KENTUCKY
Cabinet for Health and Family Services

DEPARTMENT FOR MEDICAID SERVICES: WAIVER UPDATE

PRESENTED BY:

LESLIE HOFFMANN, DIRECTOR

JUNE 2, 2016

Contents

Update on Slots…… 3
HCBS Waiver Applications Renewal Dates…… 5
Statewide Transition Plan Update…… 7
HCBS Final Rules…… 9
Ancillary Services Transition…… 16
Michelle P. Waiver Assessment Tool Pilot…… 20
Provider Resources…… 22
MWMA…… 24

Copyright © 2014 Deloitte Development LLC. All rights reserved.

Update on Slots

Waiver Slots

Waiver slots are unduplicated which means if a participant even uses one service in a waiver year, the slot cannot be reused or refilled until the following waiver year. Below is a summary of waiver slots and current wait lists.

	Waiver Slots	Wait List	Notes
ABI	383	0	
ABI-LTC	320	191	The 320 slot total includes slots reserved for MFP.
HCB	17,050	0	
MPW	10,500	5,364	
SCL	4,701	2,203	240 additional slots are approved to be added.

4

HCBS Waiver Renewals

5

HCBS Waiver Applications – Renewal/Submission Dates

The following table is a summary of the timelines associates with each of the HCBS waiver renewals.

	Public Comment	Due Date/Anticipated Submission to CMS	Effective Date
HCB	4/10/2015 – 5/10/2015	5/15/2015	July, 2016* *pending approval from CMS
SCL	4/29/2015 – 5/29/2015	6/1/2015	August, 2016* *pending approval from CMS
MIIW	5/30/2015 – 6/29/2015	7/1/2015	1/8/2016
ABI-LTC	2/26/2016 – 4/24/2016	5/2/2016	February, 2017* *pending approval from CMS
MPW	6/10/2016 – 7/9/16* *tentative	7/15/2016	February, 2017* *pending approval from CMS
ABI	8/29/2016 – 9/28/2016	10/1/2016	February, 2017* *pending approval from CMS

6

Statewide Transition Plan Update

7

HCBS Federal Final Rules State Response

While some parts of the rule require immediate implementation, CMS allows states to implement the setting requirements over five years. Specific requirements around this transition include:

State Transition Requirements		
• Submit a waiver-specific transition plan at the time of the first waiver renewal or amendment to CMS	• Submit a statewide transition plan for all waivers to CMS within 120 days of submitting the first waiver renewal or amendment	• Be in full compliance with the HCBS final rules by the timeframe approved in the transition plan, and no later than Mar. 17, 2019

Kentucky Timeline

- **Aug. 28, 2014** Submitted Michelle P. (MPW) Transition Plan
- **Dec. 19, 2014** Submitted the initial Statewide Transition Plan
- **Dec. 18, 2015** Submitted the revised Statewide Transition Plan
- **Mar. 17, 2019** Must be compliant with all setting rules

✓ Kentucky has responded to CMS questions on revised Statewide Transition Plan – hope to receive initial approval soon.

8

HCBS Federal Final Rules

9

Inclusion of HCBS Rules in DMS Regulations

The following table is a summary of the pieces of the HCBS Final Rules that were incorporated in revised DMS regulations, as well as the actual or proposed effective date of those regulations.

	HCBS Final Rules	Effective Date
ABI	• Person-centered planning • Conflict-free case management • Service plan requirements • First round setting requirements	February 5, 2016
ABI-LTC	• Person-centered planning • Conflict-free case management • Service plan requirements • First round setting requirements	February 5, 2016
MIIW	• Person-centered planning • Service plan requirements	February 5, 2016
MPW	• Person-centered planning • Conflict-free case management • Service plan requirements • First round setting requirements	June 3, 2016
HCB	• Person-centered planning • Conflict-free case management • Service plan requirements • First round setting requirements	July, 2016
SCL	• Person-centered planning • Conflict-free case management • Service plan requirements • First round setting requirements	August, 2016

10

Kentucky Implementation of Rules

Following is a summary of major implementation activities carried out by the Cabinet for Health and Family Services (CHFS) staff, with input and involvement from stakeholders.

	Completed Activities
January – March 2015	• Presented rules to participants and obtained their input on implementation at Participant forums throughout the state • Developed compliance plan template tool and hosted provider webinar for input
April – June 2015	• Distributed compliance plan templates to providers and designed evaluation criteria • Received public comments for HCB and SCL waiver renewals • Submitted HCB and SCL waiver renewals
July – September 2015	• Evaluated providers' compliance plan templates • Filed revised waiver regulations • Presented rules to various provider and advocacy groups
October – December 2015	• Updated provider compliance categories and summarized provider counts • Distributed compliance plan template evaluations to providers • Drafted and submitted updated statewide transition plan to CMS
	Current Activities
January – June 2016	• Design the process for category 4 on-site visits • Conduct on-site visits and collect evidence to submit to CMS • Provide updates to providers, self-advocates, family members, and advocates

11

Heightened Scrutiny Overview

Heightened scrutiny is the process developed by CMS to closely examine provider settings that are in locations *presumed* not to be home and community-based to determine if these settings will be able to come into compliance with the HCBS Final Rules.

***Presumed* not too be home and community-based (CMS definition)**
Any locations that have qualities of an institutional setting, including the following: • Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment • Any setting in a building on the grounds of, or immediately adjacent to, a public institution • Any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS (This includes settings that are "clustered" together where there are multiple residences/settings operationally related and co-located in close proximity, as well as farmsteads)

For settings in locations that are *presumed* not to be home and community-based:

- States do not have the authority to determine that they are in fact home and community-based. The state's responsibility is to collect information about each of these settings.
- States must submit to CMS the settings in locations *presumed* not to be home and community-based that demonstrate home and community-based characteristics and do not isolate waiver participants in order for these providers to continue in the program.
- CMS will conduct heightened scrutiny on these submitted settings and make a final determination through the collection of information related to participant experience at each of these settings.

12

Site Visit Overview

November 2015
Initial categorization of settings completed

April-July 2016
Conduct on-site visits and collect evidence of category 4 settings

October 2016
Submit HCBS evidence to CMS for review

A group consisting of **two staff** and a **self-advocate or family member** will conduct **on-site visits** to settings that have been identified as requiring heightened scrutiny in order to comply with the HCBS federal final rules.

The site visit team will fill out the observation and survey tools related to the **location, setting, staff, and participants** at each setting. They will collect information and take photos of the setting that show home and community based characteristics.

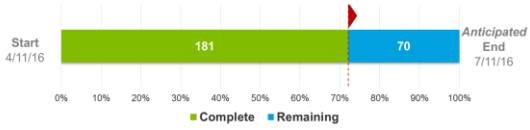
If, at the conclusion of the visit, the setting is still presumed to be not home and community based, the setting will need to undergo heightened scrutiny and collected evidence will be sent to CMS to make a final determination on each setting.

13

Site Visit – Progress Dashboard

As of 5/25/16, Kentucky has completed almost 75% of the total site visits for category 4 providers and settings.

Completed Visits	Visits Remaining	Total Visits
181 72%	70 28%	251



Please note: the total number of visits has changed from the most recent publication of the statewide transition plan due to some closures and relocations of settings that were in category 4.

14

CMS Guidance on New Settings

CMS recently released guidance about the implementation of the HCBS Final Rules related to newly opened settings. https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/faq-planned-construction.pdf

Key Points from Guidance

- As of March 17, 2014, any new waiver provider or new waiver setting opened by an existing provider must be fully compliant with the HCBS Final Rules
- New waiver providers/settings do not have the same transition timeframe until 2019 to come into compliance as existing providers/settings do
- CMS expected that providers would not invest in the construction of settings that are presumed to have institutional qualities after the publication of the federal regulation

Kentucky's Plan to Implement Guidance

- Beginning on **July 1, 2016**, Kentucky will enforce this guidance and any new waiver provider/setting will be evaluated against **all** HCBS Final Rules for full compliance prior to certification
- If an existing provider opened a new setting since June 2015 (when providers completed compliance plan templates listing all of their settings), they must send the address of the new setting(s) to DMS by June 15, 2016

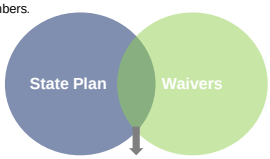
DMS sent a provider letter about this new guidance to all HCBS waiver providers explaining what will be required of them on 5/16/16.

15

Update on Ancillary Services Transition

PT/OT/ST Waiver Transition to State Plan

PT/OT/ST have been historically provided to children through EPSDT and to HCBS waiver participants. However, on 1/1/14, DMS added PT/OT/ST as covered benefits its state plan for all Medicaid members.



- Overlap between a service provided in a state plan and a service provided in the waiver is **not** allowed by the Centers for Medicare and Medicaid Services (CMS).
- There are some options for states to provide ***similar*** services in its state plan and its waiver, but the services cannot be the same in both.
  - **Extended state plan services** are only allowable in the waiver if the service in the state plan has a hard limit that cannot be exceeded by medical necessity
  - **"Other" services** are only allowable if the waiver service is distinct or materially different from the state plan service
  - **For children**, any service which CMS allows as a state plan service must be provided through the state plan. If not covered by the state, the service must be provided through Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

17

PT/OT/ST Waiver Transition to State Plan

Since DMS cannot cover PT/OT/ST in both the waivers and the state plan, DMS is transitioning these services from the HCBS waivers into the state plan at the time of renewal for each of the HCBS waivers.

	Transition in Progress
HCB	• Submitted renewal application to CMS without PT/OT/ST in April • Filed HCB regulations without PT/OT/ST as covered services in September • Transition anticipated: **July, 2016**
SCL	• Submitted renewal application to CMS without PT/OT/ST in June • Filed SCL regulations without PT/OT/ST as covered services in August • Transition anticipated: **July, 2016**
	Upcoming Transition
ABI-LTC	• Submitted renewal application to CMS in April • File ABI-LTC regulations without PT/OT/ST as covered services in June • Transition anticipated: **February, 2017**
MPW	• Submit renewal application to CMS in June, 2016 • File MPW regulations without PT/OT/ST as covered services in July • Transition anticipated: **February, 2017**
ABI	• Submit renewal application to CMS on October 1, 2016 (effective date of January 1, 2017) • File ABI regulations without PT/OT/ST as covered services in August • Transition anticipated: **February, 2017**

18

Provider Type 76 – Multi-Therapy Agency

The chart below outlines information about the Multi-Therapy Agency, Provider Type 76 program and highlights the additional information to be submitted by the provider for application processing.

Multi-Therapy Agency, Provider Type 76 (Effective June, 2016)	
Services	• Provider must be providing one or a combination of the following: **physical therapy, occupational therapy and/or speech language pathology** (PT, OT, ST)
Locations	• Provider must have **"bricks and mortar"** (a physical location where they administer services) but services may be provided outside the facility with appropriate licensure
Licensure	• License issued by the Office of Inspector General (OIG) as a **Adult Day Health, Special Health Services Clinic, Rehab Agency, or Mobile Health Service** • Note: to render these services **outside** of the licensed facility, a provider will need to be licensed as a **Mobile Health Service**
Required MAP Application Forms	• MAP-811 and MAP-811 Addendum E • MAP-347 for all licensed providers within the group (all licensed PT, OT, and ST practitioners must be active to link to the group provider)

Regulation 907 KAR 8:040 expands the PT, OT, and ST service provider base to ensure sufficient access to services for all Medicaid recipients.

19

Michelle P. Waiver Assessment Tool Pilot

MPW Assessment Tool Pilot

Many stakeholders have requested that the CHFS adopt a more validated tool that can be used for participants of all ages. The CHFS has decided to pilot the ICAP tool, a tool used by many other states with great success, to understand the impact a new assessment tool would have on the waiver.

What is the MPW Assessment Tool Pilot?

- A special project that the CHFS has started **to evaluate the impact of a new assessment tool on the existing MPW population**.
- The purpose of the pilot is to see what **impact a new assessment tool would have** on the waiver and to **collect information about the MPW population**.

Will participation in the pilot impact MPW eligibility?

- **The pilot will not impact any current MPW participant's eligibility**. Those participating in the pilot will still need to be assessed at their annual level of care date.
- Any future decision the CHFS makes about an assessment tool will **not be based solely** on the results of the pilot.

What is the process for the MPW Assessment Tool Pilot?

- **Eastern Kentucky University (EKU)** will be conducting the pilot with personnel trained in psychology.
- EKU will be using the **Inventory for Client and Agency Planning (ICAP)** tool to conduct assessments on the pilot participants.

May 2016 – Randomly select 330 current MPW participants to participate in the pilot

June 2016 – Conduct pilot using the nationally recognized ICAP tool

July 2016 – Review findings to better understand the impact of a new assessment tool

21

Resources

Resources/Upcoming Trainings

DMS will be hosting several information sessions/trainings in the next couple of months. In addition, there are resources available on the DMS webpage and through Medicaid.gov.

Recent & Upcoming Webinars/Training

PT/OT/ST Transition: Policy and Operational Impacts

- DMS and HP will discuss the transition and describe steps that providers need to take to continue rendering services to HCBS waiver participants through the State Plan
- May 31 and June 1 (Time TBD)

HCBS Waiver Documentation Training

- DMS will provide guidance to providers on how to correctly document services rendered and what is required
- June 28 (10:00 AM – 12:00 PM) and June 29 (1:30 – 3:30 PM)

Frequently Asked Questions (FAQ) on DMS Webpage

PT/OT/ST Transition: Provider FAQs

- http://chfs.ky.gov/NR/rdonlyres/3D0DEA46-9A9E-405A-99A4-A4D1102701FC/0/PTOTSTWaiverTransitionProviderFAQ_FINAL.pdf

SCL FAQs:

- http://chfs.ky.gov/dms/SCL.htm

HCBS Final Rules

- http://chfs.ky.gov/NR/rdonlyres/CEA45907-558D-46DF-994F-A823803B0C63/0/HCBSFinalRules_ComplianceFAQ_Final2.pdf

Additional federal guidance on the HCBS Final Rules is available: https://www.medicaid.gov/.

23

MWMA

MWMA – Usage and Support

The following are key usage statistics as of 5/13/16. Four training sessions have been held with 20 providers from 5-10 different agencies. The focus of the training sessions were integrated application and changes in the LOC and enrollment processes. Each session included an opportunity for Deloitte/OATS to assist providers with specific questions.

MWMA Usage Statistics	
External Users On-boarded	1,532
Enrolled Individuals	20,265
Number of LOCs entered in MWMA (new and renewal)	13,888
Number of POCs In-Progress/Complete in MWMA	6,019
Number of Case Notes entered in MWMA	243,295
Number of Integrated Applications Entered*	561
Incidents Started/Submitted*	41

Transitioned Individuals by Program					
ABI LTC	ABI	HCB	MII	MPW	SCL
233	183	8629	20	9304	3946

25