Kentucky Cabinet for Health and Family Services

Medicaid 1915(c) Home and Community Based Services Waivers

Appendix K – March 2022 Provider Relief Amendment Frequently Asked Questions

CABINET FOR HEALTH
AND FAMILY SERVICES
Medicaid Services

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Appendix K – March 2022 Provider Relief Amendment Frequently Asked Questions

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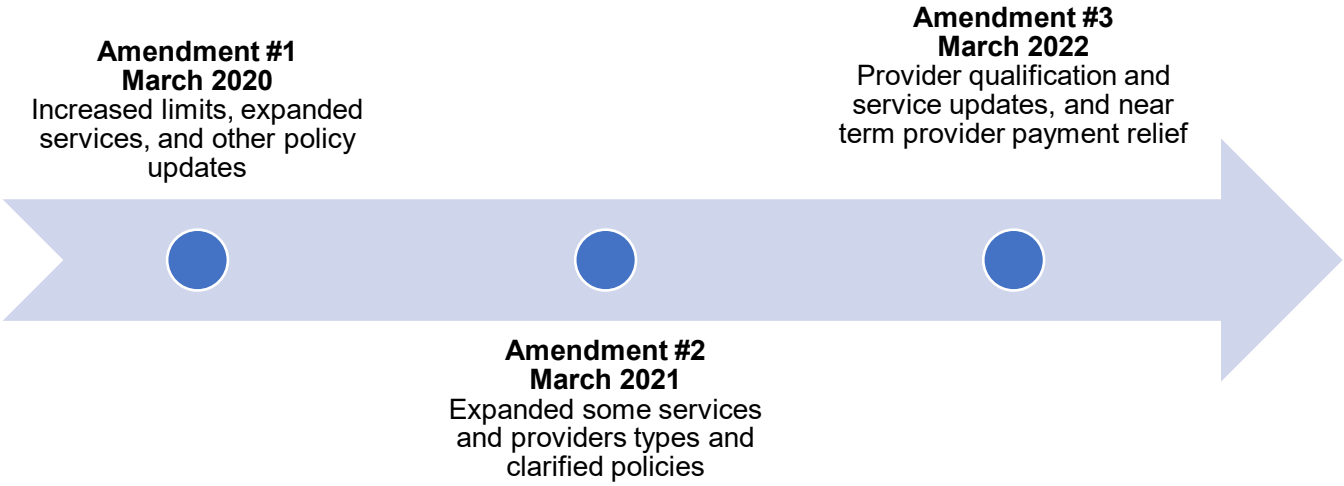
Section 1: Document Background

In January 2020, the United States Department of Health and Human Services (HHS) declared a federal public health emergency due to the spread of the novel coronavirus, or COVID-19 in the U.S. The Department for Medicaid Services (DMS) has received approval for three Appendix K amendments throughout the COVID-19 pandemic. Appendix K is an extra appendix of the 1915(c) Home and Community Based Services (HCBS) waiver application that states can use in emergency situations to make **temporary** updates to waiver programs to address programmatic needs and participant health, safety, and welfare.



Kentucky's Appendix K submissions include updates applicable to all six of the state's 1915(c) HCBS waivers: Acquired Brain Injury (ABI), Acquired Brain Injury Long Term Care (ABI LTC), Home and Community Based (HCB), Model II (MIIW), Michelle P. Waiver (MPW), and Supports for Community Living (SCL).

DMS, on behalf of the Cabinet for Health and Family Services (CHFS), is publishing this Frequently Asked Questions (FAQs) document in response to **questions received about Amendment #3**. Please refer to the DMS COVID-19 FAQ for questions and answers about amendments #1 and #2.

These questions were collected from inquiries made to the DMS Division of Community Alternatives (DCA) via email and via a provider webinar held March 31, 2022. DMS has modified some questions from the originally submitted language to be as clear as possible and not share case-specific details.

Navigating the FAQ

Readers have a couple of options for navigating to specific parts of this FAQ.

1. Questions have been grouped and are listed by topic in the "Contents" section above. Clicking on the question will take you to the answer.
2. Readers can search for keywords in the document by hitting CTRL+F on the keyboard. This will pop up a search box where the reader can enter a keyword (such as PDS) to find all questions and responses related to that topic.

FAQ Key

Each question lists the "Date Added" or "Revised." "Date Added" means the question is new to the FAQ. "Revised" means the response has been substantially updated since the last release of the FAQ.

To further assist readers, DMS has color-coded new and revised questions. The date for each new question is highlighted **yellow** and the date for each revised question is highlighted **green** in the body of the document. The numbers of added and revised questions have been highlighted in the "Contents" sections above as well.

Additional Questions

DMS will update this document as more questions are received. If you submitted a question recently, it may be included in a future update.

If you have additional waiver-related questions about Appendix K amendment #3 after reviewing this FAQ, please contact the 1915(c) Waiver Help Desk via email at 1915cwaiverhelpdesk@ky.gov or by phone at (844) 784-5614.

All waiver-related COVID-19 resources are available at https://chfs.ky.gov/agencies/dms/dca/Pages/default.aspx. Resources for all Medicaid providers are available at https://chfs.ky.gov/agencies/dms/Pages/cv.aspx.

For more information on COVID-19 in Kentucky, visit kycovid19.ky.gov.

General Appendix K – March 2022 Questions

Q1: When are the changes approved in the March 2022 version of Appendix K effective?
Date Added: 04/22/22

The Centers for Medicare and Medicaid Services (CMS) approved these changes with an effective date of January 1, 2022.

Q2: Is there a deadline for expenditure of the funds generated by the temporary rate increase?
Date Added: 05/13/22

No, there is no deadline for expenditure of the funds. Providers should remember the temporary rate increase is only available while Appendix K is in effect, however, the funds generated can be used after Appendix K expires. In this instance, provider agencies need to document how use of the funds were used to meet the 85% pass-through requirement.

Q3: When will the updates approved in the March 2022 version of Appendix K expire? Can these updates be made permanent?
Date Added: 04/22/22

Appendix K is approved for up to six months after the end of the federal public health emergency declaration. Providers will have a transition period between the end of the public health emergency and the return to normal waiver operations. DMS will notify the public regarding the transition plan within forty-eight (48) hours of the end of the federal public health emergency. DMS will provide policy guidance and technical assistance during the transition period to ensure a smooth return to normal operations and no gaps in care for participants.

Appendix K cannot remain in place beyond its approval end date. To make Appendix K updates permanent, changes would need to be incorporated into the current waiver applications and submitted to CMS for approval. Additionally, waiver-related KARs would need to be updated and approved.

Temporary Rate Increase and Retainer Payments

Q4: Which services are eligible for the temporary rate increase?
Date Added: 04/22/22

The following services are eligible for the temporary rate increase. The increased rate is 50% of the service's currently approved reimbursement rate. The increased rate applies to the traditional services only and in all waivers unless otherwise specified.

- Attendant Care
- Traditional Case Management (HCB and MPW only)
- Community Access
- Community Guide

- Community Living Supports
- Companion
- Homemaker
- Respite and Non-Specialized Respite
- Personal Assistance and Personal Care
- Skilled Services by an LPN or RN (MIIW)
- Specialized Respite
- Residential
    - Supervised Residential Level I, II, and III (ABI and ABI LTC)
    - Residential Support Level I (SCL)
        - Residential Support Level II (SCL) is not eligible for the rate increase, however, participants living in Residential Support Level II homes can receive Personal Care and Respite under the Appendix K amendment approved in March 2021.
- PDS Coordination (HCB Only)
    - The 50% increase is for the PDS case management function of the service only. The increase should only be applied to one unit of $162.50.

Q5: Where can the currently approved reimbursement rate for each waiver be found?
Date Added: 04/22/22

For most waivers, the current approved reimbursement rate for each waiver is listed in the waiver's corresponding Kentucky Administrative Regulation.

- ABI: 907 KAR 3:100
- ABI LTC: 907 KAR 3:210
- HCB: 907 KAR 7:015
- Model II: 907 KAR 1:595
- MPW: 907 KAR 1:835

Most services in the SCL waiver received a 10% rate increase in 2018 through the biennial budget process. A listing of updated rates is available in Provider Letter #A-53: New SCL Rates available at https://bit.ly/kySCLrates. Rates not listed in the letter can be found in 907 KAR 12:020.

Q6: How do providers receive the temporary rate increase for services provided since January 1, 2022?
Date Added: 04/22/22

To receive payment, provider agencies can submit adjustments to claims for affected services provided since January 1, 2022. Taking the temporary rate increase is optional and providers are not required to submit adjustments for previously provided services unless they want to claim the rate increase.

Provider agencies that intend to claim the temporary rate increase must also complete an attestation

form confirming that 85% of the increased rate will be passed on to direct service workers.

Q7: When will providers be able to bill the temporary rate increase?
Date Added: 04/22/22

Providers can begin billing the temporary rate increase after changes to the Medicaid Waiver Management Application (MWMA), the Medicaid Management Information System (MMIS), and the Netsmart electronic visit verification (EVV) system go into effect on April 29, 2022.

Q8: Will rates be automatically uploaded in the Netsmart EVV system for affected services?
Date Added: 04/22/22

Yes, the temporary maximum rate will go into the Netsmart EVV system on April 29, 2022. I**f a provider does not intend to bill the temporary maximum rate, they will need to complete an override rate in Netsmart EVV** beginning April 30, 2022. Directions for how to enter an override rate are available at https://bit.ly/evvqrgoverriderates.

Q9: Will case managers have to modify all person-centered service plans?
Revised: 05/13/22

Most person-centered service plans will not need to be modified for provider agencies to request the temporary rate increase.

For non-Residential services, MMIS has been updated to allow for billing of the temporary rate increase. Case managers **are not required to complete a modification** to the person-centered service plan (PCSP) for the temporary rate increase until the next time they modify the participant's PCSP or until the participant's re-certification, whichever comes first.

For Residential services, the need for a modification depends on the rate the Residential provider is currently billing for the participant, the dates for which the Residential provider plans to bill the temporary rate increase, and where the participant is in their level of care (LOC) year. Please see the Appendix K Temporary Rate Increase – Residential Services guide for more information.

Q10: Is a person-centered team meeting or person-centered team sign-in sheet required if a modification is needed to claim the temporary rate increase for a participant utilizing Supervised Residential Levels I, II, and III (ABI/ABI LTC) or Residential Support Level I (SCL)?
Date Added: 05/13/22

No, a person-centered team meeting or person-centered team sign-in sheet is not required for situations where a modification is needed to request the temporary rate increase for participants utilizing the Residential services listed above.

Q11: Will there be new billing codes for services eligible for the temporary rate increase?
Revised: 05/13/22

The billing codes for **most services** remain the same. A list of codes is available in the Appendix K Temporary Rate Increase Attestation Memo.

Q12: Will there be billing instructions for the temporary rate increase?
Revised: 05/13/22

DMS created a guide to billing for Residential services, as this process varies based on what the Residential provider is billing for the participant, the **For Residential services**, the need for a modification depends on the rate the Residential provider is currently billing for the participant, the dates for which the Residential provider plans to bill the temporary rate increase, and where the participant is in their level of care (LOC) year. Please see the Appendix K Temporary Rate Increase – Residential Services guide for more information on billing Residential.

For all other services impacted by the temporary rate increase, providers should continue to bill the same way they do today.

Q13: Will providers receive new prior authorizations that reflect the temporary rate increase?
Date Added: 04/22/22

No, a provider will not receive a new prior authorization unless a modification of the PCSP is completed. Providers who need a new prior authorization must coordinate with the participant's case manager.

Q14: Can DMS complete a mass adjustment on behalf of providers for the services included in the temporary rate increase?
Date Added: 04/22/22

No, DMS cannot do a mass adjustment.

Q15: How does a provider adjust claims if they bill using the Netsmart Mobile Caregiver+ EVV system?
Date Added: 05/13/22

Directions for adjusting claims are available on page 88 of the Mobile Caregiver+ Claims Console User Guide. The guide is available under User Guides in the Training section of the Mobile Caregiver+ Provider Portal. There is also a video available under Video Tutorials in the Training section of the portal.

Alternately, providers can adjust claims through MMIS, even if they originally billed using EVV.

Q16: Can providers request the temporary rate increase for any participant using Supervised Residential Levels I, II, and III (ABI and ABI LTC) or Residential Support Level I (SCL)?
Date Added: 04/22/22

Yes, the temporary rate increase can be requested for any participant receiving Supervised Residential Levels I, II, and III (ABI and ABI LTC) or Residential Support Level I (SCL). The previous enhanced rate approved in March 2020 was only available for participants receiving these services who were not attending Adult Day Training or participating in other services outside the residence due to COVID-19.

Q17: Does the temporary rate increase for Residential include weekends?
Date Added: 04/22/22

Yes, the temporary rate increase is available for any day of the week that a participant is staying at the provider residence.

Q18: Does the temporary rate increase approved in March 2022 eliminate the additional unit of case management allowed under the Appendix K amendment approved in March 2020?
Date Added: 04/22/22

No, the option to bill an additional unit of case management under the original Appendix K amendment approved in 2020 remains in place. This request should include documentation detailing additional contacts and the need for the additional unit as crisis management is already an essential part of case management services. DMS does not anticipate high rates of exceptional case management as COVID-19 cases have declined and restrictions that required changes to PCSPs have eased. DMS will conduct retrospective reviews of service increases to ensure these were implemented for appropriate, emergency-related reasons.

Q19: Does the temporary rate increase apply if eligible services are provided via telehealth?
Date Added: 04/22/22

Yes, telehealth is still allowable under the Appendix K amendment approved in March 2020. Telehealth services should meet the participant's needs, be wanted by the participant, person-centered, meaningful, and advance established goals.

Q20: Are there plans to temporarily increase rates for services not included in this Appendix K amendment?
Date Added: 04/22/22

DMS does not have plans to temporarily increase rates for additional services through another Appendix K amendment. However, DMS is currently conducting a rate study of 1915(c) HCBS services to determine any permanent updates needed to reimbursement rates. The rate study aims to develop a sound payment and rate-setting methodology, informed by analyzing the reasonable and necessary costs incurred by providers who serve waiver participants. The rate study will allow DMS to develop rates consistent with the efficiency, accessibility, and quality of care standards federally required by U.S.C. Section 1396(a)(30)(A). The resulting rates are subject to the approval of DMS, federal approval by CMS, and must be implemented in both the 1915(c) waiver applications and KARs as the standard reimbursement rate.

Q21: Why are Adult Day Health Care (ADHC) and Adult Day Training (ADT) not included in the list of services eligible for the temporary 50% increased rate?
Date Added: 04/22/22

ADHC and ADT are not included in the eligible services for the temporary 50% increased rate because they are eligible for retainer payments as outlined in the Appendix K amendment approved in

March 2022.

Q22: How do ADHC and ADT providers request retainer payments?
Revised: 05/13/22

ADHC and ADT providers interested in receiving a retainer payment should complete the Appendix K Retainer Payment Request Form and submit it to DMS by emailing it to CHFS.HCBSWorkGroup@ky.gov.

Q23: What period will DMS look at when considering retainer payments for ADHC and ADT providers?
Date Added: 04/22/22

DMS will determine the rate and scope of retainer payments based on measurable declines in reimbursement as indicated when comparing provider utilization in the 90 days prior to the public health emergency to current utilization.

85% Pass-Through for Direct Service Workers

Q24: Appendix K requires provider agencies to pass-through 85% of the temporary rate increase to direct service workers. In what ways must provider agencies pass on these funds?
Date Added: 04/22/22

Providers must pass on 85% of the temporary increased rate in the form of compensation increases, hiring and retention bonuses and other reimbursement-related incentives, such as training or extra paid time off. Agencies may be required to demonstrate compliance. DMS may recoup funds from providers who are not in compliance with the 85% pass-through requirement.

Providers should remember these funds are temporary and will no longer be available to fund long-term benefits once Appendix K ends. Permanent rate updates would not occur until after completion of the 1915(c) HCBS Rate Study that is currently underway.

Providers must outline how they plan to meet the 85% pass-through requirement using an attestation form that is required to be completed before requesting the temporary rate increase.

Q25: What is required in the attestation for providers billing the temporary 50% rate increase?
Date Added: 04/22/22

Providers should complete the attestation form issued by DMS on April 22, 2022 and return it to DMS **before** billing the temporary rate increase. The form asks providers to indicate which activities will be used to meet the 85% pass-through requirement and must be signed by the agency's CEO or president. Agencies only need to complete one form for all provider numbers they have.

Q26: If a provider agency recently increased wages for direct support professionals, can the raises count toward meeting the 85% pass-through requirement?
Revised: 05/13/22

Yes, wage increases that occurred before the temporary rate increase was approved can count toward the 85% pass-through requirement. Provider agencies should be sure to document the wage increase along with actions taken to meet the full 85%.

Q27: Do providers need to pass along the 85% percent to direct support workers who were employed by the agency on or after January 1, 2022, but who no longer work there?
Date Added: 04/22/22

No, providers do not need to pass the 85% along to individuals who are no longer employed by the agency.

Q28: Can provider agencies pass along the 85% to support, administrative, or supervisory staff or to direct service workers who provide services not included in the temporary rate increase?
Revised: 05/13/22

The 85% can only be passed on to direct service workers. The remaining 15% can be used at the agency's discretion and could include compensation increases or bonuses for support, administrative, or supervisory staff.

Q29: Can Residential house managers who provide direct care services to participants be included in the 85% pass-through requirement?
Date Added: 05/13/22

Yes, but only if they are providing direct care to waiver participants. If a house manager does not provide direct care, they cannot be included.

Q30: Can case management supervisory or management staff be included in the 85% pass-through if they carry a caseload?
Date Added: 05/13/22

Yes, case management agency supervisors or managers who carry a caseload of waiver participants can be included in the 85% pass-through requirement.

Q31: If a provider agency received the enhanced Residential rate allowed in the Appendix K amendment approved in March 2020, does the agency need to pass 85% of that rate on to direct service worker staff?
Date Added: 04/22/22

No. The enhanced Residential rate offered under the initial Appendix K amendment approved in March 2020 was intended for providers to meet increased staffing needs for participants who could

not go to ADT or access other services outside the residence due to COVID-19.

The temporary rate increase for Residential may be billed for any participant, regardless of their participation in ADT or other services outside the residence. The intention of the rate increase is to improve employee retention and recruitment.

Q32: Will the 85% pass-through be considered taxable income and be reflected on each employee's W-2? Or will it be tax-exempt like the Stimulus Checks due to it being part of the American Rescue Plan funding?
Date Added: 04/22/22

It depends on how the 85% is passed down. If passed down through wage or bonuses, this is considered taxable income. Other methods may not be taxable. DMS recommends agencies discuss what is and is not taxable with the agency accounting staff.

Provider Qualifications

Q33: What types of Associate's degrees are acceptable for case managers hired under the Appendix K provider qualifications?
Date Added: 04/22/22

DMS would expect the types of Associate's degrees for case managers hired under Appendix K to be similar to the types of Bachelor's degrees current case managers have. Any degree should be relevant to the job duties case managers perform.

Q34: Does the Associate's degree requirement apply to traditional and PDS case managers?
Date Added: 04/22/22

Yes, individuals with an Associate's degree can be hired as either traditional or PDS case managers in all waivers except Model II.

Q35: Will training for new case managers hired with an Associate's degree be the same as training for current case managers? Will there be a grace period for getting it completed?
Date Added: 04/22/22

New case managers hired with an Associate's degree should undergo the same training as current case managers, however, DMS will allow a grace period of ninety (90) days for completion. Case managers should be able to competently handle waiver participant cases before they begin working on their own.

Q36: Will case managers hired with an Associate's degree or relevant experience be able to complete all the same tasks as a case manager with a Bachelor's degree, such as performing Assessments/Reassessments in ABI and ABI LTC?
Date Added: 04/22/22

Yes, individuals with an Associate's degree and/or relevant experience hired as case managers can

perform all functions of the job.

Q37: Do 18-year-olds hired under Appendix K need to have a high school diploma or GED?
Date Added: 04/22/22

No, 18-year-olds hired under Appendix K do not need to have a high school diploma or GED. This will allow for some health program vocational school students to begin providing services as appropriate and augment provider availability to provide additional services with the increase in staff. 18-year-olds hired under Appendix K must undergo the same background screenings as all direct service workers.

Q38: Will the provider qualification modifications for case managers become permanent after Appendix K ends?
Date Added: 04/22/22

DMS recognizes the need to expand provider qualifications to increase the number of case managers. Our goal is to evaluate provider qualifications and make these updates permanent as part of the 1915(c) rate study and review of the service menu outlined in the Enhanced FMAP spending plan.

Waiver or Service-Specific Questions

Q39: Are providers required to calculate the 85% before or after accounting for the 5.5% SCL provider tax?
Revised: 05/13/22

SCL providers should calculate the 85% before accounting for the 5.5% provider tax.

Q40: If a provider is receiving exceptional supports for an SCL participant, is the temporary 50% rate increase available for that participant?
Revised: 05/13/22

If a participant receives an **exceptional rate** for a service, the service is not eligible for the temporary rate increase because the service already receives an increased rate.

If a participant receives **exceptional units** for a service, the service is eligible for the temporary 50% rate increase because the units are reimbursed with the base rate.

Q41: How should the temporary rate increase for MPW case management be billed in a monthly unit or in 15-minute units?
Date Added: 05/13/22

MPW case management should be billed as one monthly unit with a base rate of $200. When adding the temporary rate increase, the rate becomes $300 per monthly unit.

Q42: Is Respite in MPW included in the temporary 50% rate increase?
Date Added: 05/13/22

Because it is billed yearly rather than by the unit, Respite in MPW already has a flexible rate and is not included in the temporary rate increase.

Q43: How does the temporary rate increase affect the yearly service limit for MPW participants?
Date Added: 04/22/22

The $40,000/$63,000 yearly limit was increased under the initial Appendix K approved in March 2020, which is still in effect right now. The $40,000/$63,000 yearly limit will return to normal once Appendix K expires.

Q44: In ABI, which levels of Supervised Residential can have up to five participants?
Date Added: 04/22/22

The increase from three to five participants per residence applies to all three levels of Supervised Residential in the ABI and ABI LTC waivers.