KENTUCKY

Cabinet for Health and Family Services

HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER REDESIGN

DECEMBER 14, 2016

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Session Timeline

Time	Topic
9:30 – 10:15 AM	Discussion of Input from Session 1
10:15 – 11:15 AM	Overview and Discussion of Critical Elements
11:15 – 12:00 PM	Review of Key Redesign Questions
12:00 – 12:15 PM	Required Changes for Implementation
12:15 – 12:30 PM	Next Steps

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Review of Input from Session 1

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Feedback and Opportunities Offered by Stakeholders

Policy/Program Issues

- Eligibility: *Who are we serving and who should we be serving*
- Lack of standard "rules" across waivers: Service definitions (inconsistent not aligned with best practices), rates, and staffing requirements vary by waiver for the same service, **<u>consistent interpretation of regulations</u>**
- Issues with occupational therapy (OT), physical therapy (PT), and speech therapy (SP) moving to the State Plan
- Potential for behavioral supports to be removed from the waiver
- Waiting lists
- Katie Beckett Rule: Allows children of higher income parents to be served in waivers
- Access to waiver services for medically fragile individuals is not sufficient

Operational Issues

- Excessive paperwork and documentation
- Navigating new processes and systems including Medicaid Waiver Management Application (MWMA) and Benefind
- Appropriate assessment tools (Brain Injury specifically), interplay between waivers
- Independent assessments
- Workforce issues:
  - Low pay rate
  - No career ladder
  - Lack of training
- Participants/**<u>Staff/Case Managers</u>** do not understand documents/paperwork nor processes, **<u>nor what to do if there are issues with paperwork</u>**

Financial Issues

- High costs
- Fee schedule for waiver services does not have acuity levels
- Lack of technical assistance (TA) versus recoupments and citations
- Lack of training regarding recoupments
- Rates should be based on outcomes, or incentives should be offered
- Participants cannot afford to hire employees under participant directed services (PDS)
- **<u>Gap in payment (impacts individuals and providers/agencies)</u>**
- Fiscal role for PDS
- Billing issues
- Budget process is difficult and lengthy

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Feedback and Opportunities Offered by Stakeholders (cont.)

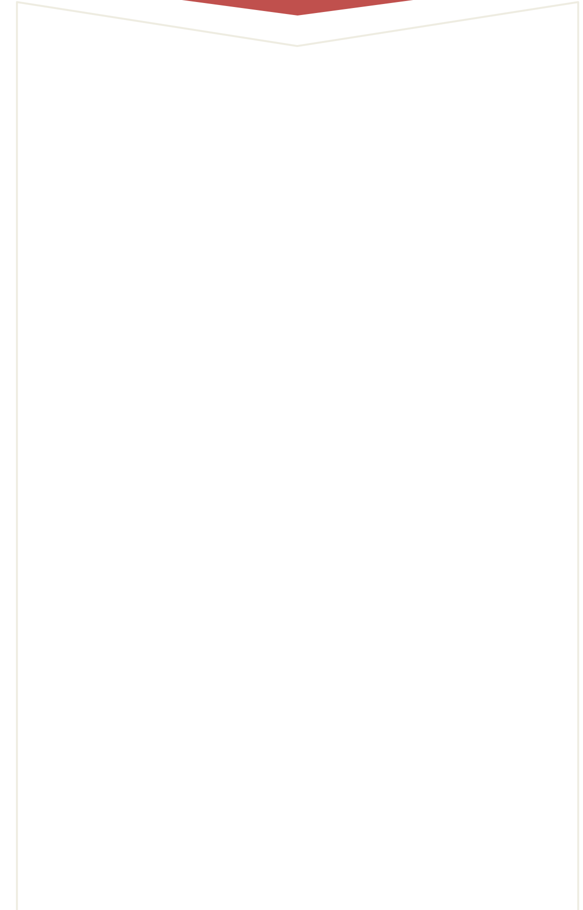
Policy/Program Issues

- Participant/family dissatisfied with the quality of services (i.e., Adult Day Training (ADT), case management/support broker, home health)
- Respite is not easily obtainable
- Some participants apply for the waiver only to obtain Medicaid and take up slots that others need
- Transportation issues
- **Community Access: Authorized services not always available**
- **Crisis Services: Lack of crisis services, no tiered payment option, and there is a feeling that they are underserved**
- **The mode of behavior supports available for individuals with brain injury is different from other waivers, and this needs to be recognized (ex: cognitive retraining)**

Operational Issues

- No training for family members on Medicaid and waivers: *How do the services help me?*
- Redundancy on recertification paperwork
- **Communications: Lack of information available to family members, “telephone” messaging, right info at the right time**
- **Training requirements are excessive (ex: crisis intervention)**
- **Utilization of Technology: Working smarter NOT harder, getting people access to technology**
- **Assistance for family members when things are not going well is needed and a direct contact is needed when issues are with the provider**
- **Deemed status if an organization is accredited**

Financial Issues



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Feedback and Opportunities Offered by Stakeholders (cont.)

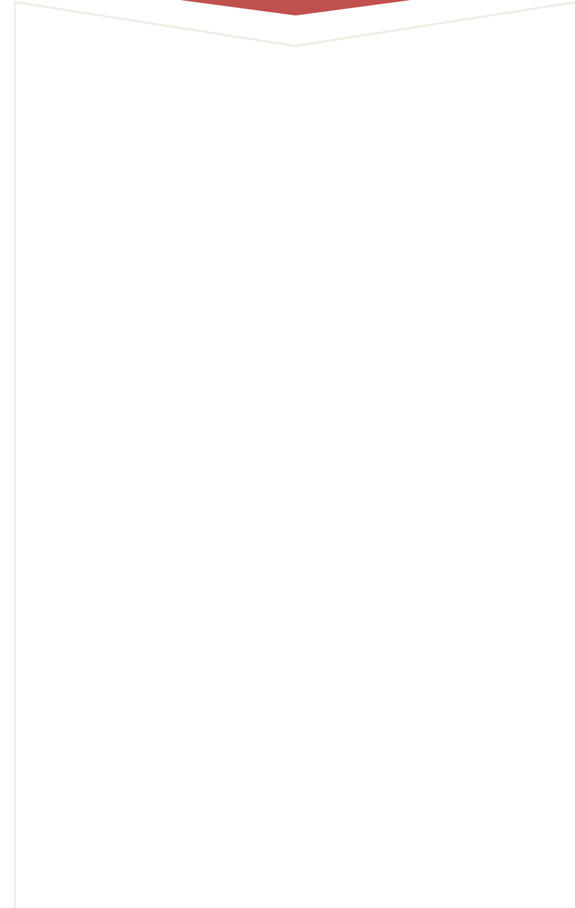
Policy/Program Issues

- **Limits on behavior supports (specifically related to SCL), (1) exceptional rate protocol, (2) 160 units a year AND out of that they have to choose between a menu of options and divide units between the services**
- **Day Programming: What does this look like/how is it funded with the requirements of the Final Rule? Adults and children have different needs**
- **No interpreter services**
- **Too many regulations make community living more of a medical model**
- **40 hour limit should be assessed**
- **Populations that are not currently served by the waivers (Examples: Mental Illness)**

Operational Issues

- **MPW: Behavior Intervention Committee (BIC), given complexity of needs, is it necessary?**
- **How we do the survey process: What are the requirements for certain levels of certification**
- **Certification regulation – SCL two year certification period is available but there is no criteria to earn it**
- **Long term: Final Rule impact on service delivery (new setting requirements)**
- **Denial after years on the waiver**
- **Renewal process is stressful and overwhelming**
- **Training: Better training for staff, multiple flavors of training**
- **Credentialing process for workforce, matches skillset**

Financial Issues



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Feedback and Opportunities Offered by Stakeholders (cont.)

Policy/Program Issues

- **Consistent interpretation of regulations**
- **Limited medically fragile day care for children**
- **Aging population as their medical status changes that they are still able to be supported, structure is pushing people towards specific services**
- **Hospice not included in SCL, residential is covered**
- **Initial time to get on waiver, longer wait for people who do not already have Medicaid**
- **24 hour care, cannot put time limits on services**
- **Self determination of care challenges**

Operational Issues

- **No specific contact in Frankfort to assist if there are issues**
- **So many opportunities for things to go wrong, difficult to identify exactly what the issue is**
- **Workforce much harder to maintain considering pay, infrastructure surrounding (related to money)**

Financial Issues

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What’s Working Well According to Stakeholders

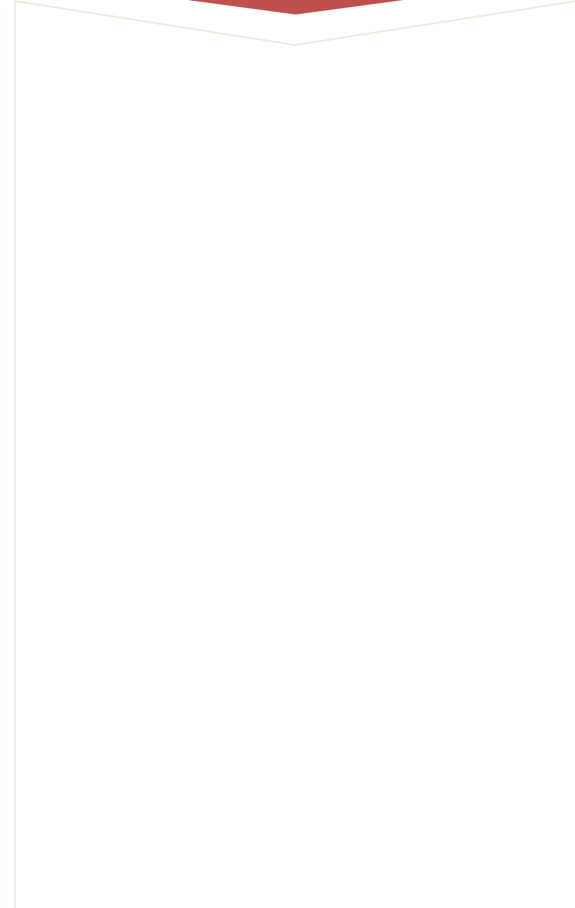
Policy/Program Successes

- PDS program (self-directed services)
- **Reintegrating people into the community and getting off the waivers; living independently**
- **Transitioning people out of institutional settings because of behavior supports**
- **Community transitions (specific service)**
- **HCB II, blending of the services**
- **Supports through MPW for Deaf and Blind Community**
- **Access to needed services: Adult Day Health Care (?), Behavioral Supports and Therapies, Community Living Supports, Supported Employment**
- **ABI Waiver recovery possibilities**
- **<u>Access to medical services (Medicaid)</u>**

Operational Successes

- Conflict free, independent case management (currently in ABI)
- Not in a managed care environment
- Individual/Family Supports: Family members providing services at home
- **Commitment to serve HCBS**
- **Outstanding providers**
- **Stakeholder groups who are willing to collaborate**
- **Acquired Brain Injury Branch (ABIB) include staff who understand waiver and can support providers**
- **Family Home Provider (FHP) and Adult Foster Care (AFC)**

Financial Successes



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Key Goals of Redesign

Goals

- **Access and Quality:** Ensure that individuals receive the services that they need, that they have access to these services, that the services are of high-quality, and that they are received in a timely manner
- **Collaboration:** Create environment that fosters continuous feedback, learning, and improvement, establishes trust among stakeholders, and encourages ambassadors for change
- **Communications:** Develop clear and consistent communications so that all stakeholders receive the same information in an understandable manner
- **Consistency:** Make waiver services more consistent (across waivers and across the state): predictable and efficient processes(including enrollment)
- **Simplification:** Streamline and simplify processes and documentation and reduce redundancies
- **Sustainability:** Design programs that will work for the long-term and are aligned/compliant with the HCBS Final Rules, and create financially sustainable program design and rates
- **Flexibility:** Seamless system that serves people across the lifespan, recognizing that events occur, and gives them what they need (a supermarket/menu of services to support their needs)

Challenges and Success Factors in Redesign

The success factors are necessary to ensure that redesign achieves its goals.

Challenges	Success Factors
• Balancing priorities across diverse populations/needs and competing interests • Getting people to accept change • Being able to successfully support consumers • Working within financial constraints • Complying with federal and state requirements that limit flexibility • Achieving stability in the underlying eligibility system • Creating options for individuals to transition out of the waivers • Communicating clearly and concisely among stakeholders • Understanding different needs between children and adults • Managing the complex and changing political environment	• Kentucky-centric approach with learnings from the successes of other states • Improved and continuous training for staff • Respectful and symbiotic stakeholder engagement • MWMA functioning that is streamlined, simplified (financial eligibility, training, local DCBS access) • Budget neutrality • Improved communications and education of legislators with a positive framework • Flexibility to cater to diverse needs • Infrastructure for recurring education and feedback • Quantitative measurement of change (LOC, Financial Eligibility)

Critical Elements

The Super Seven

First Vote Top Critical Elements		Second Vote Top Critical Elements
Routine examination of rates to reflect true cost and ensure adequate reimbursement (21)	**1**	Create consistency in service definitions, provider qualifications, reimbursement, process, and messaging (17)
Create consistency in service definitions, provider qualifications, reimbursement, process, and messaging (20)	**2**	Make caps and limits person-driven and based on independent assessment (12)
Formalize a tri-directional communications process – member, provider, cabinet – focused on what people need (11)	**3**	Increase services for individuals who are medically fragile or have complex health needs (11)
Make caps and limits person-driven and based on independent assessment (7)	**4**	Formalize a tri-directional communications process – member, provider, cabinet – focused on what people need (10)
Increase services for individuals who are medically fragile or have complex health needs (6)	**5**	Routine examination of rates to reflect true cost and ensure adequate reimbursement (9)
Improve the flexibility of rates considering acuity, geography, and a tiered system (5)	**6**	Simplified waiver regulations that provide greater flexibility (7)
Implement age-appropriate assessment tools (5)	***7***	Increased flexibility on whether family members can be paid to provider services under PDS (7)

Number of votes received during vote in (#) after each Critical Element

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Critical Elements

Providers

- Formalize a tri-directional communications process –member, provider, and cabinet – focused on what people need (1st vote – 11, 2nd vote – 10)
- Simplified waiver regulations that provide greater provider flexibility (1st – 2, 2nd – 7)
- Clear definition of roles between case manager and providers (1st – 1, 2nd – 1)

Members

- Make caps and limits person-driven and based on independent assessment (1st vote – 7, 2nd vote – 12)
- Increase services for individuals who are medically fragile or have complex health needs (1st – 6, 2nd – 11)
- Implement age-appropriate assessment tools (1st – 5)

Operations

- Create consistency in service definitions, provider qualifications, reimbursement, process, and messaging (1st vote – 20, 2nd vote – 17)
- Single organization to administer all waivers (1st – 1)
- Independent assessments (1st – 2, 2nd – 1)
- Decisions in writing and communicated broadly (1st – 1)

Financial

- Provide routine examination of rates to reflect true cost and ensure adequate reimbursement (1st vote – 21, 2nd vote – 9)
- Improve the flexibility of rates considering acuity, geography, and a tiered system (1st – 5, 2nd – 4)
- Tiered reimbursement without Prior Authorization(PR) tied to Level of Effort (LOE) (1st – 1, 2nd – 1)

Votes listed after the critical element as (1st vote – Number of votes received, 2nd vote – Number of votes received)

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Critical Elements (cont.)

Providers

- RN requirements/ med administration training (2nd – 1)
- Outcomes component to reimbursement
  - Provider-centric
  - Consistent expectations and regulations
- Flexibility and better definition of model (2nd – 1)
- Standardized licensure→ credentialing

Members

- Expanded eligibility to under-served populations (SMI, SUD, Autism, Deaf, Blind) (1st – 2, 2nd – 4)
- Increased flexibility on whether family members can be paid to provide services under PDS (1st – 2, 2nd – 7)
- Increased access to goods and services (1st – 2, 2nd – 1)
- Increased access to transportation (1st – 3, 2nd – 3)

Operations

- Back-dating prior authorizations and less paperwork (1st – 4, 2nd – 1)
- Improved visibility into surveys /audits—don't make them a surprise
- Rebuild claims /reimbursement infrastructure
- Provide clear roles and responsibilities between state departments and vendors as resources
- Train field staff on program changes

Financial

- Tiered reimbursement for crisis services (1st – 1)
- Limited PDS rates and the budget vs. hours limit (1st – 3)
- Budget neutrality (1st – 1)
- Timeliness of payments (1st – 1)
- Presumptive eligibility (1st – 4, 2nd – 3)
- Funding additions/mandates (1st – 3)

Votes listed after the critical element as (1st vote – Number of votes received, 2nd vote – Number of votes received)

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Critical Elements (cont.)

Providers

- Formalized training program—detailed, ongoing by trained trainers

Members

- Increased access to community services (2nd – 1)
- Ability to access both a support broker and case manager (2nd – 1)
- More thorough evaluations during LOC and more time allotted for assessment
- Eligibility requirements that are not IQ-driven
- Simplified content /distribution of member messaging

Operations

- Common technology interface/ communication (2nd – 1)
- Consistency among policy (regulations, provider boards, certifications) (2nd – 1)
- Make QIO tailored for medical and social models
- Knowledgeable and trained state and vendor staff

Financial

- Provider tax statute
  - Previously adjusted reimbursement
  - Tax rate has stayed same
- Durable medical equipment and goods
- Direct Service Provider (DSP) wages
  - 80% of provider costs
  - Impact on rates
- Financial component needs to be flexible, changeable, sustainable

Votes listed after the critical element as (1st vote – Number of votes received, 2nd vote – Number of votes received)

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Critical Elements (cont.)

Providers	Members	Operations	Financial
	• Improved member training on PDS	• Contingency plans to protect consumer/provider as part of roll out (2nd – 2)	• Financial impact of monitoring—how, certification and recertification, recoupments

Votes listed after the critical element as (1st vote – Number of votes received, 2nd vote – Number of votes received)

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Key Redesign Questions

Key Redesign Questions – Consistency

Element Category	Defining Questions
Consistency	• What does a consistent HCBS waiver program look like? • What components of the waivers are a priority when thinking about consistency? • Does consistency mean standardization or harmonization? • Does consistency mean across service definitions, geographies, or both?

Key Discussion Themes

- Consistency means interpretation, communication, very clear rules and guidelines that both consumers and providers understand
- Consistent requirements, best practices across the waivers
- “Everyone singing out of the same hymnal”
- Definitions for the same service should be the same across the waivers
- Predictability – Both individuals and providers know services and the services are responsive to the individuals over time

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Key Redesign Questions – Services

Element Category	Defining Questions
Services	• How should we define caps and limits moving forward? • What criteria should we use to establish caps and limits? • What are the services that we should cap and/or limit? • What should the process be for setting caps and limits? • How do we make additional services more available for the medically fragile population? • What services are most important to this population? • How do we increase access to community services, goods and services, and transportation?

Key Discussion Themes

- People need services when they need them, having more fluid access services that allow the right services at the right time
- Better independent assessment tool that is consistent both in initial and reassessment process
- Moving away from fee for service model
- Increasing the usage of telemedicine/telehealth to improve access

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Required Changes for Implementation

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Implementation Roadmap

	Required Changes for Implementation		
	Internal Policy/Procedure	State Regulation	Waiver Application
Consistency	✓	✓	✓
Services	✓	✓	✓

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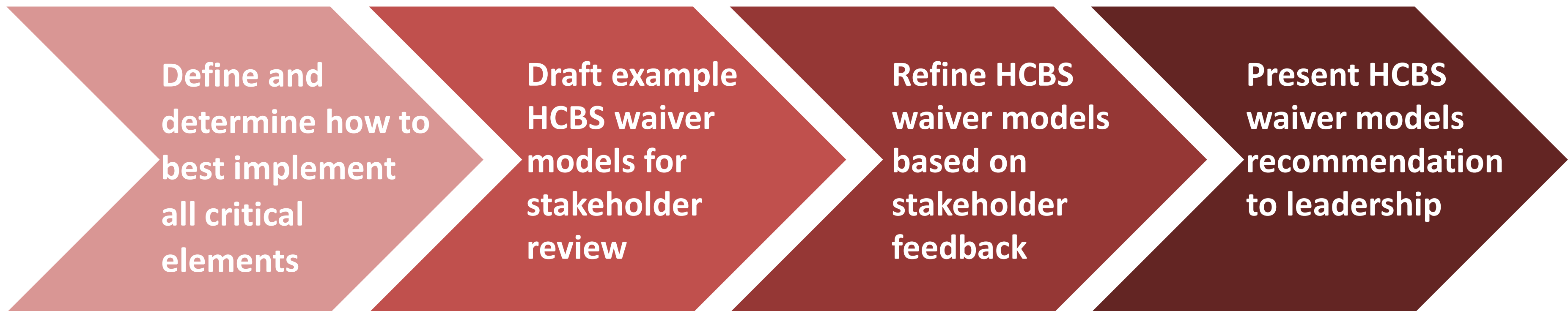
Next Steps

Next Steps

Over the next few months, we will continue developing the future state design of the HCBS waivers.

Stakeholders will have additional opportunities to provide input into the design of the HCBS waivers and to review the model that is developed prior to its submission to the Cabinet for Health and Family Services (CHFS) leadership.



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