

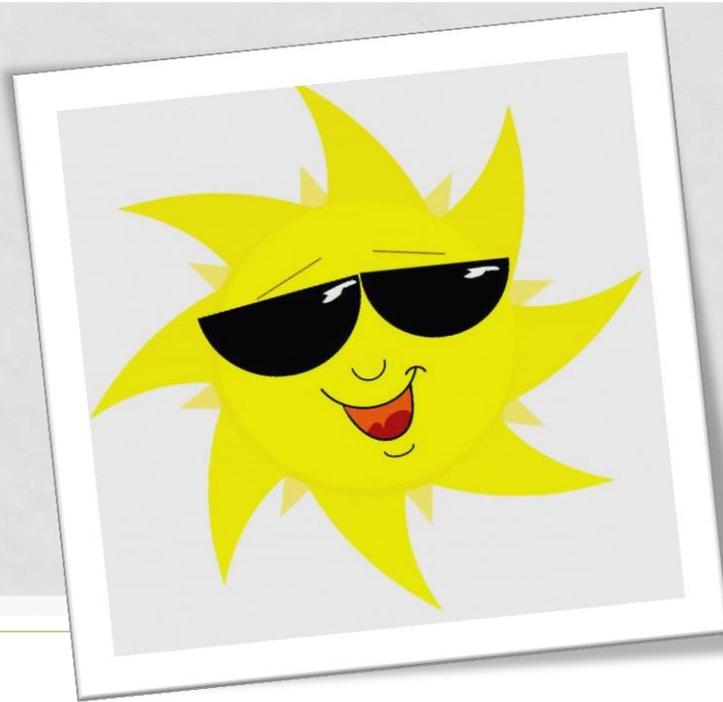


THE HOME AND COMMUNITY BASED WAIVER

RENEWAL

WHAT CHANGES AND
WHAT STAYS THE SAME





INFRASTRUCTURE CHANGES

DEPARTMENT FOR AGING AND INDEPENDENT LIVING (DAIL)

- DAIL will be the operating entity for the Home and Community Based Waiver effective July 1, 2015.
- An operating entity oversees the daily operations of the waiver, provides technical assistance and monitors providers on behalf of the Medicaid agency.
- An operating entity does not set policy. Policy is still the responsibility of the Department for Medicaid Services. DMS maintains ultimate responsibility for the waiver.

DAIL SERVICES AND PROGRAMS

- Oversees:
 - Brain Injury Trust Fund and Behavioral program
 - Aging programs
 - OAA
 - Homecare
 - Caregiver
 - State Long Term Care Ombudsman program
 - Physical Disability programs
 - Hart Supported Living
 - Personal Care Assistance Program
 - Consumer Directed Option (CDO) and Participant Directed Services (PDS) for DMS waivers.
 - Financial Management services for participant directed programs
 - State guardianship program with 4,000 wards of the state.
 - Home and Community Based Waiver

RESTRUCTURING AGING AND DISABILITY SERVICES

GOALS

1. Ensure that elderly and physically disabled Kentuckians and their families and caregivers can easily obtain information about long term care services.
2. Create a coordinated and streamlined single point of entry into long term care services for elderly and physically disabled adults regardless of the funding source
3. Create a coordinated care management process that encompasses an holistic approach to preventive, transitional and on-going care.
4. Expand community based alternatives to create a full, versatile and seamless array of long term care services.
5. Maximize funding by standardizing funding options and financial eligibility requirements.

KEY WAIVER CHANGES

- Independent Assessment
- Use of ADRCs as entry point
- Screening through Waiver Management System
- Conflict-free Case Management
- Expanded Provider Base
- Increased Adult Day Unit Rate and Hours
- Increased Environmental Modifications and added PERS

KEY WAIVER CHANGES

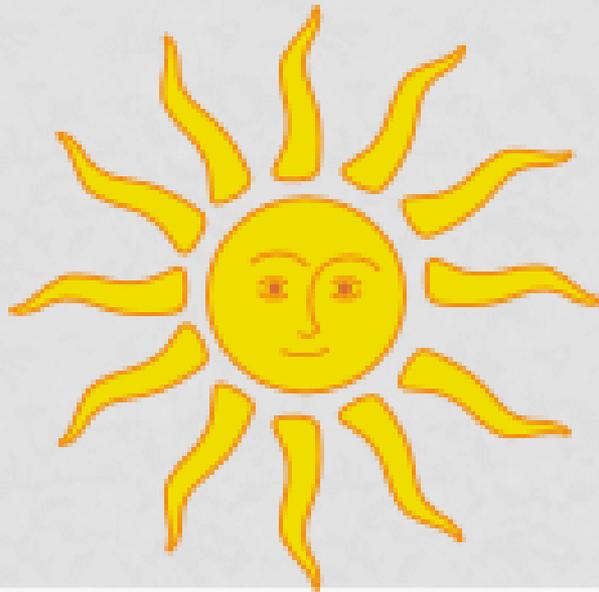
- Transition of therapies (OT, PT and SP) to state plan
- Goods and Services available in traditional
- Combined personal care and homemaking with attendant care
- Allows waiver services beyond the CON boundaries
- Person Centered Team Meetings and Plans
- Increased Participant Directed Services (PDS) requirements



PROVIDER EXPANSION

EXPANDED PROVIDERS

- Home Health Agencies
- Adult Day Health Care Centers
- Centers for Independent Living
- Area Agencies on Aging and Independent Living
- Approved meal providers
- Public Health Departments
- Participant Directed Services employees



PROVIDER TERRITORY

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BEYOND THE CON AND BACK

- Home Health and Adult Day Health Centers are confined to CON boundaries when providing Adult Day Health Care Services or Home Health Services.
- Home Health and Adult Day Health as business entities are **NOT** confined to the CON licensure boundaries for non-medical waiver services.
- If the provider is providing a waiver service, waiver regulations apply.
- If the provider is providing a state plan service, state plan regulations apply.
- If the provider is providing Medicare services, Medicare regulations and requirements apply.

ASK: Who is the payor and that will guide the rules.

MEDICARE/MEDICAID

- WHO DOES WHAT?
 - If Home Health is providing a Medicare health service (bundled), the attendant care service in waiver can still be provided.
 - The home health aide would provide personal care, the waiver attendant would provide all other services.
 - The attendant care hours may be less during that time but will be individualized depending on what is happening in the home.



SERVICES AND PROVIDERS

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SERVICES AND PROVIDERS

- Conflict Free Case Management
 - Adult Day Health Care, Home Health, Centers for Independent Living, Area Agencies on Aging and Independent Living and Public Health Departments.
- Adult Day Health Care
 - Adult Day Health Care
- Attendant Care
 - Adult Day Health Care, Home Health, Centers for Independent Living, Area Agencies on Aging and Independent Living
- Specialized Respite
 - Adult Day Health Care and Home Health

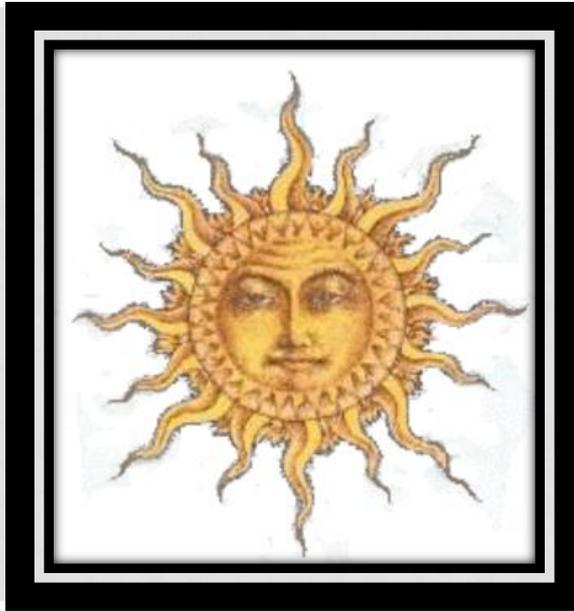
SERVICES AND PROVIDERS

- Goods and Services
 - Adult Day Health Care, Home Health, Area Agencies on Aging and Independent Living and Participant Directed Vendors
- Environmental and Home Modifications
 - Adult Day Health Care, Home Health, Centers for Independent Living, Area Agencies on Aging and Independent Living, and Participant Directed Vendors
- Home delivered meals
 - Approved meal providers

SERVICES AND PROVIDERS

- Participant Directed Coordination
 - Adult Day Health Care, Home Health, Centers for Independent Living, Area Agencies on Aging and Independent Living *Must have fiscal intermediary experience
- Non-Specialized Respite
 - PDS employees
- Home and Community Supports
 - PDS employees

SERVICE DEFINITIONS



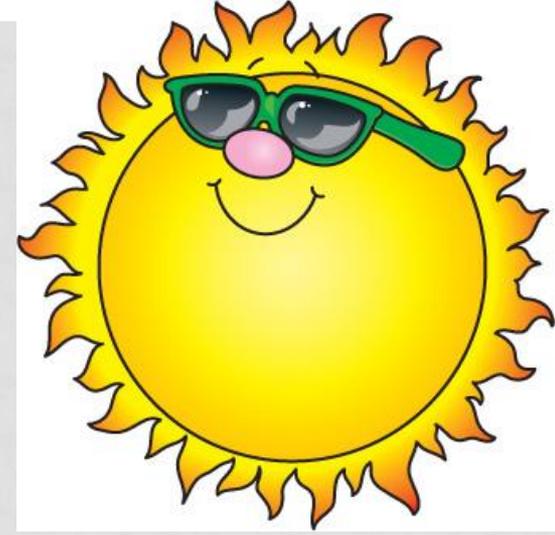
CONFLICT FREE CASE MANAGEMENT

DEFINED

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CONFLICT-FREE DEFINED

- **“Conflict free”** requires that a provider, *(including any subsidiary, partnership, not-for-profit, or for-profit business entity that has a business interest in the provider)*, who renders case management to an individual, must not also provide waiver services to that same individual, unless the provider is the only willing and qualified provider in the geographical area (30 miles from the participant’s residence).



ATTENDANT CARE

DEFINED

ATTENDANT CARE

- Attendant Care may include hands-on-assistance (actually performing a task for the person), reminding, observing, and/or guiding a waiver participant in ADLs (such as bathing, dressing, toileting, transferring and maintaining continence) and IADLs (more complex life activities such as personal hygiene, light housework, laundry, meal planning and preparation, transportation, shopping, community involvement, money management, and assistance with medication administration). This service may also include making medical appointments and accompanying the participant during medical appointments but does not include the provision of direct medical services.

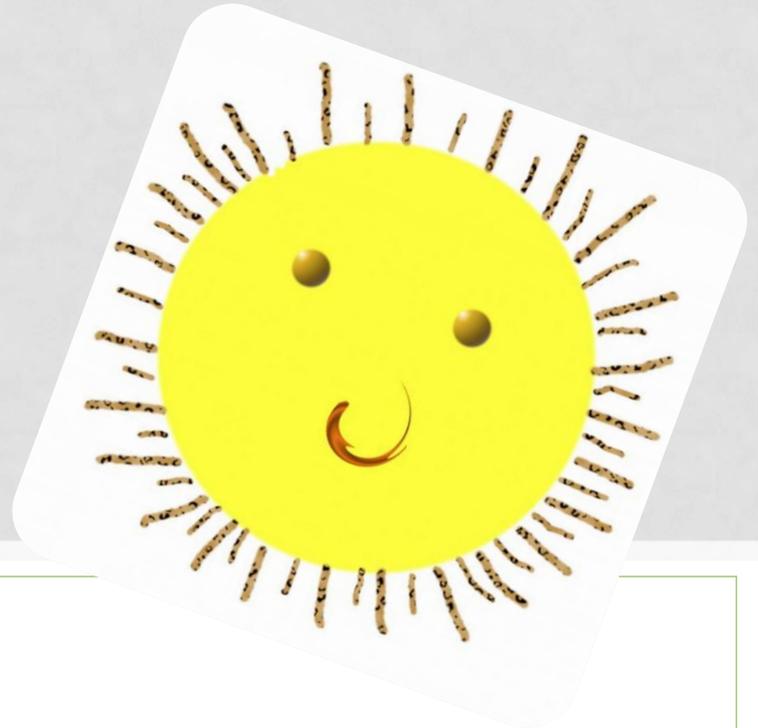


ENVIRONMENTAL OR MINOR HOME ADAPTATIONS

DEFINED

ENVIRONMENTAL OR MINOR HOME ADAPTATIONS

- Environmental or minor home adaptations
- Home modifications such as ramps, grab bars, door widening that enable the individual to remain in their own home. Also includes Personal emergency response systems.
 - For Requests prior to recertification
 - Complete MAP 95 and include quote from contractor for materials and labor costs for modifications
 - Submit to Carewise Health for authorization
 - For Requests upon Recertification:
 - Using MWMA, add to Person Centered Service Plan
 - Upload quote from contractor for materials and labor costs for modifications
 - Submit to Carewise Health for authorization



GOODS AND SERVICES

DEFINED

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GOODS AND SERVICES

- Consumers may use goods and services budgets to purchase incontinent supplies, nutritional supplements (ensure, boost, thick-it), personal care goods that are medically necessary and not covered directly under Medicaid State Plan card (psoriasis soap, eczema shampoo, etc.), goods that have been documented to stabilize health or reduce health concerns and are documented by the physician as medically necessary (probiotics, specialized vitamins, etc.), breathing treatments, assistive technology, or assistive type goods, and any service that reduces the need for personal care and/or promotes independence in the home and community. All goods and services must be documented on the MAP109 and be goal oriented in nature.
- For Requests prior to recertification
 - Complete MAP 95 and include Certificate of Medical Necessity Form
 - Submit to Carewise Health for authorization
- For Requests upon Recertification:
 - Using MWMA, add to Person Centered Service Plan
 - Upload Certificate of Medical Necessity Form
 - Submit to Carewise Health for authorization

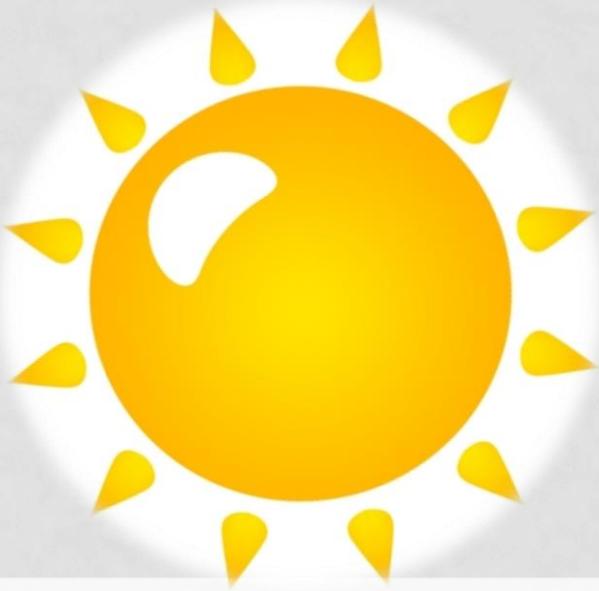
PURCHASING GOODS AND SERVICES AND ENVIRONMENTAL MODIFICATIONS

Methods of Purchase:

1. Consumers may directly purchase items that have been approved through any provider of the consumer's choice (Wal-Mart, Walgreens, Costco, Amazon.com, etc..). Consumer then submits a request for reimbursement to the CM Agency or PDC Agency. The agency issues a reimbursement check to the consumer. This option requires that the Consumer produce detailed receipts and a Rx for the supplies.

OR

2. The CM Agency or PDC Agency may order supplies through a vendor if the Consumer chooses not to purchase items themselves. Some vendor's invoice the Agency and some require credit card payment at the time of purchase. A CM or PDC must sign the request for purchase and delivery confirmation must be obtained.



SERVICES, RATES AND CODES

SERVICES

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Service	Code	Unit Value	Unit Cost	Caps
Adult Day Health	S5100	1 unit=15 minutes	\$2.83 Level I \$3.43 Level II	200 units per week
Attendant Care	580/S5108	1 unit = 15 minutes	\$6.00 per unit	Maximum 200.00 per day alone or in combination with ADHC
Case Management	590/T1016	1 unit=per month	\$100.00 per unit	Per member per month
PDS Coordination	T2040HI	2 units=per month	\$162.50 per unit	325.00 per month
Home Community Supports	S5108 HI	1 unit=per 15 minute unit	Up to \$2.88 per 15 minute unit before taxes	Maximum 200.00 per day alone or in combination with ADHC

SERVICES

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Service	Code	Unit Value	Unit Cost	Caps
Specialized Respite	660/T1005	1 unit=15 minutes	\$4.00 Level 1 \$10.00 Level 2	Level 2 requires RN or LPN under RN supervision. Maximum of \$200 per day alone or in combination with non-specialized respite. Cannot exceed \$4,000 per level of care year.
Non-Specialized Respite	T1005 HI	1 unit = 15 minutes	Up to \$2.75 per unit before taxes.	Maximum of \$200 per day alone or in combination with non-specialized respite. Cannot exceed \$4,000 per level of care year.

SERVICES

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Service	Code	Unit Value	Unit Cost	Caps
Home Delivered Meals	S5170	One hot meal	\$7.50 per meal	Maximum of one hot meal per day and five hot meals per week.
Goods and Services	999/T1999 T1999 HI		\$3,500 per level of care year	Maximum of \$3,500 per level of care year for prior approved goods and services.
Environmental or Minor Home Adaptation	290/S5165 S5165 HI		\$2,500 per level of care year	Maximum of \$2,500 per level of care year for prior approved environmental of minor home adaptations.



NEW PROCESS

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STAGES

- ✓ Screening
- ✓ Level of Care eligibility
- ✓ Financial eligibility
- ✓ Provider Selection
- ✓ Person Centered Planning Meeting
- ✓ Person Centered Service Plan Development
- ✓ Service Plan Approval
- ✓ Services Begin

STEP BY STEP PROCESS

- A provider agency (adult day health, home health, CIL, AAAIL, Public Health Department) is contacted by an outside source (family, client, doctor, neighbor) regarding the need for information or services.
- If inquiry is for basic information (where is the senior center) and no services needed, answer question and move on.
- If inquiry is regarding needed services, the provider agency (adult day health, home health, CIL, AAAIL, Public Health Department) **if also a case management agency** conducts the on-line screening in the waiver management system . The agency also gets the name, address and phone number of the Primary Care Doctor.
- If not a case management agency, refer to the local ADRC . The ADRC will conduct the screening.

STEP BY STEP PROCESS

- The case management agency or ADRC then mails the MAP 10 including a self-addressed return envelop to the individual **and** doctor. Fax and scanned copies of the MAP 10 can also be used. ** For recertification, the case manager will be required to obtain the MAP 10 and enter the completed form into the waiver management system no later than 45 days prior to recertification date.*
- **The case management agency or ADRC explains conflict free case management and mails the conflict free case management list for the area in which the participant resides to the participant.**
- In the meantime, the QIO (Carewise) reviews the screening information, which may or may not include the MAP 10.
- The QIO will determine if the individual meets basic eligibility criteria from the screening information.

STEP BY STEP PROCESS

- If no, the QIO sends the individual a letter notifying they don't meet the basic criteria and includes a list of potential resources.
- If yes, DAIL is notified of the need for the functional assessment.
- **Within 7 business days, DAIL contacts the participant. During the initial contact the Assessor:**
 - Discusses traditional, blended and PDS options;
 - Discusses conflict free case management;
 - Asks the participant who they have chosen as their case management or PDC entity; and
 - Sets the date for the assessment.
- **Following the call, the assessor notifies the case management agency of the participant's choice and the date of the assessment. The case manager continues trying to obtain the MAP 10 if it has not been entered into the system.**

STEP BY STEP PROCESS

- **The case manager will attend the assessment along with the Assessor.**
- The Assessor completes the Assessment and enters it into the Waiver Management System. LOC can not be determined until a MAP 10 is also completed and entered into the system. **If the MAP 10 is not complete the case manager will work to obtain it.**
- **At this time the participant chooses potential service providers and the case manager notifies the providers of choice.**
- **The QIO (Carewise) is notified via the Waiver Management System that the assessment and MAP 10 has been entered. The Level of Care is then determined and entered into the Waiver Management System by the QIO.**

STEP BY STEP PROCESS

- **If LOC is met, the case manager notifies the participant they must now apply for financial eligibility and provides assistance as needed.**
- The participant applies for financial eligibility. (In December 2015, the individual will receive a correspondence from MWMA and will be able to apply for Medicaid via Kynect.)
- Financial eligibility is determined and entered into the system. The Assessor (DAIL) will monitor KAMES to determine when financial eligibility is determined.

STEP BY STEP PROCESS

- Once eligibility is determined the conflict free case manager or service advisor schedules person centered planning meeting within 30 days.
- **Case Manager conducts person centered team meeting and helps the team develop the service plan (plan of care). The Assessor will be present at the meeting.**
- **Service Plan is entered into the waiver management system by the case manager.**
- Service Plan is approved by the QIO
- Services Begin!



PERSON CENTERED PROCESS

PERSON CENTERED PLANNING PROCESS

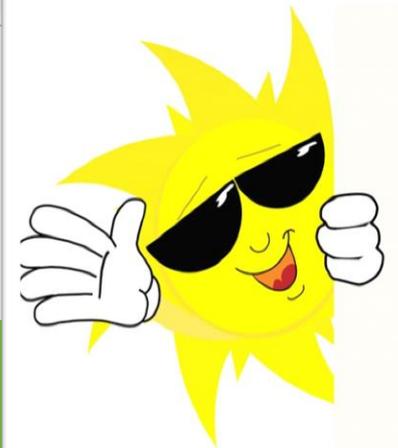
- Providers are chosen by the participant.
- Providers must participate in the person centered team meeting either by phone or in person.
- Team members may also include family members, community members or anyone of the participants choice.
- The team determines the how much, how often and the when and where services should be provided.

PERSON CENTERED SERVICE PLAN

- **The plan will list:**

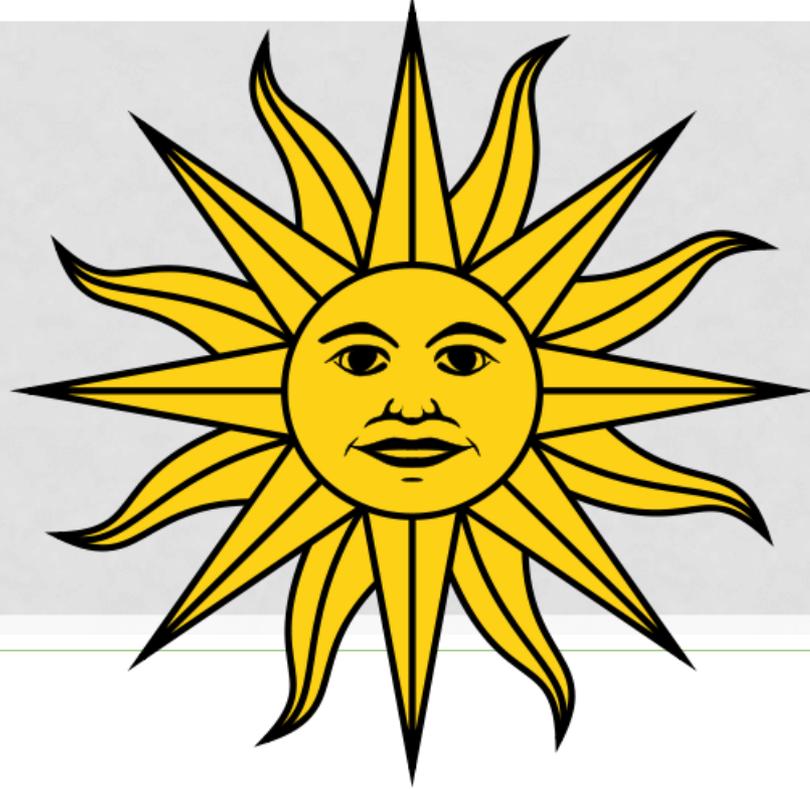
- ALL services needed; not just waiver services
- The estimated amount of time needed for each service
- Who provides the service
- Frequency of service
- Place service is to be delivered

NEW FORMS AND TOOLS



NEW TOOLS

- Assessment
 - Kentucky Home Assessment Tool (K-HAT)
 - Replaces MAP 351
- MAP 531 Conflict Free Case Management
- Person Centered Service Plan
 - MAP 109 Revised – MWMA Plan of Care
- Corrective Action Plans
- Incident Reports
- DAIL Participant Directed Services – 01 (MAP 532)
 - Immediate Family Member/Legal Guardian/Responsible Person Application for Employment



NEW REQUIREMENTS

ADULT DAY HEALTH LEVELS

- Level One and Level Two in Adult Day Health Care will be distinguished by criteria based on the Health Related Services Assessment and their relationship to Low and High intensity nursing home regulations.
- Level One will be determined by answers occurring in the white spaces on the assessment.
- Level Two requires either needs related to columns 5 or 6 in the Behaviors category plus two other Health Related Services in the yellow shaded area of the assessment page or 4 Health Related Services assessed in the yellow shaded areas of the assessment.

CORRECTIVE ACTION PLANS

- Corrective Action Plan (CAP)
 - A written plan that is developed by the case manager in conjunction with the participant, guardian, or representative if applicable, to identify, eliminate and prevent future violations from occurring.
 - Violations include:
 - The participant, family member, employee, guardian, or representative threaten or intimidate any waiver provider.
 - Failure to pay patient liability within thirty (30) days of the due date.
 - Imminent threat of harm to the participant's health, safety or welfare.
 - The participant, family member, employee, guardian or representative interferes with or denies the delivery of assessment, case management, or the service advisor.

CORRECTIVE ACTION PLANS

- Form is completed by the Case Manager/Service Advisor
- Case Manager/Service Advisor meets with participant to review CAP and obtain signatures
- Case Manager/Service Advisor monitors to ensure compliance is met within designated time frame.
- If CAP is not adhered to, Case Manager/Service Advisor shall seek termination via a formal request through DAIL

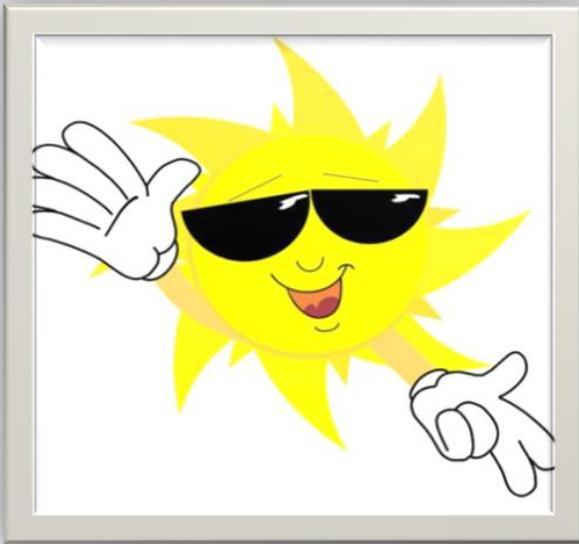
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CRITICAL INCIDENT REPORTS

- Critical Incident Reports
 - An event that potentially or actually impacts the health, safety, or welfare of the participant.
 - Includes the following:
 - Death
 - Alleged or suspected abuse, neglect or exploitation
 - Homicidal or suicidal ideation
 - Missing person
 - Medication error resulting in consultation or intervention of a skilled person
 - An event involving police or emergency response personnel intervention
 - Other action or event that may result in harm to the participant

CRITICAL INCIDENT REPORTS

- Case Manager/Service Advisor upon notification
 - Immediately assesses to determine imminent risk of health, safety and welfare of participant
 - Notifies: DCBS-Protection and Permanency
Guardian if applicable
Participant's Primary Care Provider
 - Completes Critical Incident Form Page 1 and submits to DAIL until December 2015 and then will complete within MWMA
 - Completes Critical Incident Form Page 2 (investigation/follow up) within seven (7) days of incident and submits to DAIL until December 2015 and then will complete within MWMA



NEW REQUIREMENTS FOR PARTICIPANT DIRECTED SERVICES

(FORMERLY KNOWN AS CDO)

PARTICIPANT DIRECTED SERVICES

Definitions:

“Natural Supports” means a non-paid person, persons or community resource who can provide, or has historically provided assistance to the participant or due to the familial relationship, would be expected to provide assistance.

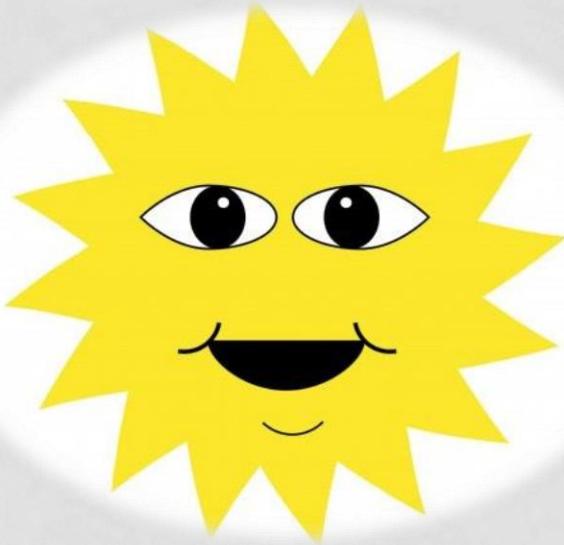
“Immediate family member” means a parent, grandparent, spouse, child, stepchild, father-in-law, mother-in-law, son-in-law, daughter-in-law, sibling, brother-in-law, sister-in-law, or grandchild. (KRS 205.8451 (13))

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PARTICIPANT DIRECTED SERVICES

- Clarifies employer requirements and expectations
- Requires increased background checks, drug testing and training and requires the cost be paid by the employer
- Requires background check for representatives
- Allows family members as providers under certain conditions

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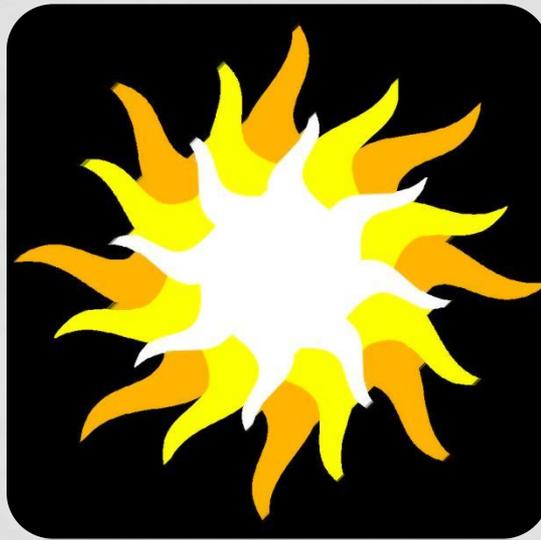
TRANSITION PROCESSES

TRANSITION PROCESS

- Assessment Transition
 - At recertification
 - July and August assessments conducted by providers as usual using the MAP 351.
 - The Case Manager will scan and attach the MAP 351 to the waiver management system.
 - LOC is approved once assessment and MAP 10 are both entered.
 - Case Manager conducts a team meeting to develop the service plan.
 - Use new services on the Service Plan
 - Use the MAP 109 as the Plan of Care
 - Bill as usual for assessment

TRANSITION PROCESS

- Conflict Free Case Management
 - Effective July 1 with a transition period until November 1 for current participants. Then each participant would switch at recertification. Process would not be completed until October 2016.
 - There is no grandfather clause.
 - New waiver participants must enroll with conflict free case management.
- PDS Rate transition
 - Under Review
- Family member transition
 - If denied they have a 3 month transition
- Level 2 Adult Day
 - Current Level 2 centers will continue to be paid at the Level 2 rate for six months. After that time the individualized rate will begin.



NEXT STEPS

MOVING ALONG

- ✓ CMS discussions and changes
- ✓ CMS approval
- ✓ Regulation development
- ✓ Emergency(E) and Ordinary(O) Regulations
(includes public comment period)
- ✓ Meet and Greet of Assessors
- ✓ June Training on Regulations and Final Forms
- ✓ TA conference calls in June, July and August

CONTACT INFORMATION

Emails should be sent to DAILHCB@ky.gov

Other contact information:

- DAIL WAIVER
 - Tonia Wells - Toniaa.Wells@ky.gov
 - Jennifer Dudinskie - Jennifer.Dudinskie@ky.gov
 - Evan Charles - Evan.Charles@ky.gov
- HCB MEAL PROVIDERS
 - Elizabeth Fiehler – ElizabethJ.Fiehler@ky.gov
- DMS
 - Gregg Stratton – Gregg.Stratton@ky.gov
- Phone Numbers
 - DAIL: 502-564-6930
 - DMS: 502-564-5560
 - HCB Waiver Number for Consumers and Providers: 877-315-0589

