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To: 1915(c) Home and Community Based Services Waiver Providers

From: Pam Smith
Director, Division of Long-Term Services and Supports

Date: December 21, 2023

Re: Appendix K Transition and Guidance

The Department for Medicaid Services submitted amended 1915(c) Home and Community Based Services (HCBS) waivers to the Centers for Medicare and Medicaid Services (CMS) during the week of November 6, 2023. The submissions were in response to CMS' State Medicaid Director letter SMD# 23-004, which directed states wanting to make any Appendix K flexibilities permanent to submit amended waiver applications no later than November 11, 2023. Per CMS guidance, all Appendix K flexibilities remain in place until the new effective date of the waiver applications DMS submitted to CMS. Information on Appendix K policies being made permanent is available at https://bit.ly/KYAppKPolicyDecisions.

In the waiver applications submitted to CMS the week of November 6, 2023, DMS proposed the following effective dates for the waiver applications:

Model II Waiver (MIIW)	January 1, 2024
Acquired Brain Injury (ABI) Acquired Brain Injury Long Term Care (ABI LTC) Home and Community Based (HCB) Michelle P. Waiver (MPW) Supports for Community Living (SCL)	April 1, 2024

DMS continues to work with CMS to confirm effective dates for each waiver. Please note **these dates are subject to change**. If these dates change, they will not be any earlier than those listed above.

DMS put Appendix K in place during the COVID-19 public health emergency (PHE) to help providers and participants cope with disruptions to waiver operations. Provider operations and participant services should largely be back to pre-PHE levels. If a provider or participant is still operating under an Appendix K policy that is not becoming permanent, efforts should be made to return to the pre-PHE policy. This may include:

- Returning person-centered service plans to pre-PHE services and limits. This may require re-evaluating a participant's current services and supports and whether any need to be changed. When evaluating services and supports, available Medicaid state plan services and community resources that can meet a participant's needs should be considered in addition to waiver services.
- Making sure employee training and other hiring requirements are up to date.
- Making sure employee background checks and other screenings are complete.

Common Questions

DMS wants to provide additional guidance on several items for which we continue to receive questions.

Attendant Care Limit – HCB

In a previous provider letter, DMS informed providers the Attendant Limit has been changed to 45 hours per week. **The following guidance supersedes the letter issued on September 25, 2023.**

Based on a review of current policy and feedback provided by stakeholders during the September 27 – October 27, 2023, formal public comment period, DMS decided to update the limit on Attendant Care in the amended HCB waiver application to the following:

- Forty-five (45) hours per week alone in combination with Adult Day Health Care (ADHC); **OR**
- $200 per day alone or in combination with ADHC.

DMS opted to allow participants to use either 45 hours per week or $200 per day to create flexibility based on the individual's person-centered needs. The person-centered team should work with the participant to determine the best limit to use based on how much Attendant Care they need. In the case of PDS, a participant paying an employee the maximum Attendant Care rate and trying to stay within the $200 per day limit would receive less than seven hours of Attendant Care per day. In that case, following the 45-hour limit may be more appropriate. Alternatively, if the participant does not pay a PDS employee the maximum rate, they can stretch the number of hours of Attendant Care per week beyond 45 hours while staying within the $200 per day limit.

$40,000/$63,000 Limit – MPW

The $40,000/$63,000 service cap (excluding Respite) is no longer in place to avoid an unintentional reduction in needed services for participants. The following services, alone or in combination, shall be limited to forty (40) hours per calendar week: Homemaker, Personal Care, Attendant Care, Supported Employment, Adult Day Health Care, Adult Day Training, Community Living Supports, Physical, Occupational, and Speech Therapy, and Behavior Supports. A parent, parents combined, or a spouse shall not provide more than forty (40) hours

of services per calendar week (Sunday to Saturday) regardless of how many children receive waiver services.

Rate Increases and Participant Directed Services

The amended waiver applications submitted in November 2023 include the 21% legislature-directed increase for non-residential services. As a reminder, all waiver participants are allowed to access the new rates of pay and determine what to pay their employees. Participants have the option to pay their PDS employee(s) a rate between what they are currently paying and up to the maximum rate.

Case managers/support brokers/service advisors shall work with waiver participants and/or PDS representatives to review their current employee(s) rate of pay and determine if an increase is appropriate. Key considerations include:

- What does the employee do for the participant?
- How much training does your employee have?
- How well does the employee do their job?
- How many hours does the employee work?
- Taxes will be taken out of any pay a PDS employee receives.
- If a participant has multiple employees, they do not need to pay all of them the same rate.

If a participant or PDS representative requests a pay increase, the case manager/support broker/service advisor should schedule a meeting to discuss it or discuss it at their next scheduled case management visit. Updating the rate should only be discussed with the participant and/or PDS representative, if applicable. **The PDS employee(s) should not be involved in discussions about raising their pay rate.**

A person-centered team meeting is not required if a participant only requests to change their PDS employee(s) pay rate. If a participant is only changing a pay rate, the following documentation is needed:

- Documentation of the meeting/discussion with the participant and/or PDS representative to discuss the pay rate. This can be documented as a case note.
- A signed contract from the participant and the PDS employee. Case managers/support brokers/service advisors can guide the completion of these steps, but it is the responsibility of the participant or the PDS representative to obtain these signatures and return the signed contract to the FMA. Pay rates cannot be changed without a signed contract in place.

A full person-centered team meeting, a team meeting sign-in sheet, and a MAP-116 are only required if the amount or scope of the service is changing.

If a participant does not pay their PDS employee(s) the maximum rate, the FMA will need to complete an override rate in the Mobile Caregiver+ EVV system. Directions for entering an override rate are available at https://bit.ly/evvqrgoverriderates.

Telehealth Guidance

The amended waiver applications include allowances for certain services to be provided either in-person or via telehealth.

Services with a Telehealth Allowance	
ABI	Behavior Programming Services Case Management Counseling (Individual and Group) Occupational Therapy Speech Therapy
ABI LTC	Behavior Programming Services Case Management Counseling (Individual and Group) Occupational Therapy Physical Therapy Speech Therapy
HCB	Case Management/Participant Directed Coordination
MPW	Positive Behavior Supports Case Management Occupational Therapy Physical Therapy Speech Therapy
SCL	Case Management Consultative Clinical and Therapeutic (CCT) Services – Nutrition CCT – Psychological Services CCT – Positive Behavior Supports

When offering services via telehealth, providers should consider the following:

- In-person services must be provided whenever possible and, at minimum, every other month.
- When services are provided via telehealth, providers must use a Health Insurance Portability and Accountability Act (HIPPA) compliant platform.
- The use of telehealth should be wanted by the participant, person-centered, meaningful, and advance established goals.
- Participants should understand they have freedom of choice regarding how services are delivered and have the right to request their preferred service delivery method (in-person or telehealth).

Additional Information and Questions

Details on other Appendix K policies that have been made permanent and/or other updates to the amended waiver applications are available at https://bit.ly/KYAppKPolicyDecisions. If you have additional questions, please reach out to the appropriate contact below.

Waiver / Topic	Agency	Contact Information
ABI, ABI LTC, or MIIW	DMS	(844) 784-5614 1915cWaiverHelpDesk@ky.gov

HCB or PDS	Department for Aging and Independent Living	(877) 315-0589, option 3 HCBInquiries@ky.gov
MPW or SCL	Department for Behavioral Health, Developmental and Intellectual Disabilities	Contact your Quality Administrator
Medicaid Waiver Management Application – Technical Assistance	DMS	(844) 784-5614, option 1 MedicaidPartnerPortal.Info@ky.gov

Sincerely,

Pam Smith, Director
Division of Long-Term Services and Supports