

Kentucky Cabinet for Health and Family Services

Medicaid 1915(c) Home and Community Based Services Waivers

COVID-19 and Appendix K – Frequently Asked Questions



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COVID-19 and Appendix K –Frequently Asked Questions

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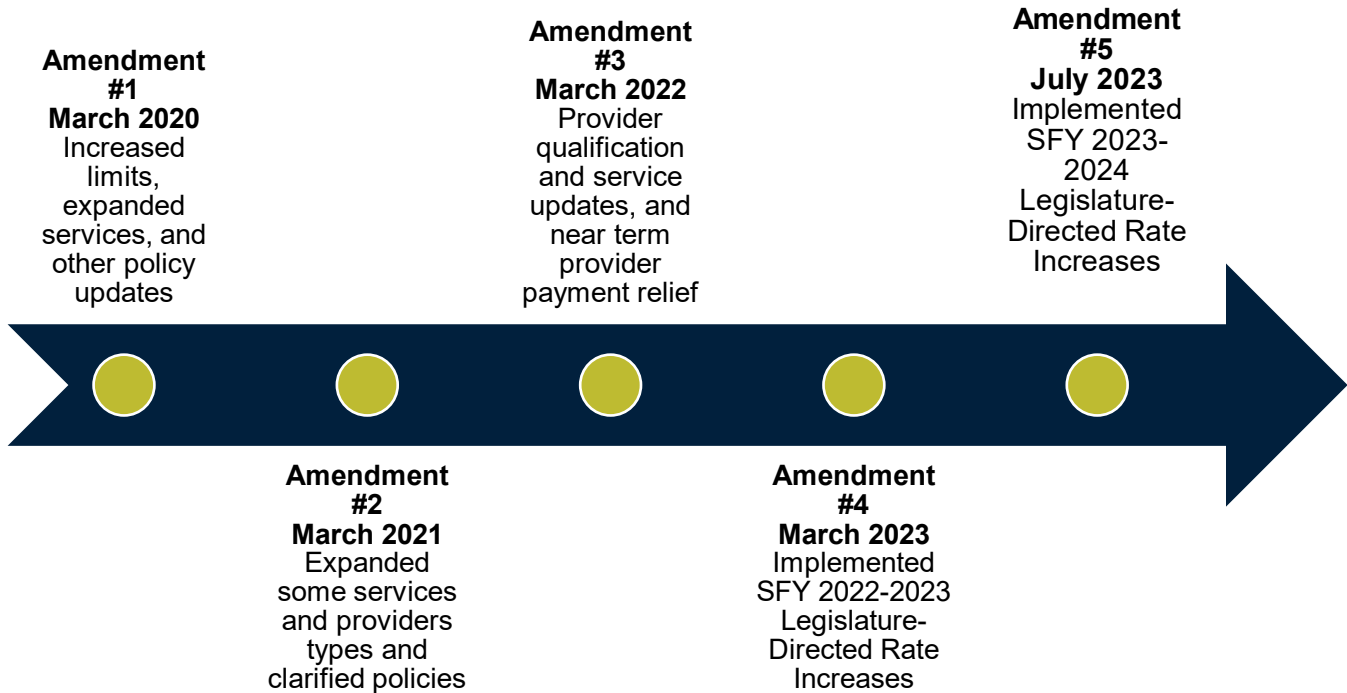
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Section 1: Document Background

In January 2020, the United States Department of Health and Human Services (HHS) declared a federal public health emergency (PHE) 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 four Appendix K amendments throughout the PHE. Appendix K is an extra appendix of the 1915(c) Home and Community Based Services (HCBS) waiver application that states can use in emergencies 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 COVID-19 and all four Appendix K amendments. This FAQ combines questions from DMS’ original 1915(c) HCBS COVID-19 FAQ with the Appendix K – March 2022 Provider Relief FAQ and adds questions about the legislature-directed rate increase included in Appendix K amendment #4.

All questions were collected from inquiries made to the DMS Division of Long-Term Services and Supports (LTSS). DMS has modified some questions from the originally submitted language to be as clear as possible and not share case-specific details. Some questions from the original COVID-19 FAQ and the Appendix K – March 2022 FAQ have been removed or revised due to the evolving nature of the PHE.

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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.

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 newly added question is highlighted **yellow** and the date for each newly 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 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/Pages/cv.aspx>.

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

General COVID-19 and Appendix K Information

Q1: What is Appendix K?

Revised: 04/28/23

Appendix K is an additional appendix of the 1915(c) HCBS waiver application. It is enacted during emergencies to allow states to make temporary changes to waiver policies that address programmatic needs and participant health, safety, and welfare for the duration of the emergency. DMS initially submitted and received CMS approval for Appendix K due to COVID-19 in March 2020. CMS approved amendments to Appendix K in March 2021, March 2022, and March 2023.

Q2: When will the updates approved in Appendix K expire? Can these updates be made permanent?

Revised: 04/28/23

The COVID-19 federal PHE expires at the end of the day on May 11, 2023. The expiration date for Kentucky's Appendix K amendment is six months after the end of the federal PHE, which will extend waiver flexibilities to November 11, 2023, and allow for a transition period back to normal waiver operations. 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 Kentucky Administrative Regulations must be updated and approved.

Q3: Is the recording and presentation from the Appendix K transition webinar held on July 12, 2023, available online?

Date Added: 08/11/23

The recording and presentation are available on the DMS COVID-19 information page at <https://bit.ly/KYDMSInfoCOVID19>.

Q4: Where can I find information about pre-PHE waiver policy and procedures?

Date Added: 08/11/23

For information on pre-COVID policy and operations, please refer to the waiver-related Kentucky Administrative Regulations. A list of waiver-related Kentucky Administrative Regulations is available on the DMS LTSS webpage at <https://bit.ly/KYMedicaidLTSSInfo> and at legislature.ky.gov. For Appendix K transition information, go to <https://bit.ly/KYDMSInfoCOVID19>.

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Q5: If a waiver participant needs their initial or annual assessment completed, how should the assessor complete the assessment/re-assessment?

Revised: 06/28/23

DMS issued a notice to assessors on March 16, 2020, that all assessments and re-assessments should be completed via phone or using remote options (such as FaceTime, Skype, etc.) to prevent the spread of COVID-19. Due to the widespread availability of precautionary measures, such as vaccines and masks, **DMS has directed assessors to resume in-person assessments and reassessments when possible.**

DMS recognizes COVID-19 still poses a threat to some 1915(c) HCBS waiver participants and phone or remote options remain allowable until Appendix K expires. Phone or remote options should be compliant with the Health Information Portability Act (HIPAA) and the method used must allow for direct interaction between the waiver participant and the case manager (e-mail or leaving a message is not considered interactive). For guidance on assessments and reassessments, please see the [letter DMS issued to assessors on December 19, 2022](#).

Q6: Should case managers/support brokers/service advisors continue to conduct remote person-centered team meetings and visits with waiver participants or should in-person visits resume?

Revised: 06/28/23

DMS issued a notice to case managers on March 13, 2020, that all in-person case management activities should be completed via phone or using remote options (such as FaceTime, Skype, etc.) to prevent the spread of COVID-19. Due to the widespread availability of precautionary measures, such as vaccines and masks, **DMS has directed case managers/support brokers/service advisors to resume pre-COVID procedures for in-person assessments/reassessments, person-centered team meetings, and visits. The only exception to this would be documentation that the participant requested a virtual meeting due to COVID-19 related reasons.**

DMS recognizes COVID-19 still poses a threat to some 1915(c) HCBS waiver participants and phone or remote options remain allowable until Appendix K expires. Phone or remote options should be compliant with HIPAA and the method used must allow for direct interaction between the waiver participant and the case manager (e-mail or leaving a message is not considered interactive). For guidance on in-person case management visits, please see the [letter DMS issued on July 12, 2022](#).

Q7: Will telehealth remain an option for case management activities such as person-centered planning and monthly visits once Appendix K expires?

Date Added: 08/11/23

The frequency and method of team and monthly meetings will revert to pre-COVID policies as defined in each waiver-related Kentucky Administrative Regulation after November 11, 2023. Some waiver Kentucky Administrative Regulations allow for telephonic contact. Please review the waiver Kentucky Administrative Regulations for details. DMS is still evaluating future telehealth policy for 1915(c) HCBS waivers. Any permanent updates will need to be added to future waiver amendments and Kentucky Administrative Regulations for approval.

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Q8: If a non-case management provider agency doesn't have enough staff to send a representative to an in-person person-centered service plan meeting, can they still attend virtually?

Date Added: 08/11/23

The person-centered planning meeting should consist of the case manager, the participant, the participant's guardian and/or authorized representative (if needed), a representative from each provider agency delivering services to the participant, and any other individual(s) of the participant's choosing. If a non-case management provider is unable to send a representative in-person, the representative may attend via remote options.

Q9: Can the person-centered planning team meeting and required case management contacts be completed remotely once Appendix K expires?

Date Added: 08/11/23

The frequency and method of the person-centered planning team meeting and required case management contacts will revert to pre-PHE policies as defined in each waiver-specific Kentucky Administrative Regulation. DMS is still evaluating future telehealth policy for 1915(c) HCBS waivers. Any permanent updates will need to be added to future waiver amendments and Kentucky Administrative Regulation updates for approval.

Q10: If a case management agency does not have the capability to provide services using remote options (such as FaceTime, Skype, etc.), are they allowed to conduct waiver participant visits via phone?

Date Added: 3/20/20

Yes, it is acceptable to conduct meetings with waiver participants via phone if an agency does not have the capability to conduct meetings via remote options.

Q11: How should a case manager/support broker/service advisor obtain any necessary signatures for visits that took place via phone or online?

Revised: 04/28/23

Consent may be obtained verbally from the participant and/or authorized representative. Provider consent to deliver the services must be obtained in writing. This can include an electronic signature, an email, or via text message documented by a screenshot. Notes should indicate the signatures were collected either verbally, through email, or by text due to COVID-19.

If the participant is unable to consent verbally, please have them or their authorized representative sign at the next face-to-face visit and note the reason for a lack of signature in the case note.

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Q12: How should a case manager/support broker/service advisor complete and upload monthly notes for visits that took place via phone or online? What should be entered for note type and meeting location?

Revised: 4/24/20

The case manager/support broker/service advisor should use the “Monthly Summary” option as the “Note Type” and use the “Phone Contact” option as the “Meeting Location” when recording the monthly case note in the Medicaid Waiver Management Application (MWMA). The note should be detailed and include the date and time the meeting took place, how it was conducted (i.e. via phone, Skype, etc.). Please be sure to indicate COVID-19 as the reason the meeting did not occur face-to-face.

Q13: Do providers need to continue submitting incident reports when a participant experiences a service disruption due to COVID-19, tests positive for COVID-19, or is exposed to provider staff who have tested positive for COVID-19?

Date Added: 04/28/23

Providers no longer need to submit incident reports for service disruptions caused by COVID-19, positive COVID-19 cases, or COVID-19 exposures unless they fall under the reporting requirements outlined in the [Incident Reporting Instructional Guide for 1915\(c\) HCBS Waiver Services](#). For example, the death of a participant due to COVID-19 would still be reported as DMS requires an incident report for any participant's death.

Q14: How have the requirements for case managers/support brokers/service advisors changed under Appendix K? Will these requirements be made permanent?

Date Added: 08/11/23

Per Appendix K, Licensed Practical Nurses (LPN), individuals who have an associate’s degree, and individuals with relevant experience that substitutes for a degree can be hired as a case manager/support broker/service advisor for any waiver except MIIW. 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.

- If an individual is an LPN or has a degree in a human services field, they are not required to have any experience.
- If an individual who has a degree that is not in a human services field, they should have relevant work experience. For example, an individual with a degree in accounting must have experience relevant to the waiver programs and/or waiver population as their degree coursework would not have prepared them to work in this field.
- If an individual does not have a degree, they should have relevant experience with the waiver programs and/or waiver population.

Individuals hired as a case manager/support broker/service advisor who are LPNs or have an associate’s degree and/or relevant experience should undergo the same training as current case managers/support brokers/service advisors, however, DMS will allow a grace period of ninety (90) days for completion. Case managers/support brokers/service advisors should be able to competently

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handle waiver participant cases before they begin working on their own and are allowed to perform all the same functions of the job as any other case manager/support broker/service advisor.

Q15: 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.

Q16: Will the provider qualification modifications for case managers become permanent after Appendix K expires?

Revised: 04/28/23

DMS recognizes the need for expanded provider qualifications to increase the number of case managers. Our goal is to evaluate provider qualifications and make these updates permanent in future waiver amendments and Kentucky Administrative Regulation updates.

Q17: How should a case manager/support broker/service advisor request Home Delivered Meals on the person-centered service plan for ABI/ABI LTC, MPW or SCL?

Date Added: 4/7/20

DMS issued updated billing instructions for this service on April 6, 2020. The updated billing instructions are available at <https://chfs.ky.gov/agencies/dms/dca/Documents/covid19waiverbilling.pdf>.

Q18: What is the billing code for Home Delivered Meals? Is it in the MWMA dropdown menu?

Date Added: 4/7/20

For provider type 42, use code 991. For all other provider types, use code S5170.

Q19: What is the reimbursement rate for Home Delivered Meals?

Date Added: 4/7/20

Home Delivered Meals will be reimbursed at the current rate for HCB, which is \$7.50 per meal. This information is in 907 KAR 7:015 (<https://apps.legislature.ky.gov/law/kar/907/007/015.pdf>) and is included in updated billing instructions available at <https://chfs.ky.gov/agencies/dms/dca/Documents/covid19waiverbilling.pdf>.

Q20: How is the cost of meal prep and transport billed when providing Home Delivered Meals?

Date Added: 4/24/20

Home Delivered Meals will be reimbursed at the current rate for HCB, which is \$7.50 per meal. This information is in 907 KAR 7:015 (<https://apps.legislature.ky.gov/law/kar/907/007/015.pdf>) and is

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included in updated billing instructions available at <https://chfs.ky.gov/agencies/dms/dca/Documents/covid19waiverbilling.pdf>.

Q21: Will ADHCs be reimbursed for Home Delivered Meals?

Date Added: 4/7/20

Yes. Home Delivered Meals will be reimbursed at the current rate for HCB, which is \$7.50 per meal. This information is in 907 KAR 7:015 (<https://apps.legislature.ky.gov/law/kar/907/007/015.pdf>) and the updated billing instructions are available at <https://chfs.ky.gov/agencies/dms/dca/Documents/covid19waiverbilling.pdf>.

Q22: When providing Home Delivered Meals, can an ADHC bill Attendant Care for the time it takes to prepare and deliver meals?

Date Added: 4/24/20

No, this is an inappropriate use of Attendant Care and potential duplication of services. Reimbursement of Home Delivered Meals is intended to fund obtaining food, preparing, and delivering the meal. Attendants can only bill the time spent preparing a home delivered meal for a participant to eat (i.e. microwaving the meal or preparing a place setting, etc.).

Q23: If a provider is interested in offering Home Delivered Meals under Appendix K, who should they contact to get approval?

Date Added: 4/7/20

Providers, regardless of which waiver(s) they currently service, may provide Home Delivered Meals and do not need DMS approval while Appendix K is in effect. The definition of Home Delivered Meals in Appendix K is available at <https://chfs.ky.gov/agencies/dms/dca/Documents/appendixk.pdf>. DMS issued updated billing instructions for this service on April 6, 2020. The updated billing instructions are available at <https://chfs.ky.gov/agencies/dms/dca/Documents/covid19waiverbilling.pdf>.

Q24: Can a case management agency provide Home Delivered Meals to the participants they serve?

Date Added: 4/7/20

Yes, this is allowed under Appendix K. Conflicted services will still be reviewed but there will be more consideration given to exceptions beyond the 30-mile radius due to COVID-19.

Q25: Can an agency provide Home Delivered Meals to participants they do not currently serve?

Date Added: 4/24/20

Yes, an agency can provide this service to any 1915(c) HCBS waiver participant who needs it, except for participants of the Model II waiver. The participant's case manager should modify the person-centered plan to add this service.

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Q26: If a participant returns to ADHC or ADT after it reopens, can they continue to receive Home Delivered Meals? If so, how should this be worded in MWMA?

Date Added: 6/24/20

Yes, a participant can continue to receive the expanded Home Delivered Meals on dates of service where they do not attend ADHC or ADT. This is allowed until Appendix K expires. The case manager/support broker/service advisor should indicate in MWMA how many days of the week the participant attends ADHC or ADT and how many days they receive Home Delivered Meals.

Q27: Is a listing of Home Delivered Meals providers available?

Revised: 4/24/20

DMS compiled a listing of providers offering home delivered meal under Appendix K. It is available at <https://bit.ly/kycovid19hdm>.

If an agency plans to provide Home Delivered Meals, please submit your name, county and contact information to the 1915(c) Waiver Help Desk at 1915cWaiverHelpDesk@ky.gov or (844) 784-5614. Please let other providers in your area know if you plan to offer Home Delivered Meals as well.

Q28: What types of Home Delivered Meals can be provided?

Revised: 04/01/21

Providers can deliver hot, shelf-stable or frozen meals. Any provider of Home Delivered Meals should be considerate of the participant's dietary needs and preferences when delivering the service and adhere to food safety best practices such as those described by the U.S. Department of Agriculture (USDA). Information is available at <https://www.fsis.usda.gov/food-safety>.

The Home Delivered Meals service is for the delivery of meals only. This service cannot be used for the purchase and delivery of bulk groceries.

Q29: Can an agency sub-contract with a frozen meal provider under Appendix K?

Date Added: 4/7/20

Yes, this is allowed until Appendix K expires.

Q30: Do the meals provided have to come from a licensed catering company?

Date Added: 4/7/20

No, however, any provider of Home Delivered Meals should be considerate of the participant's dietary needs and preferences when delivering the service and adhere to food safety best practices such as those described by the USDA. Information is available at <https://www.fsis.usda.gov/food-safety>.

COVID-19 and Appendix K –Frequently Asked Questions

Q31: Can a provider work with a local restaurant or catering company to deliver meals to participants?

Date Added: 4/24/20

Yes, this is allowed under Appendix K. Any provider of Home Delivered Meals should be considerate of the participant's dietary needs and preferences when delivering the service and adhere to food safety best practices such as those described by the USDA. Information is available at <https://www.fsis.usda.gov/food-safety>.

Q32: Can two meals be delivered at once? For example, can a provider deliver at 10:30am for lunch and drop off breakfast for the following day?

Date Added: 4/24/20

Yes, a provider can drop off multiple meals at once. Meals can be hot, shelf-stable, or frozen. Any provider of Home Delivered Meals should be considerate of the participant's dietary needs and preferences when delivering the service and adhere to food safety best practices such as those described by the USDA. Information is available at <https://www.fsis.usda.gov/food-safety>.

Q33: Can participants receive up to three meals per day?

Revised: 04/28/23

No, CMS only allows Medicaid to reimburse up to two meals per day. Participants who need assistance with grocery shopping or meal prep can receive one of the following services:

- **ABI:** Companion
- **ABI LTC:** CLS
- **HCB:** Attendant Care/Home and Community Supports
- **MPW:** CLS
- **SCL:** Personal Assistance

Participants can access a third meal using non-Medicaid funded programs.

Q34: Can a participant in residential receive Home Delivered Meals?

Revised: 4/24/20

No, the residential provider remains responsible for providing meals for participants in Supervised Residential Level I, II, and III in ABI and ABI LTC and Residential Support Level I and II in SCL. DMS is allowing participants in Technology Assisted Residential in SCL to receive Home Delivered Meals.

COVID-19 and Appendix K –Frequently Asked Questions

Q35: Can a PDS participant receive Home Delivered Meals?

Date Added: 4/24/20

Yes. In most situations this is allowed as DMS wants all participants to have access to food during COVID-19. This includes situations where a PDS participant lives alone, lacks natural supports, or is having difficulty acquiring food due to financial concerns, access to the grocery store, or the absence of a caregiver because of COVID-19. Duplicate billing of Home Delivered Meals and PDS completion of shopping and meal preparation is not permitted, beyond what is required to prepare a Home Delivered Meal for the participant to eat (i.e. microwaving the meal or preparing a place-setting, etc.).

Q36: Is the meal required to meet certain nutritional guidelines?

Date Added: 4/24/20

Any provider of Home Delivered Meals should be considerate of the participant's dietary needs and preferences when delivering the service and adhere to food safety best practices such as those described by the USDA. Information is available at <https://www.fsis.usda.gov/food-safety>.

Q37: How will Home Delivered Meals change after Appendix K expires?

Date Added: 08/11/23

After November 11, 2023, Home Delivered Meals will revert to pre-PHE policy. Home Delivered Meals will only be available to participants in the HCB waiver and the limit will go back to one hot meal per day and five hot meals per week. Participants in HCB cannot receive Home Delivered Meals while they are at the ADHC, however, they can receive one meal during the timeframe when they are not at ADHC.

Q38: Can providers deliver services remotely due to COVID-19?

Revised: 08/11/23

Due to the widespread availability of precautionary measures, such as vaccines and masks, **DMS encourages providers to return to in-person services when possible.** DMS recognizes COVID-19 still poses a threat to some 1915(c) HCBS waiver participants and service delivery via telehealth remains allowable until Appendix K expires.

Services that could be provided via telehealth include:

- Physical, Occupational, or Speech Therapy
- Supported Employment
- Behavior supports and counseling services
- In-home services such as Personal Care or Homemaking (cueing and prompting support only)
- Case Management.

Participation in services via telehealth should be wanted by the participant, person-centered, meaningful, and advance established goals. Hands-on direct care services can only be reimbursed if performed in person.

COVID-19 and Appendix K –Frequently Asked Questions

Q39: Will providers continue to be allowed to deliver services via telehealth after Appendix K expires?

Date Added: 08/11/23

Service requirements will revert to pre-COVID policies as defined in each waiver-related KAR.

While waiver services are community-based, DMS recognizes allowing participants to interact with healthcare professionals and providers via telehealth can be both beneficial and person-centered. DMS will consider incorporating some form of telehealth into the 1915(c) HCBS waivers permanently. Any permanent policy changes will be made through future waiver amendments and Kentucky Administrative Regulation updates.

Q40: If a provider delivers a service via telehealth, does the participant's person-centered service plan need to be revised beforehand?

Date Added: 4/7/20

No, plans do not need to be revised before delivering services via telehealth. A case note should be entered that reflects any dialogue with the participant and the person-centered team about this shift, the participant's desire to make the shift, and any outcomes of discussions.

Q41: If services are provided through a telehealth platform, how should they be documented in the note?

Date Added: 4/7/20

This change only modifies the method in which the service is being delivered. All standard post-delivery documentation practices still stand and should continue, including case manager oversight and monitoring of the effectiveness of service delivery. The case note should reflect any dialogue with the participant and the person-centered team about this shift, the participant's desire to make the shift, and any outcomes of discussions.

Q42: Are verbal consents for telehealth permissible?

Date Added: 4/7/20

Participation in services via telehealth should be wanted by the participant, person-centered, meaningful, and advance established goals.

A case note should be entered that reflects any dialogue with the participant and the person-centered team about this shift, the participant's desire to make the shift, and any outcomes of discussions.

Q43: Do telehealth services have to be provided through a video conferencing platform or can they be provided over the phone?

Revised: 04/28/23

Telehealth services are most appropriate for services where providers are instructing or cueing the participant and, therefore, providers need the video component to monitor that care and services are delivered successfully advanced a need or goal.

COVID-19 and Appendix K –Frequently Asked Questions

Participation in services via telehealth should be wanted by the participant, person-centered, meaningful, and advance established goals. A case note should be entered that reflects any dialogue with the participant and the person-centered team about this shift, the participant’s desire to make the shift, and any outcomes of discussions.

Q44: Which platforms are approved for telehealth during COVID-19?

Revised: 08/11/23

The Office for Civil Rights (OCR) within the Department of Health and Human Services (HHS) relaxed its enforcement of the Health Insurance Portability and Accountability Act (HIPAA) for certain non-public-facing applications, however, [this relaxed enforcement ended along with the federal PHE at](#) 11:59 p.m. on May 11, 2023. The OCR did not enforce penalties for the good faith provision of telehealth. Common applications that were exempted included, but were not limited to:

- Apple FaceTime
- Facebook Messenger Video Chat
- Google Hangouts Video
- Skype
- Zoom

Please note: Platforms such as the ones listed above are generally not HIPAA-compliant modalities for the provision of telehealth services. [HHS provides a list of some vendors](#) that represent that they have HIPAA-compliant video communication products and will agree to enter into a HIPAA Business Associates Agreement (BAA). Additional guidance on BAAs, including sample BAA provisions, is available at <https://www.hhs.gov/hipaa/for-professionals/covered-entities/sample-business-associate-agreement-provisions/index.html>.

Public-facing services are specifically not allowed by OCR and should not be used for the provision of telehealth. These include, but are not limited to:

- Facebook Live
- Twitch
- TikTok

OCR gave a 90-day transition period for providers to come into compliance with HIPAA rules for telehealth. The transition period began on May 12, 2023, and ended at 11:59 p.m. on August 9, 2023.

COVID-19 and Appendix K –Frequently Asked Questions

Q45: A waiver participant is experiencing difficulty finding needed supplies, such as incontinence supplies. How can providers help them?

Date Added: 3/24/20

DMS will allow Goods and Services providers to provide supplies to participants in all waivers, regardless of which waiver the provider typically serves. For example, a provider who only bills Goods and Services through HCB can bill for this service using any waiver under Appendix K. Providers of Goods and Services who are authorized by Medicaid programs in other states may also furnish and bill for supplies.

Q46: When trying to obtain supplies for waiver participants, should the case manager/support broker/service advisor do a modification if they need to use a different source than what is prior authorized on the participant's plan?

Revised: 04/28/23

Case managers/support brokers/service advisors should only modify the source on the plan if they run out of funds approved on the prior authorization.

Q47: If a participant is currently receiving Residential Support Level II in SCL, are they also eligible to receive Respite due to COVID-19?

Revised: 04/28/23

Yes, this is allowed for Residential Support Level II in the SCL waiver only. Residential Support Level II includes participants residing in adult foster care or with a family home provider.

Throughout the PHE, DMS has received feedback indicating access to Respite has been helpful to Residential Support Level II providers. DMS is considering making this allowance permanent in future waiver amendments and Kentucky Administrative Regulation updates.

Q48: Can an employee, PDS or agency, begin work without a completed background check?

Revised: 04/28/23

This is allowed until Appendix K expires, however, **DMS requests agencies return to pre-COVID background screening procedures when possible.**

If the results of a background check or other screening make the employee ineligible and they have already started working, services will be allowed to continue until an alternative employee is found. The exception is cases where the employee poses immediate jeopardy to the health, safety, and/or welfare of the participant or has a substantiated finding of past abuse, neglect, exploitation, or violent felony.

COVID-19 and Appendix K –Frequently Asked Questions

Q49: Can provider agencies or PDS employers use background checks on an employee that were completed by a different provider agency or PDS employer?

Date Added: 3/24/20

Yes, this is allowed under Appendix K.

Q50: Do employers, agency or PDS, need proof background checks were requested prior to the employee delivering services?

Date Added: 4/24/20

Agency and PDS employers should retain documentation of when the background check was requested.

Q51: When a PDS employee is hired using a background check done by another PDS employer or by an agency, will a new background check need to be done once Appendix K expires or will the previously completed background check be sufficient?

Revised: 04/28/23

The typical PDS employee background check requirements will be reinstated when Appendix K expires. When possible, employees should continue to work to confirm these pre-employment requirements. This includes obtaining an updated background check.

To reduce the burden on participants using PDS, DMS is considering changes to the PDS background check policy in future waiver amendments and Kentucky Administrative Regulation updates.

Q52: Will immediate family members approved as PDS employees under Appendix K have to undergo the normal approval process once it ends? Will they have to stop services immediately or can they continue to work until the Department for Aging and Independent Living (DAIL) makes a decision on the immediate family member request?

Revised: 08/11/23

Yes, the immediate family member must undergo the approval process as required by the applicable waiver program once Appendix K ends. The approval process will take place at the time of the participant's annual re-certification. The immediate family member **is allowed to continue working** as the participant's PDS employee after Appendix K expires and while going through the approval process.

Q53: Can the immediate family member approval process be sent to DAIL before November 11, 2023, and/or before the participant's recertification date?

Date Added: 08/11/23

No, please do not initiate the immediate family member approval process before the participant's recertification date. DMS and DAIL will send more information about the process closer to expiration date of Appendix K. The immediate family member **is allowed to continue working** as the participant's PDS employee after Appendix K expires and while going through the approval process.

Version 4

Updated: 09/01/23

COVID-19 and Appendix K –Frequently Asked Questions

Q54: Once Appendix K expires, how long will agency and PDS employees have to update requirements (such as training, CPR and first aid certifications, and tuberculosis screenings)?

Revised: 08/11/23

All DSPs and PDS employee should be up to date on CPR certification requirements when Appendix K expires on November 11, 2023.

Q55: Online options for CPR certification have become more common since the COVID-19 pandemic began. Do online certifications meet waiver CPR and first aid training requirements?

Date Added: 08/11/23

To meet waiver requirements, direct service providers and participant-directed services employees must complete training where they receive a certification from a nationally accredited entity. While many of these entities offer online classes, in-person instruction may be required to complete certification. DSPs and PDS employees should review any CPR course selections closely before enrolling to make sure they complete all requirements needed to receive CPR certification. All DSPs and PDS employee should be up to date on CPR certification requirements when Appendix K expires on November 11, 2023.

COVID-19 and Appendix K –Frequently Asked Questions

Q56: Will the end of the PHE affect Medicaid financial eligibility for waiver participants?

Date Added: 06/28/23

During the PHE, DMS paused annual Medicaid renewals. All Medicaid members must have their financial eligibility for coverage renewed when Kentucky resumes annual Medicaid renewals in April 2023. These renewals will be spread out over 12 months.

DMS will send a notification to each member sixty (60) days before their Medicaid renewal date. To make sure individuals do not miss this notice, case managers/support brokers/service advisors, social workers, and/or the participant's guardians should confirm that the participant's information in kynect is up to date, be aware of the member's renewal date, and ensure that member is responding to notices received. The member will need to take action on these notices. The information in kynect can be updated online at kynect.ky.gov or by calling kynect at (855) 459-6328.

After June 30, 2023, case managers/support brokers/service advisors may run a Medicaid Renewal Report in MWMA to generate a list of all participants who have a renewal coming up in given month. A user guide for running the report is [available in TRIS](#).

Case managers/support brokers/service advisors who want a report before June 30 may contact the 1915(c) Waiver Help Desk via phone at (844) 784-5614 or via email at 1915cWaiverHelpDesk@ky.gov to have a report run. When contacting the 1915(c) Waiver Help Desk, please include the month for which you want the report and the name of your agency.

More information about Medicaid renewals is available at <https://khbe.ky.gov/Enrollment/Pages/PHEUnwinding.aspx>

Temporary 50% Rate Increase and 85% Pass-Through Requirement

Q57: 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.

Q58: Is there a deadline for the expenditure of the funds generated by the March 2022 temporary 50% rate increase?

Date Added: 05/13/22

No, there is no deadline for the 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 the use of the funds met the 85% pass-through requirement.

COVID-19 and Appendix K –Frequently Asked Questions

Q59: Which services are eligible for the temporary 50% rate increase?

Revised: 04/28/23

The following services are eligible for the temporary 50% rate increase. The increased rate is 50% of the approved reimbursement rate in effect on December 31, 2019. The increased rate applies to traditional services only and in all waivers unless otherwise specified. **Providers billing the temporary 50% rate increase cannot also bill the 10% rate increase in the 2022-2024 biennial budget bill.**

- 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
- 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.

Q60: Where can the approved reimbursement rate in effect on December 31, 2019, for each waiver be found?

Revised: 04/28/23

For most waivers, the approved reimbursement rate in effect on December 31, 2019, 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](#).

COVID-19 and Appendix K –Frequently Asked Questions

Q61: How do providers receive the temporary 50% 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 50% 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 50% rate increase must also complete an attestation form confirming that 85% of the increased rate will be passed on to direct service workers.

Q62: Will case managers have to modify all person-centered service plans?

Revised: 04/28/23

The Medicaid Management Information System (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 update the participant's PCSP or until the participant's re-certification, whichever comes first.

Q63: Are there new billing codes for services eligible for the temporary 50% 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](#).

Q64: Are there billing instructions for the temporary 50% rate increase?

Revised: 04/28/23

No. Providers should continue to bill the same way they do today.

Q65: Do providers need new prior authorizations that reflect the temporary 50% rate increase?

Date Added: 04/28/23

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.

COVID-19 and Appendix K –Frequently Asked Questions

Q66: How does a provider adjust claims if they bill using the Netsmart Mobile Caregiver+ Electronic Visit Verification (EVV) system?

Revised: 04/28/23

Directions for adjusting claims are available in 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. Alternatively, providers can adjust claims through MMIS even if they originally billed using EVV.

Q67: Does the temporary 50% rate increase approved in March 2022 eliminate the additional unit of case management allowed under the Appendix K amendment approved in March 2020?

Revised: 08/11/23

If a case manager/support broker/service advisor feels an individual case requires support beyond what is expected of a case manager/support broker/service advisor, please contact the 1915(c) Waiver Help Desk at (844) 784-5614 or 1915cWaiverHelpDesk@ky.gov.

Q68: Does the temporary rate increase apply if eligible services are provided via telehealth?

Revised: 04/28/23

Yes, services delivered via telehealth are eligible for the 50% temporary rate increase.

Due to the widespread availability of precautionary measures, such as vaccines and masks, **DMS encourages providers to return to in-person services when possible**. DMS recognizes COVID-19 still poses a threat to some 1915(c) HCBS waiver participants and service delivery via telehealth remains allowable until Appendix K expires.

Telehealth services should meet the participant's needs, be wanted by the participant, person-centered, meaningful, and advance established goals.

Q69: Appendix K – March 2022 requires provider agencies to pass-through 85% of the temporary 50% rate increase to direct service workers. In what ways must provider agencies pass on these funds?

Revised: 04/28/23

Providers must pass on 85% of the temporary 50% rate increase 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.

Providers must outline how they plan to meet the 85% pass-through requirement when submitting the [Appendix K Temporary Rate Increase Attestation Form](#), which is required before billing the temporary 50% rate increase.

COVID-19 and Appendix K –Frequently Asked Questions

Q70: What is required in the attestation for providers billing the temporary 50% rate increase?

Date Added: 04/22/22

Providers should complete the [Appendix K Temporary Rate Increase 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.

Q71: 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 50% 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%.

Q72: 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.

Q73: 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 50% 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.

Q74: 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.

COVID-19 and Appendix K –Frequently Asked Questions

Q75: 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 wages 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.

Q76: 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.

Q77: 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.

Q78: Should the temporary rate increase for MPW case management be billed in one monthly unit or 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.

Q79: Is Respite in MPW included in the temporary 50% rate increase?

Revised: 06/28/23

Because Respite in MPW does not have a set rate per unit, it is not included in the temporary 50% rate increase. The provider determines the rate billed based on the participant's individual, person-centered need and the level of experience of the direct service worker.

COVID-19 and Appendix K –Frequently Asked Questions

Q80: How does the temporary 50% rate increase affect the yearly service limit for MPW participants?

Revised: 09/01/23

The \$40,000/\$63,000 yearly limit was temporarily increased under the initial Appendix K approved in March 2020 and will remain in effect until Appendix K expires. DMS recognizes after the expiration of Appendix K, the current \$40,000/\$63,000 limit could unintentionally cause a reduction in needed services for participants. Case managers and support brokers should base the PCSP on each participant's assessed need, goals, and desired outcomes. Service needs should be thoroughly documented in the PCSP and case notes and be supported by the participant's functional assessment and other documentation from licensed professional that have active roles in the participant's life. Each request will be reviewed on a case-by-case using this documentation. In some cases, the limits may be exceeded. Recoupments will not be issued if the PCSP cost exceeds the \$40,000/\$63,000 limit and the services delivered were authorized on the PCSP.

DMS is evaluating whether to continue with a dollar amount limit in MPW or shift to limits on individual services in the future. If the MPW limit remains a dollar amount, it will be adjusted based on rate increases to ensure no MPW participants will see a reduction in services and can continue to receive the person-centered level of support they need. Any update to limits in MPW will be made in future waiver amendments and Kentucky Administrative Regulation updates. Stakeholders will have the opportunity to comment on any waiver amendments or Kentucky Administrative Regulation updates before they are final.

Q81: What happens to the 50% temporary rate increase when Appendix K expires?

Date Added:

The temporary 50% rate increase will be discontinued after November 11, 2023. Beginning November 12, 2023, providers can bill the legislature-directed rate that went into effect on July 1, 2023.

Q82: Will rates in the Netsmart EVV system for services eligible for the temporary 50% rate increase update automatically after November 11, 2023, or do providers need to make adjustments in the systems?

Date Added:

For traditional services, the maximum rate in Netsmart EVV is the temporary 50% Appendix K rate. If a provider agency is billing the reimbursement rate for state fiscal year 2023-2024, the agency should enter override rates in the EVV system. Directions for entering an override rate are available at <https://bit.ly/evvqrgoverriderates>.

Legislature-Directed Rate Increase

Q83: What changes are included in the March 2023 version of Appendix K?

Revised: 08/11/23

The Appendix K amendment approved in March 2023 implemented rate increases for state fiscal year 2022-2023 that were approved by the Kentucky General Assembly in the 2022-2024 biennial state budget. Based on discussions with CMS, DMS was advised the most efficient way to advance the

Version 4

Updated: 09/01/23

COVID-19 and Appendix K –Frequently Asked Questions

biennial budget bill rate increases was to submit an Appendix K amendment. Use of the Appendix K amendment was recommended because DMS does not have a long-term approved rate methodology in its existing 1915(c) HCBS waivers.

The approved 2022-2024 budget bill and subsequent Appendix K amendment included the following increases for ABI, ABI LTC, HCB, MPW, and SCL:

- The 50% rate increase available under Appendix K for some residential services became **permanent in the 2022-2024 biennial budget**. This applied to SCL Residential Support Level I and all ABI and ABI LTC residential services.
- All other services in ABI, ABI LTC, HCB, MPW, and SCL received a 10% rate increase in state fiscal year 2022-2023 and an additional 10% rate increase in state fiscal year 2023-2024.

Q84: When does the rate increase take effect?

Revised: 08/11/23

The first 10% of the rate increase took effect at the start of the 2022-2023 state fiscal year on July 1, 2022. The second 10% of the rate increase took effect at the start of the 2023-2024 state fiscal year on July 1, 2023.

Q85: When can providers begin billing the legislature-directed increase?

Revised: 08/11/23

MMIS updates are complete, and providers can bill the legislature-directed increase at any time.

Q86: How is the additional 10% calculated for services that received a second 10% rate increase in the 2023-2024 state fiscal year?

Date Added: 08/11/23

The additional 10% is calculated using the July 1, 2022, rate. Here is an example using the Community Access, Individual service in the Supports for Community Living waiver.

Base Rate (as of December 31, 2019) = \$8.80 per unit.

July 1, 2022 Rate (Base Rate + 10%) = \$9.68 per unit.

July 1, 2023 Rate (July 1, 2022 rate + 10%) = \$10.65 per unit.

DMS will release a listing of all current waiver rates soon.

Q87: Is the legislature-directed rate increase permanent?

Date Added: 04/28/23

The legislature-directed rate increase will last the duration of the 2022-2024 biennial budget.

Per House Bill 1, *“It is the intent of the 2022 General Assembly that General Fund dollars will be appropriated to maintain the funding initiatives outlined in paragraph (a) of this subsection after the funds from the enhanced FMAP for Home and Community Based Services authorized by Section 9817 of the American Rescue Plan Act of 2021 are no longer available.”*

COVID-19 and Appendix K –Frequently Asked Questions

Q88: What action do traditional providers need to take to receive the legislature-directed rate increase for state fiscal year 2022-2023?

Revised: 08/11/23

DMS completed a mass adjustment for eligible claims with paid dates April 17, 2023, or earlier. Providers are responsible to adjust any claims for paid dates April 18, 2023, or later billed at the lower rate.

Q89: When will mass adjustments occur?

Revised: 08/11/23

DMS completed a mass adjustment for eligible claims with paid dates April 17, 2023, or earlier. Providers are responsible to adjust any claims for paid dates April 18, 2023, or later billed at the lower rate.

Q90: Which claims from state fiscal year 2022-2023 received a mass adjustment?

Revised: 06/28/23

The mass adjustment for state fiscal year 2022-2023 only applied to claims for **traditional services** where:

- The date of service is July 1, 2022, or later; and
- The service is **only** eligible for the 50% legislature-directed rate increase for Residential services (excluding SCL Residential Support Level II); or
- The service is **only** eligible for the 10% legislature-directed rate increase and the provider did not bill the temporary 50% rate increase (if eligible).

Q91: How were mass adjustments paid out: in a lump sum or per ICN and claim number?

Revised: 06/28/23

Mass adjustments were conducted per ICN.

Q92: Were the mass adjustments linked to claims for reconciliation?

Date Added: 06/28/23

Yes, the mass adjustments were tied to the original claim so providers will be able to compare.

Q93: Did providers receive an ad hoc report of which claims were included in the mass adjustment?

Revised: 06/28/23

No. Providers received updated remittance advice with the adjustment ICN.

COVID-19 and Appendix K –Frequently Asked Questions

Q94: Do providers need a new prior authorization due to the increase in the rate?

Date Added: 04/28/23

No, providers do not need a new prior authorization due to the rate increase.

Q95: Can providers continue billing the temporary 50% Appendix K rate for eligible services until Appendix K expires? Will the provider receive the legislature directed rate increase after the Appendix K rate expires?

Date Added: 04/28/23

Yes, providers have the option to continue billing the temporary 50% Appendix K rate for eligible services. The provider should begin billing the 10% increase rate on claims with dates of service after the expiration of Appendix K.

Q96: If a provider wants to stop billing the temporary 50% Appendix K rate and only bill the legislature-directed rate increase, what do they need to do?

Date Added: 04/28/23

The provider can discontinue billing the temporary 50% Appendix K rate and begin billing the legislature-directed rate increase at any time.

Q97: Does the 85% pass-through requirement apply to legislature-directed rate increases? When will this requirement be discontinued?

Date Added: 04/28/23

No. The Kentucky General Assembly outlined the provisions of the legislative-directed rate increases in the 2022-2024 biennial budget, which does not include any pass-through requirement. Providers billing the legislature-directed rate increases only do not have to meet the 85% pass-through requirement. SCL Residential Support Level I and ABI Residential providers can discontinue the 85% pass-through for claims billed on or after July 1, 2022.

The intent of both the 50% temporary Appendix K rate and the legislature-directed rate increase is to give provider agencies additional funds to recruit and retain a strong direct service provider workforce. In a DMS survey sent in 2021, more than 70% of providers said they believed increased wages would help with direct service provider workforce stabilization and growth. DMS encourages provider agencies to continue investing a portion of the rate increase into the direct service workforce, which will benefit agencies and 1915(c) HCBS waiver participants.

Q98: Does the 85% pass-through requirement apply to providers who choose to bill the 50% temporary Appendix K rate for eligible non-residential services?

Date Added: 04/28/23

Yes. Providers of non-residential services billing the temporary 50% Appendix K rate **must continue** passing through the 85% until Appendix K expires on November 11, 2023.

COVID-19 and Appendix K –Frequently Asked Questions

Q99: Should providers use the COVID-19 code when billing the legislature-directed rate increase for SCL Residential Support Level I or ABI Residential?

Date Added: 04/28/23

Providers can continue billing the code listed on the participant's current prior authorization. When the participant is due for recertification, the case manager/support broker/service advisor should request the service using the pre-COVID code.

Q100: Can the legislature-directed rates be changed so they are equal across waivers for similar services? For example, Personal Care in MPW pays \$8.35 per unit and Personal Assistance in SCL pays \$6.70 per unit.

Date Added: 04/28/23

The 2022-2024 budget bill increases apply to the base rate in effect for each waiver service on December 31, 2019. DMS is unable to change base rates at this time because Kentucky does not have a long-term approved rate methodology in its existing 1915(c) HCBS waivers. DMS recently completed a rate study, which developed a sound payment and rate-setting methodology informed by reasonable and necessary provider costs and aimed to reduce payment disparities across waivers. The rate study findings, along with a financial impact analysis, are with executive CHFS and state leadership for final decisions about implementation.

Q101: Is Respite in MPW included in the legislature-directed rate increase?

Revised: 06/28/23

Respite in MPW does not have a set rate per unit. The provider determines the rate billed based on the participant's individual, person-centered need and the level of experience of the direct service worker. The legislature-directed increase raises the Respite limit for state fiscal year 2022-2023 from \$4,000 to \$4,400.

Q102: Will the \$40,000/\$63,000 expenditure limit in MPW be adjusted to accommodate rate increases?

Revised: 09/01/23

The \$40,000/\$63,000 yearly limit was temporarily increased under the initial Appendix K approved in March 2020 and will remain in effect until Appendix K expires. DMS recognizes after the expiration of Appendix K, the current \$40,000/\$63,000 limit could unintentionally cause a reduction in needed services for participants. Case managers and support brokers should base the PCSP on each participant's assessed need, goals, and desired outcomes. Service needs should be thoroughly documented in the PCSP and case notes and be supported by the participant's functional assessment and other documentation from licensed professional that have active roles in the participant's life. Each request will be reviewed on a case-by-case using this documentation. In some cases, the limits may be exceeded. Recoupments will not be issued if the PCSP cost exceeds the \$40,000/\$63,000 limit and the services delivered were authorized on the PCSP.

Version 4

Updated: 09/01/23

COVID-19 and Appendix K –Frequently Asked Questions

DMS is evaluating whether to continue with a dollar amount limit in MPW or shift to limits on individual services in the future. If the MPW limit remains a dollar amount, it will be adjusted based on rate increases to ensure no MPW participants will see a reduction in services and can continue to receive the person-centered level of support they need. Any update to limits in MPW will be made in future waiver amendments and Kentucky Administrative Regulation updates. Stakeholders will have the opportunity to comment on any waiver amendments or Kentucky Administrative Regulation updates before they are final.

Q103: Is the rate for Michelle P. Waiver assessments increasing?

Date Added: 04/28/23

No. The rate for Michelle P. Waiver assessments is set by the contract between the Cabinet for Health and Family Services and the state’s Community Mental Health Centers.

Q104: Is the \$200 daily maximum in HCB being increased?

Revised: 09/01/23

DMS recognizes with recent rate increases, the current \$200 daily maximum in HCB could unintentionally cause a reduction in needed services for participants. Case managers and service advisors should base the PCSP on each participant’s assessed needs, goals, and desired outcomes. Service needs should be thoroughly documented in the PCSP and case notes and be supported by the participant’s functional assessment and other documentation from licensed professionals that have an active role in the participant’s life. Each request will be reviewed on a case-by-case basis using this documentation. In some cases, the limits may be exceeded. Recoupments will not be issued if the PCSP exceeds the \$200 daily maximum and the services delivered were authorized on the PCSP.

DMS will evaluate the \$200 daily maximum and make any needed adjustments in future waiver amendments and Kentucky Administrative Regulation updates. Stakeholders will have the opportunity to comment on any waiver amendments or Kentucky Administrative Regulation updates before they are final.

Q105: Will waiver-related Kentucky Administrative Regulations be changed to match the legislature-directed increase in base rates?

Date Added: 04/28/23

Yes. DMS recently completed a rate study for all 1915(c) Home and Community Based Services waivers in Kentucky. We anticipate amending the waiver-related Kentucky Administrative Regulations and waiver applications pending decisions about the study implementation.

Q106: Was there another rate increase for non-residential services on July 1, 2023?

Revised: 08/11/23

The 2022-2024 biennial budget included a second increase of 10% for all 1915(c) HCBS waiver services in state fiscal year 2023-2024, except:

- Model II Waiver Services
- SCL Residential Support Level I

COVID-19 and Appendix K –Frequently Asked Questions

- All ABI and ABI LTC Residential Services

Legislature-Directed Rate Increase and PDS

Q107: Are all Participant-Directed Services (PDS) incorporated in the mass adjustment?

Date Added : 06/28/23

No. DMS did not include any services provided by PDS employees in the mass adjustment. Services delivered via the PDS model are exempt from backpay for the July 1, 2022, legislature-directed rate increase.

DMS will adjust claims for Case Management or Support Broker services that were not eligible for the 50% temporary rate increase or where the 50% temporary rate increase was not billed.

Q108: Can PDS employees receive a pay increase for services they have already provided?

Date Added : 06/28/23

No, PDS employees are not eligible for backpay and can only receive a pay increase going forward. As part of the employee contract, the participant will need to choose a future date upon which the PDS employee's pay increase will take effect.

Q109: Why are PDS employees not eligible for back pay?

Date Added : 06/28/23

The intent of the legislature-directed rate increase is to strengthen the direct service provider workforce through recruitment and retention. Back pay is used to compensate providers for pay raises, bonuses, and/or additional benefits already given to direct service workers. PDS employers do not typically incur the same expenses, therefore, back pay is not available for PDS employees. PDS employers have the option to raise employee pay rates going forward.

Q110: Are participants required to increase a PDS employee's pay?

Date Added : 06/28/23

Participants using PDS **are not required** to increase their PDS employee's pay. Participants should make this decision free from pressure or influence from the PDS employee and decisions about pay should be justified based on the type of support the individual PDS employee provides, their skills, and their level of training. PDS employers may also wish to consider whether they are having difficulty recruiting or retaining employees when deciding on a pay rate.

Q111: When can PDS employees begin receiving pay increases? Can it only be done at the time of the participant's recertification?

Date Added : 06/28/23

Participants can request pay increases for their PDS employee(s) at any time, however, Area Development Districts and Community Mental Health Centers are allowed to create a reasonable schedule on which pay increase requests are fulfilled.

COVID-19 and Appendix K –Frequently Asked Questions

It is important to note that while a higher max rate is available, participants using PDS **are not required** to increase their PDS employee's pay. Participants should make this decision free from pressure or influence from the PDS employee and decisions about pay should be justified based on the type of support the individual PDS employee provides, their skills, and their level of training. PDS employers may also wish to consider whether they are having difficulty recruiting or retaining employees when deciding on a pay rate.

Q112: What role does the case manager/support broker/service advisor have in determining PDS employee pay rates?

Date Added : 06/28/23

Case managers/support brokers/service advisors are not responsible to determine the pay rate for a participant's PDS employee(s), however, they can provide guidance throughout the process. This may include explaining the maximum rates and limits for each service, helping them consider each employee's skill and training level, what the employee will do for them and the employee's schedule, and by answering questions about the employee contract and assisting with completion of the employee contract.