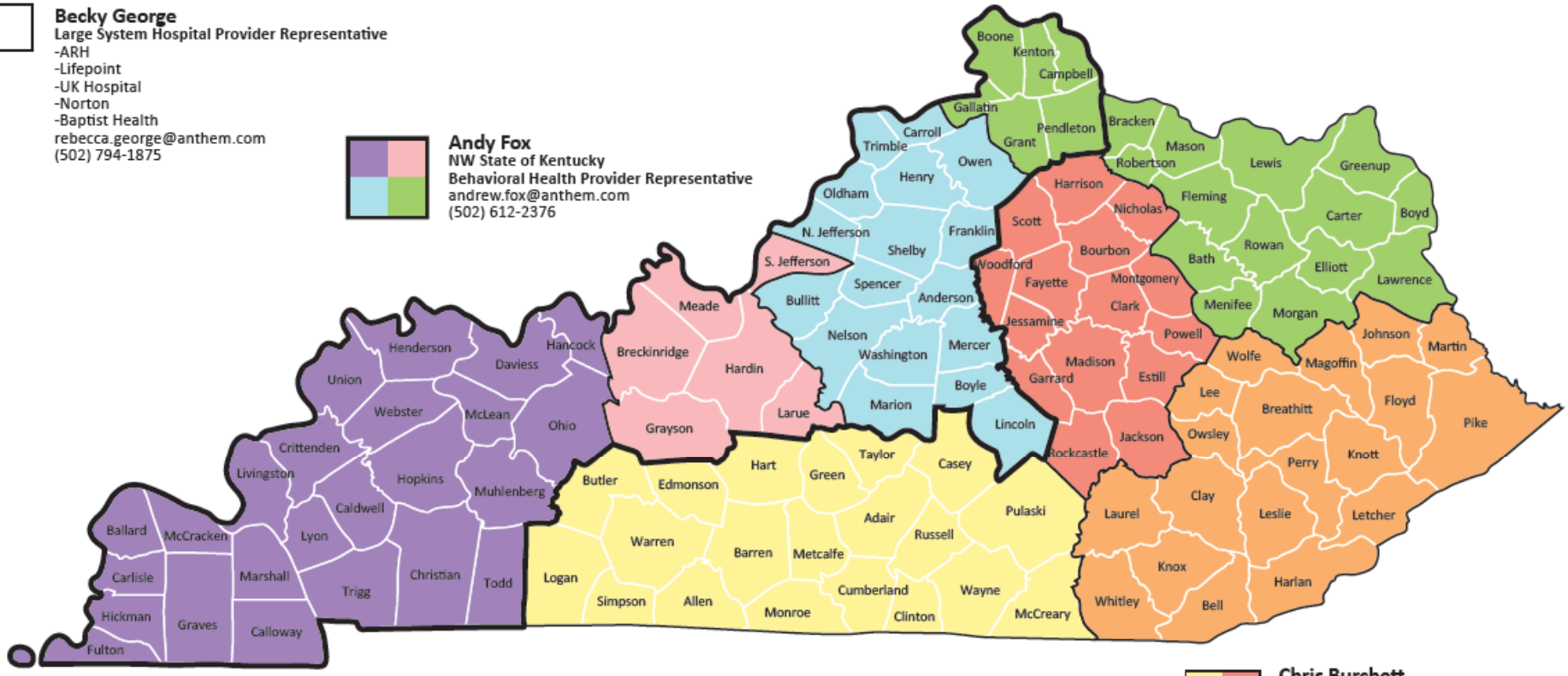

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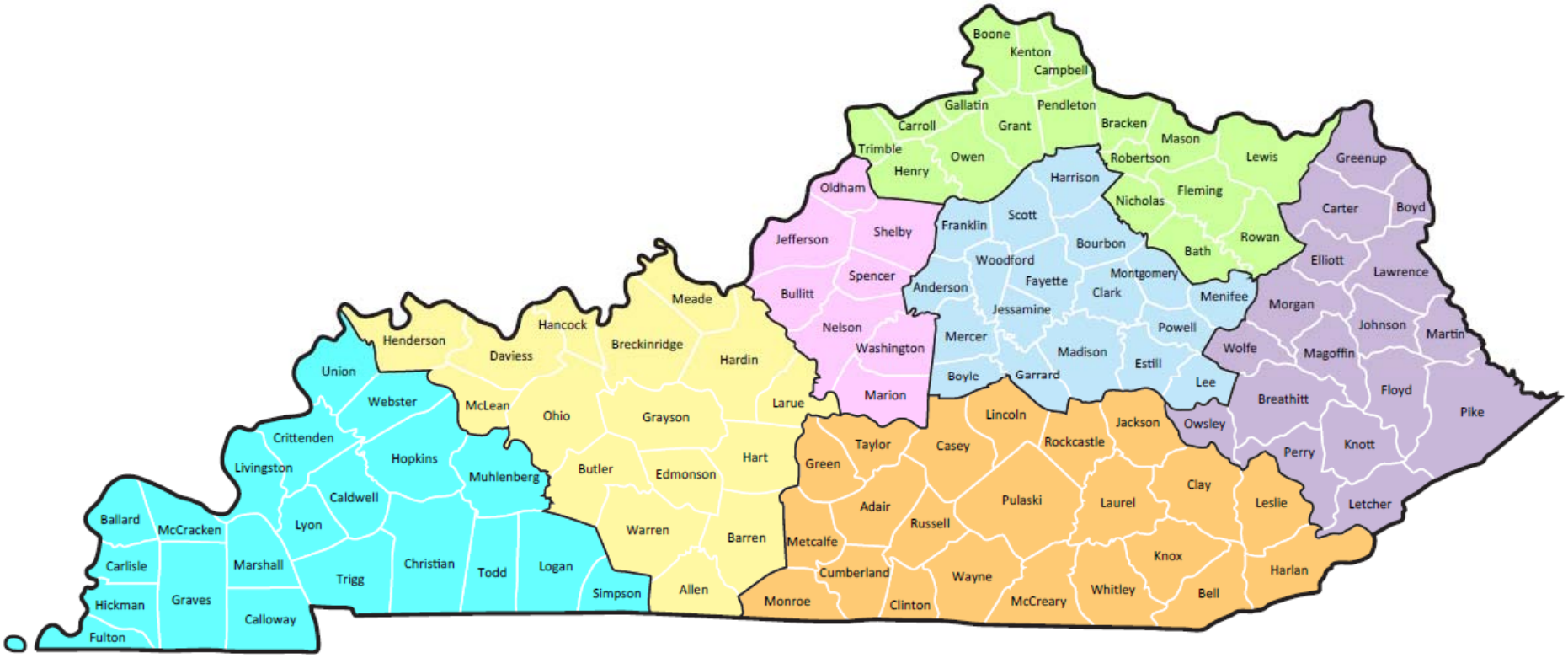
Marketing Outreach Territories

Anthem BlueCross BlueShield Medicaid



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Revised June, 2016 | J. Barnett

Value Added Benefits for our Members & Community Partnerships

Community Partnerships

- Memberships to 17 Boys & Girls Clubs
- Neighborhood House in Portland
- YMCA
- Homeless Coalitions
- March of Dimes
- Anti-Bullying Materials

Value Added Benefits

- Sports Physicals
- Crib & Car Seats
- SafeLink Phones
- Hearing Aid Batteries

Early and Periodic Screening, Diagnostic & Treatment (EPSDT)

- EPSDT Resources:
  - Tool Kit
    https://mediproviders.anthem.com/Documents/KYKY_CAID_EPSDTToolkit.pdf
  - Administration of EPSDT Screenings and Special Services

https://mediproviders.anthem.com/Documents/KYKY_CAID_ProviderAdminofEPSDTScreenings.pdf

  - CMS Guide to EPSDT Coverage

https://mediproviders.anthem.com/Documents/KYKY_CAID_CMSGuideEPSDTCoverage.pdf

Anthem BlueCross BlueShield Medicaid

Care Coordination

- **Care Coordination** offers assistance to members who need help in setting up medical appointments, finding specific providers, transportation and identifying community resources for food, housing, utilities, and other areas of need for a short period of time.
- **Physical Health/Behavioral Health** integrative services that includes collaboration with utilization management, social services, 24-hour nurse line, and providers directly involved with the member.
- **Dedicated** 24-hour behavioral health crisis line.
- **Case Management** works with members who may have a serious or complicated health needs. The Case Manager completes an assessment and develops a unique care plan with the member and their provider to coordinate their physical health, behavioral health and psychosocial needs.
- **Credentials** of the staff include: Case Management (CCM) and Integrated Case Management Certification (ICGM).

Behavioral Health Authorization Process

Behavioral Health Program Goals

- ✓ Right care, right place, right time services
- ✓ Reduce inappropriate admissions and readmissions
- ✓ Provide integrated, seamless delivery of physical and behavioral health services
- ✓ Disease management of chronic conditions often involving physical health, behavioral health and substance use disorder comorbidities
- ✓ National Committee for Quality Assurance (NCQA) Accreditation
- ✓ Healthcare Effectiveness Data and Information Set (HEDIS)* and other quality measure attainment

Behavioral Health Authorization Process

Clinical Review:

- Clinical intake team performs initial reviews for acute care via live calls or form review:
  - Provides opportunity to discuss/review more appropriate level of care when criteria for inpatient are not met
  - Begins discussion of treatment and discharge planning, coordination of care needs, and readmission issues

Anthem BlueCross BlueShield Medicaid

Behavioral Health Authorization Process

- Concurrent reviewers or outpatient care managers review subsequent care or outpatient services:
  - How reasons for admission are being addressed
  - If readmission, what is being done differently
  - Progress in treatment per treatment guidelines
  - Discharge planning and barriers to discharge
  - Discharge follow-up appointment within 7 days
  - Coordination of care issues/needs
  - Family/support system and outpatient provider involvement in treatment

Anthem BlueCross BlueShield Medicaid

Does the Service Require Authorization?

- A number of services always require authorization, including inpatient, residential, partial hospital, intensive outpatient, psych and neuropsychological testing. If you are not sure, you can use the Precertification Lookup Tool to determine authorization requirements: https://mediproviders.anthem.com/ky/pages/precert.aspx

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Does the Service Require Authorization?

Anthem BlueCross BlueShield Medicaid

Kentucky Providers

Login | Register

- Home
- Claims
- Precertification
- Medical
- Pharmacy
- Provider Education
- Find a Doctor
- Other Services

Precertification

Nonparticipating providers

All services you render require precertification.

Fax: 1-800-964-3627
Call: 1-800-901-0020

Participating Providers

Precertification Lookup Tool

This tool is for outpatient services only.

Inpatient services always require precertification.

Please note: Does not show benefits coverage — refer to our state-specific provider manuals for coverage/limitations

Forms and Other Resources

- Precertification Form
- Coverage Guidelines
- 2014 CPT Radiology Codes Requiring Review

Market: Select Market
Line of Business: Select Line Of Business
CPT/HCPCS Code or Code Description:
Submit

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Anthem BlueCross BlueShield Medicaid

How to Request an Authorization

- Contact the Utilization Management Department, 24 hours a day, 7 days a week for authorization: 1-855-661-2028
- Complete required forms and submit
  - By fax:
    - Inpatient and RTC: 1-877-434-7578
    - Outpatient: 1-800-505-1193
  - By web portal: http://www.availity.com/register-now-for-web-portal-access/

Anthem BlueCross BlueShield Medicaid

Authorization Request Forms

- Behavioral Health Initial Review Form
- Concurrent Review Form
- Discharge Note Form
- Behavioral Health Outpatient Request Form
- Psychiatric Testing Form
- Coordination of Care Form

PF-AKY-0052-14_BH Initial Review_FINAL.p

Concurrent Review Form_KY.pdf

Discharge Note Form_KY.pdf

KYKY_CAID_OTRForm .pdf

Acrobat Document

PF-AKY-0029-14 Coordination of Care F

Anthem BlueCross BlueShield Medicaid

Case Management

Programs for specific diagnosis and at risk groups:

- Neonatal Intensive Care
- High Risk Obstetrics

Tailored Programs

- Complex Case Management
- Foster Care and Guardianship

Member Satisfaction Rate with Case Management

Anthem's performance goal of 95% "Very Satisfied/Satisfied" was met for all measures of member satisfaction with the case management program. Overall satisfaction with the program achieved a combined satisfaction score of 97% or Very Satisfied/Satisfied.

Anthem. BlueCross BlueShield
Medicaid

Disease Management

- In 2015, Disease Management enrolled 29,245 members into several different programs. These programs included asthma, hypertension, chronic kidney disease, chronic obstructive pulmonary disease, coronary artery disease, diabetes and heart failure management.

- Among members enrolled in 2015, 40.4% were enrolled in the Hypertension program, 22.2% in the Diabetes program and 13.9% were enrolled in the Asthma disease management program.

- Member satisfaction with the disease management program overall was rated 4.9 on a scale from 1-5 and a 4.3 on information obtained that will help them discuss health issues with their personal doctor.

Care On Call 24-Hour Nurse Line

Our members can call our Nurse Line to get help or information 24/7

- Triage members' medical concerns to the most appropriate level of care, whether it be the ER, an Urgent Care, the doctor's office or self care at home
- Assist the member to locate urgent care
- Assist a member to find a PCP or specialist in their location
- Answer general health related questions

Emergency Room Utilization

- Member education on appropriate Emergency Room (ER) usage
- 24-hour Nurse Line contributes to redirecting members to alternate care, such as urgent care clinics
- ER visits/1000 have decreased

Year Visits (per thousand)	1Q	2Q	3Q	4Q
2015	916	940	941	937
2014	1,018	1,100	1,085	1,019

Anthem BlueCross BlueShield Medicaid

Quality Outcomes

- Member satisfaction with Anthem during the first operational year utilizing the **CAHPS® 2015 5.0 Adult** survey results showed Anthem receiving the highest score of all 5 MCOs on **Getting Care Quickly** and **Adult Doctor Availability**.

- During the first operational year quality review utilizing HEDIS ® measurements, Anthem received the highest rating of all 5 MCOs in multiple measures including **Comprehensive Diabetes Care** retinal eye exams and HbA1c testing; **Controlling High Blood Pressure; Antidepressant Medication Management.**

Anthem BlueCross BlueShield Medicaid

Performance Improvement Projects

- Reducing Avoidable ER Visits While Increasing PCP Visits (2014-2017)
- Statewide PIP – Safe and Judicious Antipsychotic Medication Use in Children and Adolescents (2014-2017)
- Increasing Annual Dental Visits in EPSDT Population (2015-2018)
- Prevention of Physical Health Risks in the Seriously Mentally Ill Population (2015-2018)
- Centers for Medicare & Medicaid Services (CMS) Oral Health Initiative- *Performance Improvement Project (PIP) Learning Collaborative*
- Focus Study Activity:
  Follow-up After Hospitalization for Mental Illness

Anthem BlueCross BlueShield Medicaid

Appeals and Grievances

- Separate and distinct appeal processes are in place for Anthem members and providers, depending on the denied services or claims.

- Appeals and Grievance forms can be accessed from the website. (www.anthem.com.kymedicaiddoc)

- Claims/Payment appeals must be received within 90 days of remittance date. Appeals of medical necessity denials or administrative denials must be filed within 30 calendar days of the postmark date of Anthem Medicaid's denial notification.

- Appeals and Grievances can be mailed or faxed to the applicable fax number on the form.

- Effective 7/1/16, Senate Bill 20 allows providers to pursue an administrative appeals hearing after exhausting the health plan's written appeals process. These requests must be submitted in writing to the Division of Administrative Hearings of the Cabinet for Health and Family Services.

Anthem Medicaid Key Contact Information

Provider Services	1-855-661-2028
Provider Relations	502-619-6800 ext. 26771
Member Services	1-855-690-7784
Care on Call	1-866-864-2544
Precertification	1-855-661-2028
Pharmacy Pre-Authorization	1-800-770-2809

Paper Claim Submission	Kentucky Claims Anthem Blue Cross and Blue Shield Medicaid P.O. Box 61010 Virginia Beach, VA 23466-1010
Electronic Claim Submission	Professional Payer ID: 00660 Institutional Payer ID: 00160

Anthem BlueCross BlueShield Medicaid

Helping people achieve

Lifelong well-being

Humana CareSource SIAC Presentation

July 27, 2016

Humana

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EPSDT Benefit

- **Early Periodic Screening Diagnosis and Treatment (EPSDT) is a federally mandated program developed for Medicaid recipients through the age of 20**
- **The program is designed to ensure comprehensive preventive healthcare services and supports two goals:**
  - Access to necessary health resources
  - Assistance for parents and guardians in appropriate use of resources
- **It is the goal of Humana - CareSource that all children and adolescents younger than 21 receive regular EPSDT visits including, but not limited to:**
  - Comprehensive health and development history
  - Physical exam
  - Immunizations
  - Laboratory screenings (including lead toxicity)
  - Dental, Hearing, Vision
  - Health education (anticipatory guidance including child development, healthy lifestyles, accident & disease prevention, at-risk and risk behaviors including mental health & substance use)

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EPSDT Benefit:
Special Services

Members may receive EPSDT Special Services regardless of whether or not service(s) are covered under the state Medicaid plan.

- These services may include:
  - Health-related care
  - Diagnostic services
  - Preventive services
  - Rehabilitative services, treatment, or other measures

EPSDT diagnostic or treatment services and EPSDT Special Services shall be covered subject to Prior Authorization requirements.
Services defined as medically necessary are those which correct or ameliorate a defect, physical or mental illness, or recipient condition.

Humana

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Provider Network Adequacy

The Humana - CareSource statewide Medicaid provider network has been developed based on Humana's mature and comprehensive commercial provider network. Our strong provider network is enhanced by all safety net providers in the Commonwealth along with Medicaid focused providers and services.

We are proud to have assisted 787 providers in obtaining Medicaid certifications.

Our statewide network includes over 20,000 dedicated providers including:

• Hospitals	124
• PCPs	3,784
• Specialists	13,047
• Dental Providers	796
• Behavioral Health Providers	1,846
• Vision Providers	623
• Pharmacy	966

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Provider Relationships

Humana – CareSource wants to make it simple for providers so that they can provide the best service for our members.

Provider Engagement Representatives:

- Perform provider orientations
- Provide provider education
- Attend Joint Operations Committee (JOC) meetings
- Attend various TAC and Association meetings
- Assist with all provider inquiries
- Assist with claims escalation issues
- Report Fraud, Waste and Abuse if identified
- Connect providers with Case Management when necessary

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Regional Representation

Humana - CareSource has team members located across the Commonwealth which include:

- 15 RN and 4 Social Work Care Managers
- 7 Community Education Representatives
- 4 Provider Engagement Specialists/Account Managers
- 6 Provider Engagement Representatives

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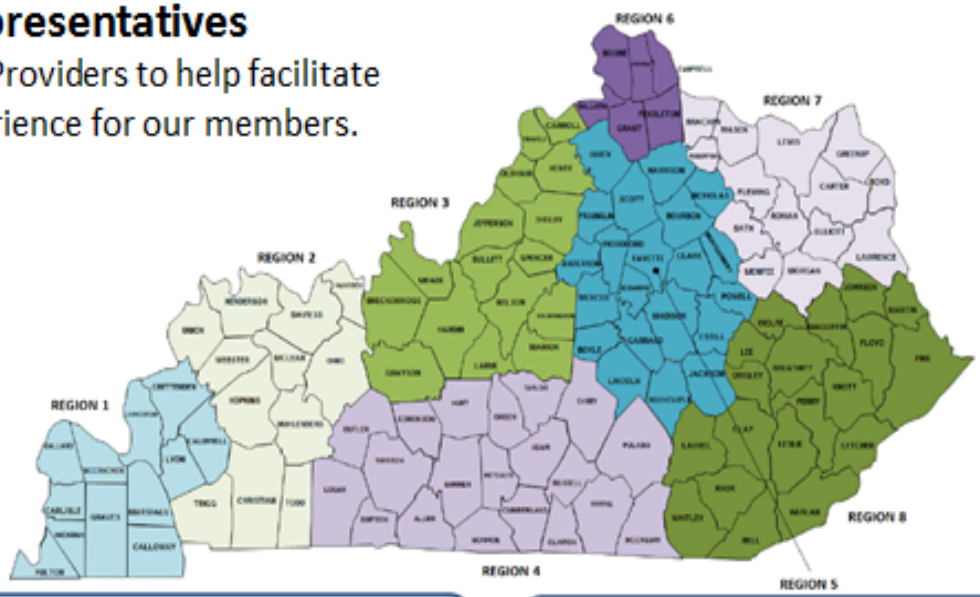
Regional Representation

Dedicated Provider Relations Representatives

Working to build strong partnerships with Providers to help facilitate a high quality of care and a respectful experience for our members.



1
Mark Leonard – 270-217-6673
Mark.Leonard@CareSource.com
Kelly Dockter Dean 502-494-9639
Mary.Dockterdean@CareSource.com

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Trista Daugherty – 606-341-4679
Trista.Daughterty@CareSource.com

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Prior Authorization Process

Physical Health Services

Prior Authorizations for health care services can be obtained by contacting the medical management department via the secure provider portal, email, fax, phone, or mail:

- Provider portal: https://providerportal.caresource.com/KY/User/Login.aspx?ReturnUrl=%2fky
- Email: kymedicalmanagement@caresource.com
- Fax: 1-888-246-7043
- Phone: 1-855-852-7005 and follow the prompts for PA requests
- Mail: Humana – CareSource
  Attn: Kentucky Medical Management
  P.O. Box 8738
  Dayton, OH 45401

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CareSource

Prior Authorization Process

Physical Health Services

When requesting an authorization, please provide the following information:

- Member/patient name and Humana – CareSource member ID number
- Provider name and NPI
- Anticipated date of service
- Diagnosis code and narrative
- Procedure, treatment, or service requested
- Number of visits requested, if applicable
- Reason for referring to an out-of-plan provider, if applicable
- Clinical information to support the medical necessity of the service

For additional information regarding the prior authorization process, please refer to the provider manual found here: https://www.caresource.com/providers/kentucky/medicaid/plan-resources/provider-manual/

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Prior Authorization Process

Behavioral Health Services

No authorization is required for traditional outpatient services – some examples:

- Medication management/Injection/Administration/Comprehensive Med Services
- Diagnostic Interview/Evaluation
- Mental Health/Substance Abuse assessment and screenings
- Screening, Brief Intervention and Referral to Treatment (SBIRT)
- Peer Support
- Individual, Family and Group Therapy
- Crisis Services (including Therapy, ER intervention, Mobile Crisis)
- Targeted Case Management
- Comprehensive Community Support

Authorization is required for the following outpatient Services:

- Therapeutic Rehabilitation Services – after initial 30 days
- Day Treatment – after initial 30 days
- Psych/Neuropsych Testing after initial 8 hours

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Prior Authorization Process

Behavioral Health Services

Telephonic Prior Authorization is required for the following:

- Inpatient Mental Health & Substance Abuse Services
- Extended Care Unit & other EPSDT Services
- PRTF
- Residential Crisis Stabilization
- Partial Hospitalization
- Intensive Outpatient
- Assertive Community Treatment

eServices Authorization is required within 30 days of initial date of services:

- Day Treatment
- Therapeutic Rehabilitation Services

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Services Offered

Care Management

- Includes proactive, holistic, and member-centric multidisciplinary management of the member, focusing on timely and collaborative coordination of care and services
- Targeted for members with complex medical and/or behavioral health care coordination needs stemming from a health care event or diagnosis that requires extensive care coordination
- Registered Nurses and Social Workers act as a team with members, caregivers, and providers to ensure the member receives appropriate medical and behavioral health care
- Care Managers assist members in locating providers and obtaining appointments, supplies, and equipment, as well as finding community based services such as food and housing resources, clothing, and transportation

Transitional Care Management

- Augments our Care Management program to ensure a smoother transition for members from the hospital or other facility setting to home
- Developed for that period of time when coming home from the hospital or other facility creates additional short term needs such as home health, outpatient therapies, equipment, supplies, and additional appointments

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Services Offered

Disease Management

- The central goal is to empower members and/or caregivers to effectively optimize health, manage disease signs and symptoms, and prevent complications through adherence to medication plans, regular monitoring of applicable labs/vital signs, knowledge of disease processes and the influence of comorbidities, preventive health opportunities (i.e. healthy diet, exercise and other lifestyle choices), and partnerships with providers. Additional program goals are to improve the health of the disease management populations, improve member experience, and reduce costs of care
- Consists of specialized nurse outreach, care plan, and/or educational mailings for members with asthma and diabetes

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Services Offered

CareSource Kentucky Maternal Child Health Program

- A population based program that provides interconception, prenatal, postpartum, well child, and family planning education and community resources to improve the physical and mental health, safety, and well-being of the mother and infant from the prenatal period through the baby's first year of life
- Nurses with appropriate experience outreach to members via telephone, at community events, and/or attend appointments with them or visit them at home based on the member's preference
- Rewards and incentives offered for attending appointments and obtaining infant care totaling $150

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Appeals Process

Timeframe:

- 365** days from the date of service or discharge to file a claim appeal
- 180** days from the date of service or discharge to file a retro authorization request or a clinical appeal (requires medical necessity determination)

** Unless otherwise specified in the provider contract

Humana

CareSource

Appeals Process

Grievances and claims appeals can be submitted through the provider portal, mail or fax. For grievances or appeals submitted in writing, please include: the member's name and Humana – CareSource member ID number; the provider's name and ID number; and the code(s) and reason for reconsideration of the determination.

- **Secure provider portal** https://providerportal.caresource.com/ky
- **Mai**l: Humana – CareSource
  Attn: Provider Appeals
  P.O. Box 823
  Dayton, OH 45401
- **Fax**: 1-855-262-9793

If submitting a timely filing appeal, include proof of original receipt of the claim by fax or Electronic Data Information (EDI) for reconsideration.

If the appeal is regarding a clinical edit denial, the appeal must have all the supporting documentation as to the justification of reversing the determination

**Appeals received by mail take approximately 10 days to appear in workflow.

**Provider's must submit member written consent to file an appeal on the members behalf. The consent must be specific to the service being appealed and is only applicable to that appeal.

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Questions

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Passport Health Plan
SIAC Requested Information

Prepared for:

SIAC Meeting

July 27, 2016

Administrative Office of the Courts

Requested Information

- EPSDT Benefit
- Regional Representation
- Prior Authorization Process
- Provider Relationships
- Network Adequacy
- Services Offered (care management, etc.)
- Appeal Process

EPSDT Services

- Members access EPSDT (extended care units) residential care upon transition from acute mental health services to further stabilize and address their needs;
- Additionally, members may access specialized residential programs for substance use disorder, sexual acting out treatment.

PASSPORT HEALTH PLAN

Regional Representation: Passport Membership 6/27/16

	Non-Expansion Membership	Expansion Membership	TOTAL
Region 0	60	7	67
Region 1	2,518	3,315	5,833
Region 2	4,845	5,059	9,904
Region 3	142,744	60,774	203,518
Region 4	7,655	9,256	16,911
Region 5	11,801	13,708	25,509
Region 6	4,095	4,578	8,673
Region 7	3,216	3,516	6,732
Region 8	7,301	8,797	16,098
Total	**184,235**	**109,010**	**293,245**

PASSPORT HEALTH PLAN

Prior Authorization Requirements

No authorization required for:

- Medication management
- Injection Administration
- Comprehensive Medication Services
- Diagnostic Interview / Evaluation
- Mental Health/Substance Abuse Assessments and Screenings
- Screening, Brief Intervention and Referral to Treatment (SBIRT)
- Peer Support
- Group Therapy
- Health & Behavioral Assessment, Group and Intervention
- Substance Abuse Prevention Services
- Service Planning
- Crisis Services (including Therapy, Emergency Intervention, and Mobile Crisis)
- Psychoanalysis
- Narcosynthesis for Psych Diagnosis
- Biofeedback
- Alcohol and/or Drug Services, brief intervention

PASSPORT HEALTH PLAN

Prior Authorization Requirements

For all other services, including individual and family therapy:

- Providers may see the member for 30 visits without prior authorization.
- Submission of electronic Outpatient Request Form (eORF) is required by 30th visit.
- eORF form can be downloaded at **https://provider.beaconhs.com,** under "Provider Tools" and can be faxed to 781-994-7633 or submitted directly through eServices.

PASSPORT HEALTH PLAN

Prior Authorization Requirements

PASSPORT HEALTH PLAN

INPATIENT AUTHORIZATIONS

Telephonic Prior Authorization is Required for the following:

- Inpatient Mental Health
- Extended Care Unit (EPSDT Residential)
- Psychiatric Residential Treatment Facility (Level I and II)
- Substance Abuse Detoxification (in IMD and/or psych unit)
- Inpatient SA Rehabilitation
- Residential Services for Substance Use Disorder
- EPSDT Residential for Specialized Children Services
- Crisis Stabilization Unit
- ECT

FOR AUTHORIZATIONS CALL: 855-834-5651

Prior Authorization Requirements

PASSPORT HEALTH PLAN

COMMUNITY SUPPORT SERVICES	
Telephonic Prior Authorization is Required for the following: • **Partial Hospitalization** • **Intensive Outpatient** • **Assertive Community Treatment** **FOR AUTHORIZATIONS CALL: 1-855-834-5651**	**eServices Authorization is required within 2 weeks of initial date of service:** • Day Treatment • Therapeutic Rehabilitation Program • Mental Health Service NOS • Alcohol / Drug Service NOS • Targeted Case Management – Adult • Community Support Svcs • Skills Development & Training

Provider Relationships

- To join our Network:
  - Go to www.passporthealthplan.com
  - Request a packet under the provider tab
- Contact our BH Provider Representatives:
  - PassportBehavioralHealth@passporthealthplan.com
  - Provider Services: 1-800-578-0755
  - BH Hotline: 1-855-834-5651

PASSPORT HEALTH PLAN

Network Adequacy:
Count of Behavioral Health Providers by Region

DMS Type	Description	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Out of State	TOTAL
03	Behavioral Health Service Organization	2	0	25	3	12	1	0	2	0	**45**
26	Residential Crisis Stabilization Unit	0	0	0	0	0	0	0	0	0	**0**
62	Licensed Professional Art Therapist	0	0	20	0	0	0	0	1	0	**21**
63	Applied Behavior Analyst	1	0	19	9	0	0	0	0	0	**29**
66	Behavioral Health Multi-Specialty Group	5	8	47	19	30	7	6	17	7	**146**
81	Licensed Professional Clinical Counselor	10	43	138	123	91	44	45	65	2	**561**
82	Licensed Clinical Social Worker	14	49	272	75	141	48	21	54	6	**680**
83	Licensed Marriage and Family Therapist	2	3	70	26	11	4	3	1	0	**120**
84	Licensed Psychological Practitioner	1	2	8	4	8	0	1	6	0	**30**
89	Licensed Psychologist	7	9	86	10	30	7	5	9	13	**176**
	DO	0	1	3	0	2	1	3	6	1	**17**
	MD	11	20	126	21	102	18	30	38	28	**394**
	APRN	3	40	50	7	20	24	21	53	5	**223**

PASSPORT HEALTH PLAN

Services Offered

- Passport offers a variety of outpatient, inpatient and diversionary levels of care to support each member
- Passport welcomes the opportunity to provide members with additional resources to identify a provider in the community to engage in services

Care Advisors

- Licensed/certified medical and behavioral health professionals
- Create a care plan with the member that targets the member's identified goals
- Assist with referrals/resources, and advocate for effective care
- Provide coordination of care and act as liaison to enhance communication among providers on behalf of members
- Guide members in increasing skills and knowledge as they move toward self-management

PASSPORT HEALTH PLAN

Care Coordination Programs

- Behavioral Health
- Foster Care
- Guardianship
- Embedded Case Management
- EPSDT
- Catastrophic Care
- Complex Care
- Condition Care
  - Maternity
  - Obesity (adults and children)
  - Asthma (children)
  - Chronic Obstructive Pulmonary Disorder
  - Diabetes (adults and children)
  - Coronary Artery Disease
  - Congestive Heart Failure

PASSPORT HEALTH PLAN

Behavioral Health Case Management

Case Coordination

Consultations are episodic case management interventions aimed at integrating medical and behavioral health care, and improving access to services. Members are typically identified by Medical Case Managers, PCPs or other community providers seeing behavioral health input and information regarding insurance based and community services. Consultations are generally opened and closed within 30 days. They may include member outreach contacts.

Case Coordination

Is a short term intervention for members with potential risk due to barriers in services, poor transitional care, and/or co-morbid medical issues that require brief targeted care management interventions.

PASSPORT HEALTH PLAN

Behavioral Health Case Management – Intensive Case Management (ICM)

Criteria include but are not limited to:

- Prior history of acute admissions with re-admission within 60 days
- High lethality
- Severe, persistent psychiatric symptoms, and lack of family, or social support which puts the member at risk of acute admission
- Co-morbid medical condition combined with psychiatric and/or substance abuse issues could result in exacerbation of fragile medical status
- Pregnant, or 90 days post partum and using substances, or requires acute behavioral health services
- Child living with significant family dysfunction and instability following discharge from inpatient which places the member at risk of requiring acute admission that requires assistance to link family, providers and state agencies

PASSPORT HEALTH PLAN

Foster Care and Guardianship Specialists

- Act as liaisons for members in the following categories:
  - Foster Care
  - DJJ
  - Adoption subsidy
  - State guardianship
  - Adults transitioning from Personal Care Homes and Psychiatric Hospitals

- Specialists provide coordination of care and participate in transition planning

PASSPORT HEALTH PLAN

Appeals Processes

- Providers may submit Passport appeals directly to Beacon.

- Appeal requests may be made by calling **1-855-834-5651**, or by mail to:

  Passport Health Plan Appeals
  Attn: Beacon Health Options
  500 Unicorn Park Drive, Suite 103
  Woburn, MA 01801

- Once providers have received a final determination from Beacon, they may request an external appeal or State Fair Hearing with the Commonwealth of KY.

PASSPORT HEALTH PLAN

Contact Information

- Elizabeth W. McKune, Ed.D., PCMH-CCE
- Director, Behavioral Health
- Liz.McKune@passporthealthplan.com
- (502) 585-7988

PASSPORT HEALTH PLAN

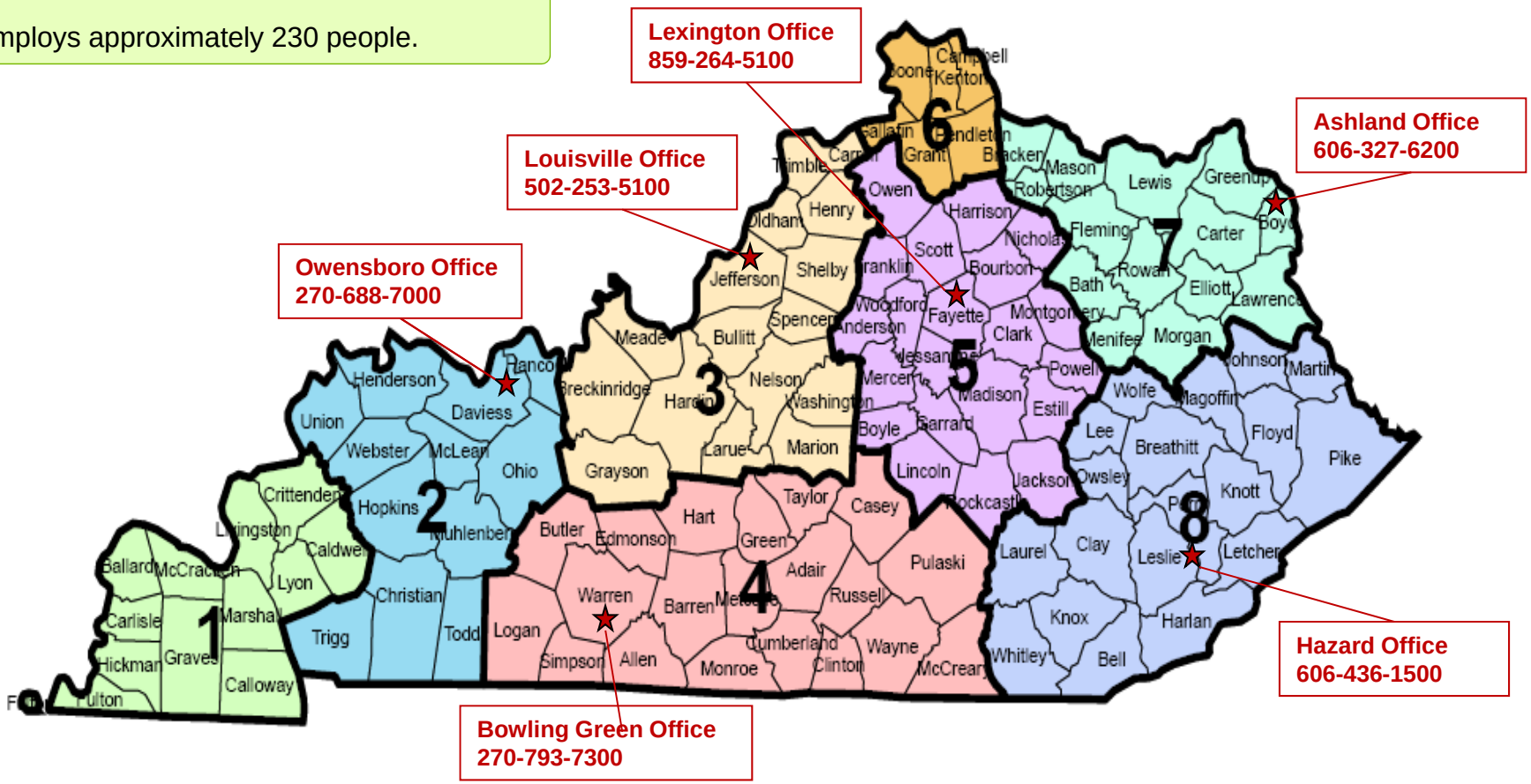
WellCare Health Plans, Inc.

SIAC

July 26, 2016

WellCare of Kentucky Offices

- Local presence with 6 locations.
- Employs approximately 230 people.



We have six offices staffed with Provider Relations Representatives, Community Advocates and Case/Disease Managers that live in those communities to provide services for members and providers.

Kentucky Presence

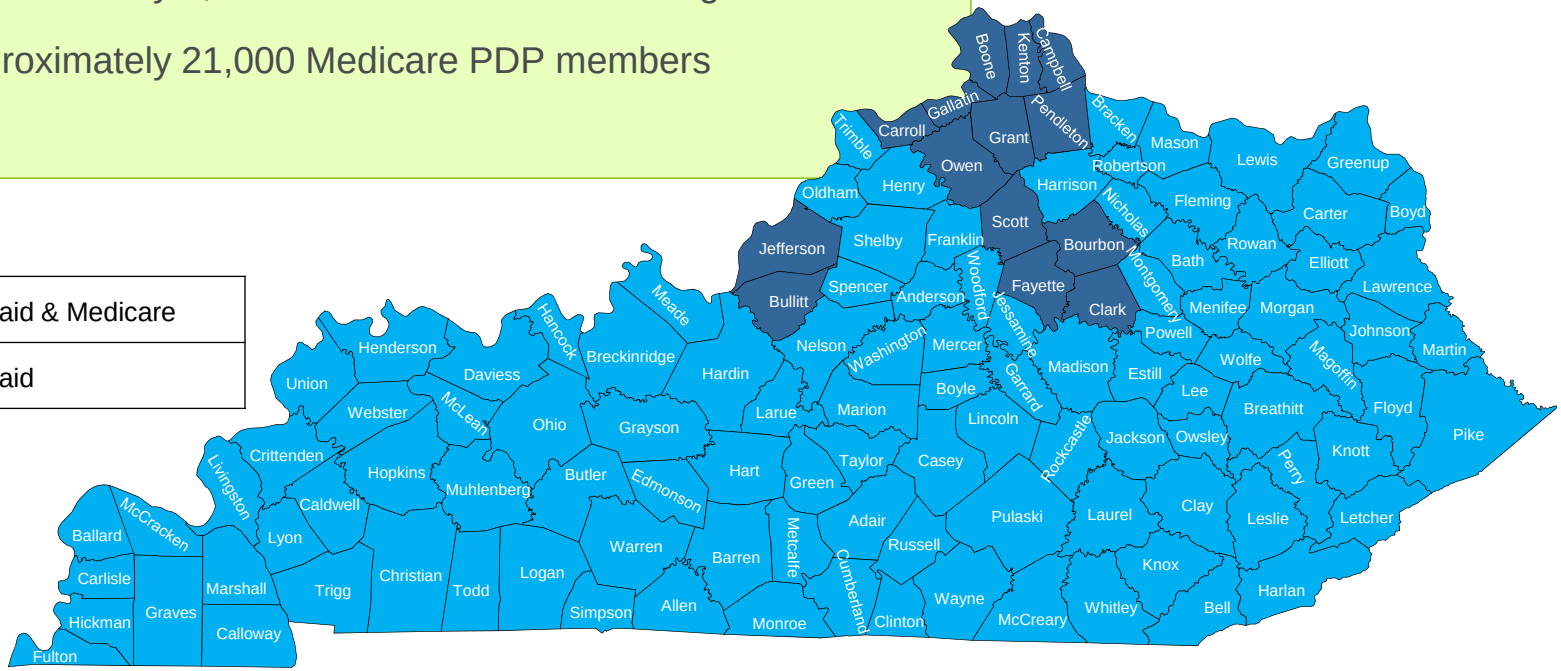
WellCare Health Plans

WellCare serves approximately 468,000 members across the state.

- Serves approximately 357,000 KMD members.
- Serves approximately 75,000 KAB - ABD members
- Serves approximately 7,000 KHK & Foster Care members.
- Serves approximately 8,000 KMR - Medicare Advantage members.
- Serves approximately 21,000 Medicare PDP members

HEALTH PLAN NCQA ACCREDITATION COMMENDABLE

	Medicaid & Medicare
	Medicaid



Essentials Of WellCare's Enhanced Care Model

WellCare's enhanced model of care:

- Uses trusted **evidence-based guidelines** to drive Clinical & Quality of Care interventions.
- Addresses our members' complex needs using a **high touch community-based** approach to **promote their optimal health and wellness**.
- We leverage community resources to act as a **bridge between the formal health care system and the members we serve**.

Kentucky Field Service Coordination -Behavioral Health

Kate Miller, Behavioral Health Program Manager

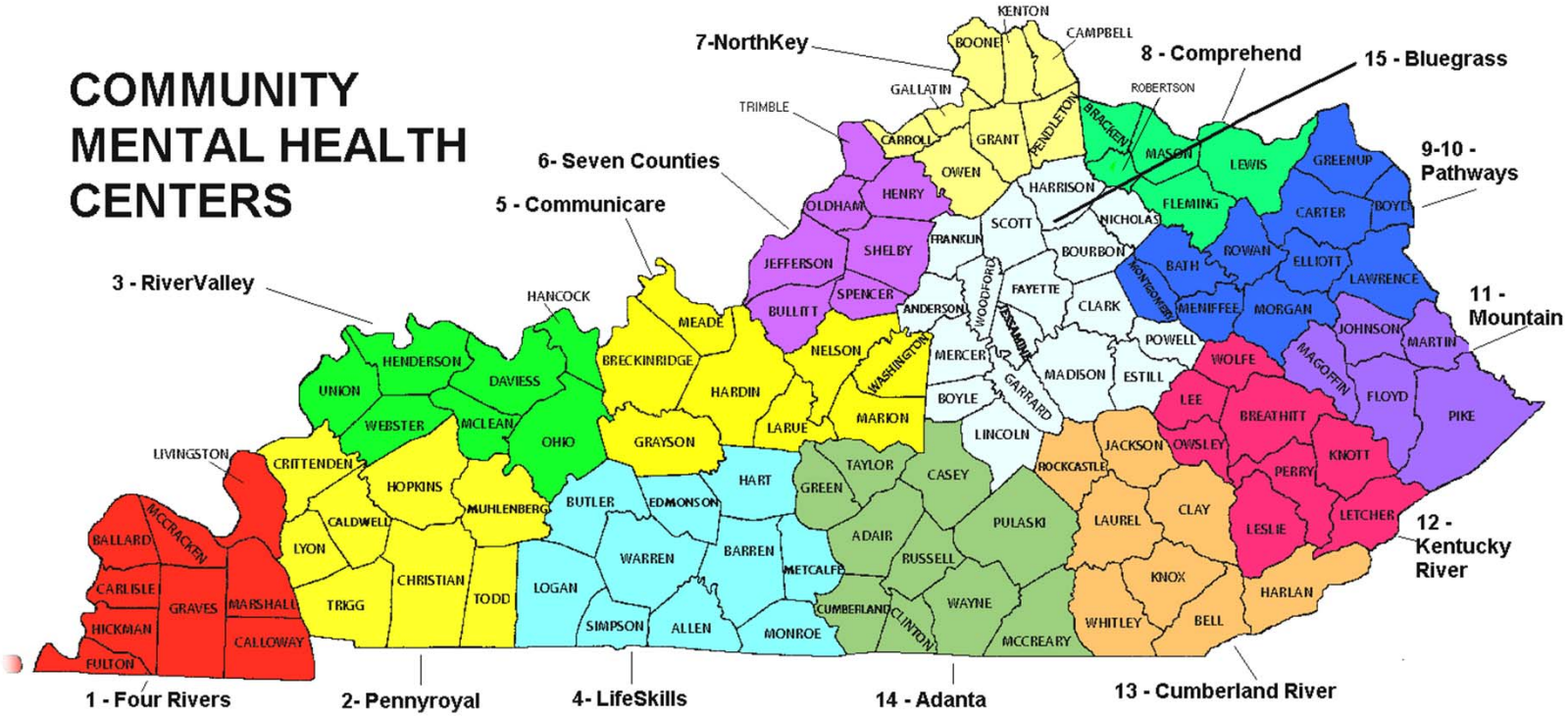
kathryn.miller@wellcare.com

Cell 502-548-5113

Leann Magre, Sr. Manager, Foster Care, Adoption & Guardianship

leann.magre@wellcare.com

Cell 502-640-1957

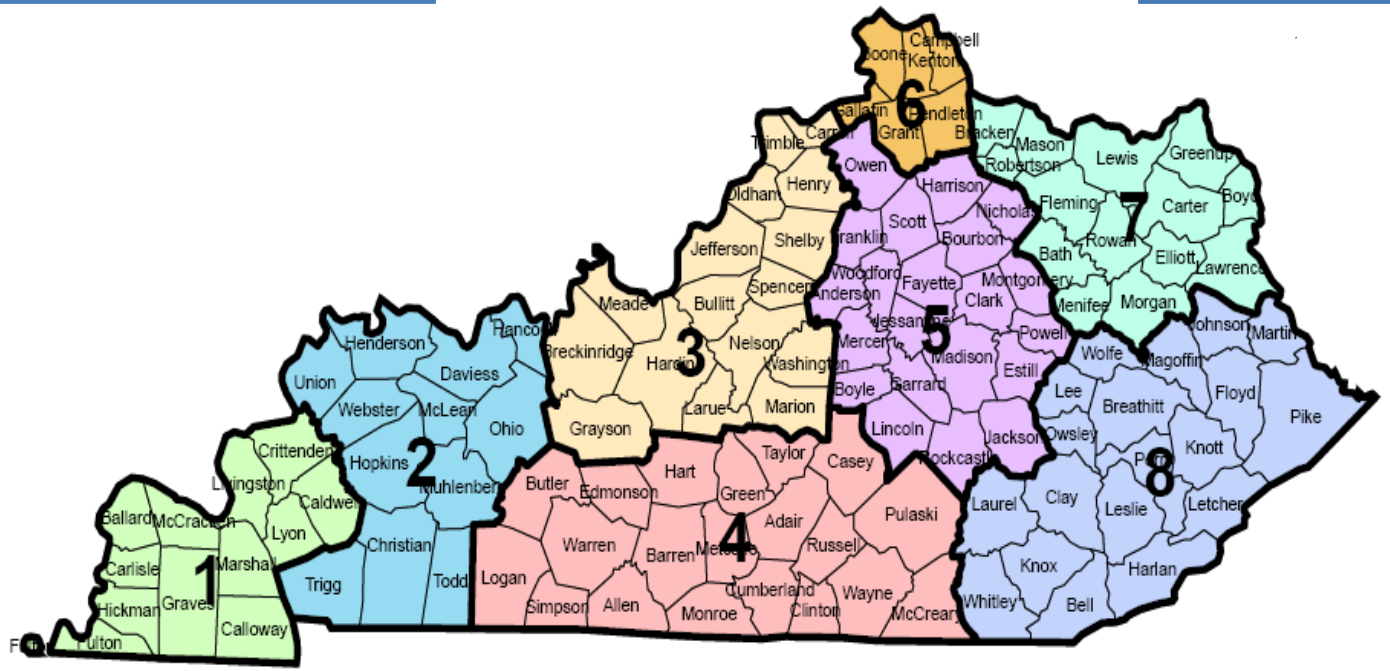


Kentucky Field Service Coordination List-Physical Health

WellCare Health Plans

Terri Flanigan
Vice President, Field Health Services
terri.flanigan@wellcare.com
Cell 216-255-7710

Shannon Jones
Sr. Director, Field Service Coordination
shannon.jones@wellcare.com
Cell 502-689-6776



Region 1, 2 and 4
Trudy Smyth, Sr. Manager
Cell 502-689-6713
trudy.smyth@wellcare.com
BG Office 270-793-7301
Owensboro Office 270-688-7000

Region 3 and 6
Donna Chapman, Manager
Cell 502-640-1981
donna.chapman@wellcare.com
Louisville Office 502-253-5100

Region 5 and 7
Paula Franklin, Manager
Cell 502-689-6405
paula.franklin@wellcare.com
Ashland Office 606-327-6200
Lexington Office 859-264-5100

Region 8
Leeann Caudill, Manager
Cell 502-689-6801
leeann.caudill@wellcare.com
Hazard Office 606-436-1500

WellCare Health Plans

WellCare Health Plans, Inc.
Health*Connections* Model
Program Summary
(Updated: March 2016)

Background

WellCare removes social barriers to accessing health care by connecting members to local, community-based public assistance programs and services called the "Social Safety Net."

Since 2009, the federal government has reduced funding for Social Safety Net services by half, while the need for services rose to a historic high. As a result, organizations comprising the Social Safety Net continue to face funding challenges, leading to additional program closure.

The goal of the Health*Connections* Model is to improve the health and vitality of our members and communities by sustaining the Social Safety Net and quantifying its impact on health outcomes.

Program Elements

The Health*Connections* Model is founded on community health principles coupled with managed care rigor. To achieve this goal, WellCare has identified four complementary program elements:

1. **CommUnity Activities**: Community-based health and wellness events.
2. **Health*Connections* Councils (HCC)**: Community planning councils focused on sustaining the Social Safety Net.
3. **CommUnity Health Investment Program**: Grants for program innovation.
4. **Social Service Utilization Support**: Facilitating member connections to social services and bridging gaps in service availability.

Conceptual Design

Methods

Using Community-Based Research Methods (CBRM) and Community Health Needs Assessment (CHNA) tools, WellCare introduced a CommUnity Advocacy function within its market operations to launch local community planning and mobilizing efforts designed to quantify and sustain the Social Safety Net.

Data Collection: *Qualitative*

WellCare completed in-depth interviews and focus groups to collect qualitative data using Healthy Environments Partnership tools promoted through the American Public Health Association and others. In addition, survey feedback is collected through individual CommUnity Health Investment Programs, and WellCare built continuous feedback mechanisms into the Health*Connections* Council management process.

Data Collection: *Quantitative*

WellCare captures referrals to social services as well as network gap information when a referral is attempted but a service is unavailable and then filled by mobilizing.

Measures

(Program Launch Nov. 2011 – March 2016)

CommUnity Activities

- **2,580** total activities reaching more than **1.8 million** stakeholders in **Kentucky**

Health*Connections* Councils

- Hosted **29** councils resulting in more than **29** pilots and representing more than **1,450** hours of community planning/investment.

CommUnity Health Investment Programs

- Invested more than **$488,500** into local social innovation projects.
- Designed and launched more than **124** pilots to leverage evidence-based or evidence-informed wellness/disease management programs.
- Tested **4** different models and strategies to evaluate the link between social services and health outcomes.

Social Service Utilization Support

- Referred **4,904** people to **12,181** community-based programs and services.
- Catalogued nearly **7,700** organizations in Kentucky.
- Bridged more than **200** gaps in the social service network.
- CommUnity Assistance Line (CAL):
  - Launched in 2015.
  - Connects members who are not in case management.
  - An average of more than **120** referrals per month.
  - Represents **15.5%** of total referrals.

External Evaluation

(Data Collected from CY2013 – CY2015)

WellCare engaged the Robert Wood Johnson Foundation's National Coordinating Center for Public Health Systems and Services Research (housed at the University of Kentucky) to evaluate Health*Connections*.

A study of nearly **8,400** participants (43% in Kentucky), showed reductions in:

- **Emergency Department Use** **17%**
- **Emergency Department Spending** **26%**
- **Inpatient Spending** **53%**
- **Outpatient Spending** **23%**
- **Professional Spending** **24%**

Participants were referred to an average of **three** social services for a total access rate of **18%.**

Total medical spending was reduced by **$450** per member, per year for each social service accessed.

Most frequently used social services:

- **Transportation** **15%**
- **Food Assistance** **14%**
- **Utility Assistance** **11%**

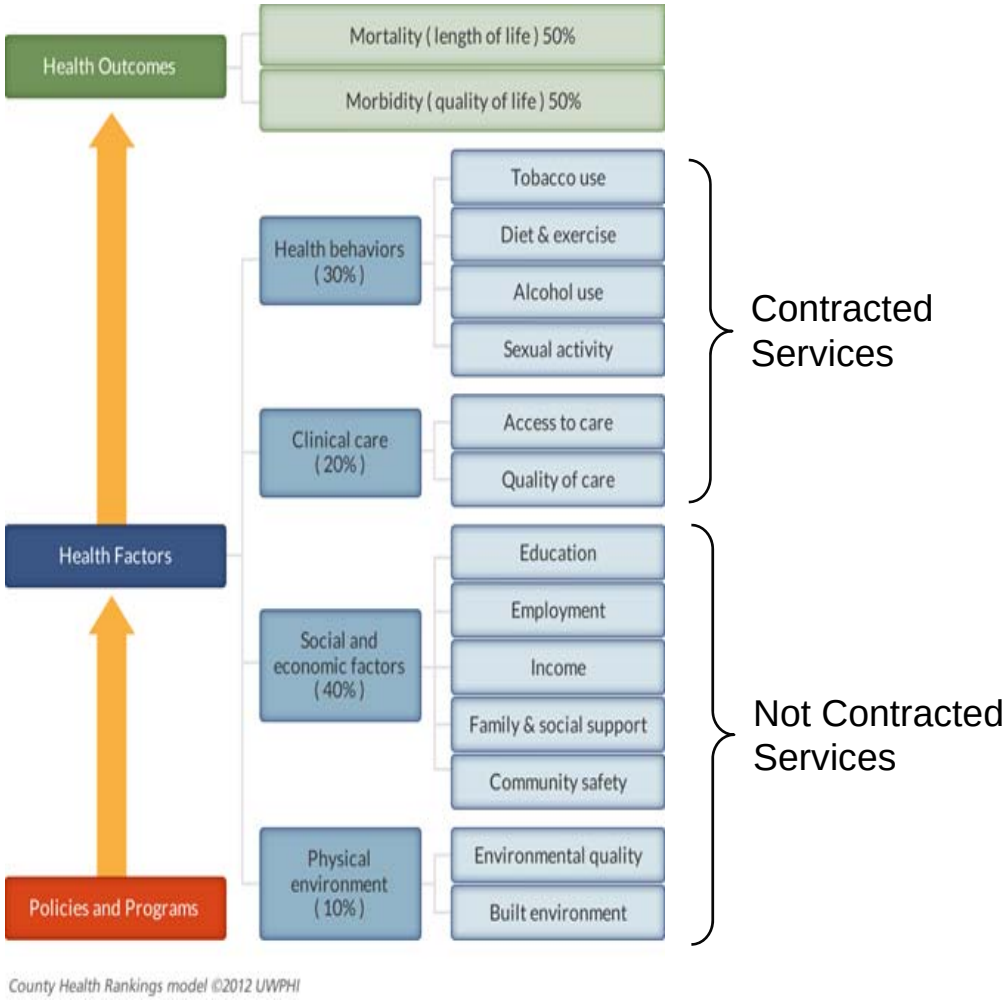
2016 Strategic Plan

In 2016, WellCare plans to reach 3440 people and refer them to 10,320 social services, increasing the access rate to **25%** by contracting with social service providers and piloting methods for automation.

CommUnity Advocacy Overview

WellCare Health Plans

WellCare Addresses All Health Factors Leading to Positive Health Outcomes



Community Advocacy

Social and economic factors create barriers to positive health outcomes.

To address member needs and strengthen the communities we serve, Community Advocacy identifies gaps in the social safety net and works with local communities to fill the gaps.

CommUnity Command Center

A collection of databases used to refer members and their families to community-based programs and services such as food banks, shelters, parenting classes. Contains information on:

- 110,000 social services
- 2,286 community activities
- 3,538 health/wellness programs
- 15 different community health grants

Community Assistance Line

WellCare Health Plans

Refer any WellCare member in need of a social service not in Case Management

WellCare Health Plans

Get connected with the right social services.

CALL
KY CommUnity Assistance Line (CAL) 1-866-775-2192
Video Relay 1-855-628-7552

Free for WellCare of Kentucky members.

- ☐ Transportation
- ☐ Homeless Services
- ☐ Food Assistance
- ☐ Education Assistance
- ☐ Financial Assistance (Utility, Rent)
- ☐ Respite Care
- ☐ Support Groups
- ☐ Other
- ☐ Disability-related Services

Covered Services - EPSDT

WellCare Health Plans

- Providers will be sent a monthly membership list which specifies the health assessment for eligible children who have not had an encounter within 120 days of joining the plan or are not in compliance with the EPSDT Program.
- Any provider who provides Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening service are responsible for:
  - Monitoring, tracking and following up with members:
    - Who have not had a health assessment screening
    - Who miss appointments to assist them in obtaining an appointment
    - To ensure they receive the necessary medical services
  - Ensuring members receive the proper referrals to treat any conditions or problems identified during the health assessment.
  - Assisting members with transition to other appropriate care for children who age-out of EPSDT services.
- The Provider's compliance with member monitoring, tracking and follow-up, will be assessed through random Medical Record Review audits conducted by the WellCare Quality Improvement Department and corrective action plans will be required for providers who are below 80 percent compliance with all elements of the review.
- For more information on EPSDT Covered Services or the periodicity schedule, refer to the Provider Manual and the Pediatric Preventive Health Care Guidelines at www.kentucky.wellcare.com. Or for more information on the Department's administrative regulations, visit the Department's website at http://chfs.ky.gov/dms/.

Obtaining Authorization & Utilization Management

WellCare Health Plans

- **Prior Authorization**
  - WellCare requires prior authorization for elective or non-emergency services as designated by WellCare.
  - Reasons for requiring authorization may include:
    - Review for medical necessity
    - Appropriateness of rendering provider
    - Appropriateness of setting
    - Case and Disease Management considerations

To find out if a service requires authorization, please use the auth look up tool with Kentucky Medicaid selected as line of business.

https://kentucky.wellcare.com/auth_lookup

For many outpatient services, the initial 20 therapy sessions do not require authorization.

For other services (IOP, PHP, TCM) clinical information is required at the time of the request. These forms can be found:

https://kentucky.wellcare.com/Provider/Forms_and_Documents

Utilization Management

WellCare Health Plans

Prior authorization requirements:

- The forms to request authorization are available on the website.
- Providers may use the WellCare form or the KY State Universal form to request authorization
- The form is to be completed in its **entirety** and faxed to WellCare or submitted online.
- A determination will be made within 48 hours of receipt of information

Utilization Management

WellCare Health Plans

- **WellCare Utilization Management Telephone Numbers:**
- Urgent authorizations and Provider Services **(855) 620-1861**
- Inpatient Hospitalization Clinical Submissions **Fax (877) 338-3686**
- Outpatient Authorization Request Submissions **Fax (877) 544-2007**
- **Crisis Hotline 1-855-661-6973**

For real-time authorization responses, submit your secure request online. Please submit your request for more services at least two weeks prior to the completion of the current authorized services (s).

For other WellCare Phone Numbers see Well Care Quick Reference Guide in handout

Appeals

WellCare Health Plans

- Providers have the right to file an appeal regarding provider payment or contractual issues.
- If the case is not appealed within the applicable timeframe, it will be denied for untimely filing.
- WellCare will review the case for medical necessity and conformity to WellCare guidelines. Cases lacking necessary documentation will be denied.
- When submitting an appeal:
  - Supply specific, pertinent documentation that supports the appeal
  - Include all medical records that apply to the service
  - Submit the appeal & accompanying documentation to the address on the Quick Reference Guide (QRG)
- Upon review of the appeal, WellCare will either reverse or affirm the original decision and notify the provider.

- For more information on provider appeals, including submission timeframes, how to submit and determination timeframes, refer to the Provider Manual and the Quick Reference Guide.

WellCare Website Content

The WellCare Web site information:

http://kentucky.wellcare.com/

http://kentucky.wellcare.com/provider/resources

WellCare Website Content

WellCare of Kentucky Provider: Resources

The resources on this page will assist you in working with WellCare of Kentucky. Click on the names of the materials listed to access more information. These materials may change over time so please check back to make sure you have the most up-to-date version.

WellCare of Kentucky Provider Manual

An extension of the Participation Agreement and a resource that provides guidelines on health plan coverage procedures, policies and other information related to the provision of health care services to our members. This document should be used simultaneously with the Provider Quick Reference Guide and other reference resources.

WellCare of Kentucky Provider Quick Reference Guide

Provides WellCare contact information and authorization guidelines
https://kentucky.wellcare.com/WCAssets/kentucky/assets/ky_caid_qrg_04_2014.pdf

Claims EDI

RelayHealth, a division of McKesson, manages all claims electronic data interchange (EDI) between WellCare and our providers. If you need assistance in making a connection with RelayHealth, or if you have any questions, contact RelayHealth at 1-888-499-5465, or your vendor may call 1-888-743-8735.

WellCare Website content

WellCare of Kentucky Medicaid Provider Comprehensive Preferred Drug List

This document contains information about the drugs we cover in this plan. Please note that the WellCare of Kentucky Medicaid Preferred Drug List is updated quarterly.

WellCare of Kentucky Medicaid Provider Forms and Documents

Template forms and documents for appeals, authorizations, claims, pharmacy services and more.

Clinical Coverage Guidelines

Evidence-based guidelines detailing the medical necessity of, and sets consistent criteria for coverage of, given procedures or technologies to ensure greater consistency and efficiency in clinical decision making.

Clinical Practice Guidelines

Best-practice guidelines used to guide efforts in improving the quality of care in our membership. CPGs are based on available clinical outcome and scientific evidence-based content developed by expert professional and clinical society recommendations.

For More Information…

WellCare Health Plans

- Review the ***Provider Manual*** for more detailed information about provider requirements and how-to's including:

Provider and Member Administrative Guidelines	Claims	Credentialing
Utilization Management and Case & Disease Management	Quality Improvement	Appeals and Grievances
Delegated Entities	Compliance	Pharmacy Services

- Refer to the ***Provider Resource Guide*** and ***Provider How-To Guide*** as your one-stop-shop guides to the most common transactions with WellCare, including:
  - Registering for, and how to use, WellCare's provider portal such as member eligibility and co-pay information, authorization requests, claims status and inquiry, provider news and more;
  - How to file a claim via paper, electronically or via WellCare's Direct Data Entry (DDE);
  - How to file a grievance; and
  - How to file an appeal.
- Refer to the ***Quick Reference Guide*** for authorization requirements, addresses and phone numbers for key departments.
- Refer to the ***Clinical Practice Guidelines*** and ***Clinical Coverage Guidelines*** to determine medical necessity, criteria for coverage of a procedure or technology, and best practice recommendations based on available clinical outcomes and scientific evidence.
- Contact your Provider Relations representative to schedule an in-service meeting.

Questions?

WellCare Health Plans

Thank You.