WISE Workgroup Report: State Response

Background

The Kansas Department for Health and Environment (KDHE) and the Kansas Department for Aging and Disability Services (KDADS) are proposing the integration of the Home and Community Based Service (HCBS) Medicaid waiver programs. The goal of waiver integration is to create parity for populations served through HCBS programs, offer a broader array of services, improve transitions between HCBS programs, support development and expansion of community-based services, and to make things simpler for KanCare members.

Purpose

The purpose of the Waiver Integration Stakeholder Engagement Workgroup **(**WISE Workgroup) is to provide recommendations concerning five key focus areas including:

- Access, Eligibility and Navigation
- Service Provision and Limitations
- Provider Qualifications and Licensing
- Policy and Regulation Review
- Education, Training and Communications

Through a series of four (4) meetings, these groups convened to discuss wavier integration from the perspective of their focus area. The following recommendations are the outcome of these meetings.

Focus Group Recommendations

I. **Access, Eligibility, and Navigation**

A. Access

1. The transition for a recipient to the 1115 Waiver should occur no later than their birth month. An exception process should be defined to allow for earlier transitions when needed in order to access new services. *State response: The Centers for Medicare and Medicaid Services (CMS) will not permit the State to operate simultaneously 1915(c) waivers for part of each disability population, while other parts of the same population receive their HCBS services through the*

1115 demonstration waiver. When the 1915(c) waivers are integrated into the 1115 waiver, the 1915(c) waivers must be terminated.

2. For those whose eligibility is determined 45 days or less from the date of implementation of the 1115 Waiver, the Individual Service Plan of Care (ISPOC) may include both 1915(c) Waiver services and 1115 Waiver services that start on day of implementation. This will eliminate the need for the ISPOC to be redone shortly after eligibility is established to incorporate the new services when needed. *State response: The Centers for Medicare and Medicaid Services (CMS) will not permit the State to operate simultaneously 1915(c) waivers for part of each disability population, while other parts of the same population receive their HCBS services through the 1115 demonstration waiver. When the 1915(c) waivers are integrated into the 1115 waiver, the 1915(c) waivers must be terminated.*

3. Eliminate waitlists. In the event this is unachievable, no disability population should be disproportionately negatively affected if there is an increased need in one disability population. *State response: The State agrees that waiting lists should be eliminated when possible and savings allow this. Currently Special Terms and Conditions 47 (Earmarked Cost Savings) of the existing 115 demonstration specifies that Kansas must designate a portion of the savings from the 1115 demonstration to moving people from existing waiting lists to HCBS within existing state legislature appropriations.*

4. Cost savings through efficiencies under the 1115 Waiver should be allocated first to the waitlist. Furthermore, the group requests that this is both written into the proposed 1115 Waiver and into contracts that KDADS develops with the MCO's. *State response: The State agrees that waiting lists should be eliminated when possible and savings allow this. Currently Special Terms and Conditions 47 (Earmarked Cost Savings) of the existing 1115 demonstration specifies that Kansas must designate a portion of the savings from the 1115 demonstration to moving people from existing waiting lists to HCBS within existing state legislature appropriations. NOTE: KDHE maintains the contracts with MCOs, but the savings accruing from waiver integration accrues to the State and not the MCOs; therefore, applying savings to removal of people from the waiting list is a State responsibility and not an MCO one. The MCOs will continue to be able to offer "in lieu of" services under waiver integration.*

5. Recipients should qualify for the wavier based on need rather than date of request or wants. The needs assessment criteria should be reviewed and strengthened so as to be more objective and consistent across the waivers. *State response: We agree.*

6. Maintain the current pathway to eligibility to receive HCBS wavier services. *State response: We agree.*

7. Crisis requests should be decided within one business day of the receipt of the request. *State response: One business day is not a reasonable expectation, but we will meet a 10 business day timeline.*

B. Eligibility

1. Rather than creating Child and Adult Packages, set the age for service through the service limitation definitions.[1] *State response: Based upon consultation with our technical assistance consultant, we plan to offer two benefit packages.*

2. During the period of transition to the 1115 Waiver, annual assessments should continue on the same schedule. *State response: We agree.*

3. Any protection offered to recipients under the 1915(c) Waiver should be written into the 1115 Waiver. The group specifically recommends that it is prohibited to deny an individual access to the 1115 Waiver based on the Integrated Service Plan of Care exceeding institutional care costs. *State response: We agree, provided there is no federal prohibition in doing so.*

C. Navigation

1. The participant/family should be notified at least 60 days before current waiver services will end. The participant/family should be given information on options for other waiver eligibility, the eligibility determination process and other relevant information. If the participant is eligible for another waiver, the agency completing the Notice of Action is responsible for connecting the participant with the next waiver program. The goals are to eliminate interruptions in waiver eligibility and create a smooth transition. *State response: We agree sufficient notice should be sent to ensure continuity of services.*

2. Establish HCBS Eligibility Coalitions at the local level. These coalitions should focus on improving collaboration, coordination and increasing a shared understanding of the eligibility process across disability populations. This should be written into contracts and the coalition should meet at least quarterly. *State response: We agree that such local coalitions would be useful, but we will not dictate that they occur.*

3. Develop a Basic 1115 Waiver Training that is delivered or otherwise made available to providers, stakeholders and participants to improve the shared understanding of the 1115 Waiver. *State response: We have already begun offering such training in a one-hour presentation provided by KDHE. These will continue through the planning and implementation phases of waiver integration.*

[1] If there must be packages for reasons such as EPSDT, we recommend that the Child Package runs from 0-18th birthday. The Adult Package should cover 18 years old and older. For services to the TA and SED population, services should remain available until their 22nd birthday.

II. **Service Provision and Limitations**

A. Overall Recommendations

1. Upon the adoption of the below recommendations, we tentatively recommend that there be only one waiver with a single menu of comprehensive services. If the State is going to create a single, integrated waiver, then the recommendations and protections in this report must be adopted and fully implemented. *State response: The WISE workgroup and focus groups were convened to provide advice and input to the State; however, the State Executive and Legislative branches, as well as the Centers for Medicare and Medicaid (CMS) retain the ultimate decision-making authority regarding design of the KanCare program and waiver integration.*

B. Changes In Services- Expansion

1. Expand employment supports, including but not limited to pre/post-employment services, to all populations, where needed, for the successful employment of the consumer, offering competitive and integrated employment as the first option. *State responses: We agree and note that expanding employment supports is one of the reasons for waiver integration.*

2. Expand transitional living skills service to other consumers who have a need. *State response: We are convening a WISE 2.0 focus group to examine this in relationship to supports broker/navigator/community transition specialist.*

3. Expand all other therapies, including cognitive rehabilitation, OT, PT, etc., to those who have a rehabilitative need to extend therapy beyond that which is covered in the state plan, including those with acquired brain injury. *State response: Waiver integration is not designed to expand coverage to populations not already covered by the current seven 1915(c) HCBS waivers. We propose extending therapy coverage beyond State Plan coverage to some of these existing populations, as long as it is medically necessary and there is clear evidence that therapy can be of clinical benefit.*

C. Combination of Services *State response: We agree with all the recommendations in this section.*

1. Combine personal care assistance services into a single service.

2. Combine all respite care except medical respite. Maintain medical respite as a separate service due to provider qualifications and duties.

3. Combine medical alert/personal emergency response system services. Maintain installation as a separate service.

4. Combine health maintenance/ wellness monitoring.

5. Combine assistive services, assistive technology and home modification.

D. New Service Recommendations *State response: At this time since no new funding will be available for Waiver Integration, the only new service we can consider is Support Broker/Service Coordinator. Even this service will be contingent upon projected savings resulting from service substitution.*

1. Sign Language Therapy

2. Support Service Provision

i. This service provides visual communication facilitation for consumers who are blind or deaf/blind.

3. Support Broker/ Service Coordinator

i. This service would provide the hands-on support needed by consumers that is not currently available for some populations and is not billable though Targeted Case Management.

III. Provider Qualifications and Licensing

A. Overall Recommendations

1. Standardize the MCO credentialing and renewal packets *State response: We agree and support this recommendation.*

2. Develop an integrated licensing and credentialing process. *State response: Due to the nature of certain professional licensing requirements, state boards are involved. MCOs, KDADS and KDHE cannot necessarily integrate those with the MCO credentialing process.*

3. Provider qualifications should be simplified and broadened to be appropriate to additional disability populations . *State response: We agree to the extent that this is possible and doesn't conflict with individual clinician licensing requirements.*

4. Additional follow up work is needed. *State response: We agree and believe this work will need to be done after the services are defined and the waiver amendment is submitted.*

B. This focus group provided the comparison cross walk below showing current waver services and recommended provider qualifications changes. These recommendations

were provided using the following principles to guide discussion. *State response: We agree with all three recommendations listed below.*

1. Reduce administrate burdens and streamline process for providers.

2. Ensure providers are qualified.

3. Maintain choice for providers and participants.

C. Service Qualification Matrix *State response: Once the service packages are finalized, we will determine any changes needed to provider qualifications.*

Service	Current Waivers							Provider Qualification Changes Recommended
	IDD	FE	PD	TBI	SED	AU	TA	
Adult Day Care		X						No changes
Assistive Services/Assistive Technology/Home Modifications	X	X	X	X			X	Remove CDDO qualification requirement for IDD. Contractors to be licensed/bonded by city/county regulations (same as current).
Behavior Therapy				X				BCBA OR Masters in behavioral science or special ed. certification; 40 hours of training related to population served or 1 year of experience serving the population
Cognitive Rehabilitation				X				Masters in behavioral science field or special ed. certification; 40 hours of training related to population served or 1 year of experience serving the population
Comprehensive Support		X						No changes
Consultative Clinical & Therapeutic Services (Autism Specialist)						X		BCBA OR Masters in behavioral science field and completion of the state curriculum plus 1,000 hours of training with autism population for BCBA or 2,000 for master's degree.
Day Supports	X							No changes but would not recommend combining adults and children in the same program.
Family Adjustment						X		No changes

Financial Management	X	X	X	X			X	No changes
Health Maintenance							X	No changes
Home Telehealth		X						No changes
Home-Delivered Meal			X	X				No changes
Independent Living/Skills Building					X			No changes except if not working with SED population then supervision would be by a licensed entity (not limited to CMHC).
Intensive Individual Supports						X		21 yrs of age; Work under BCBA or Masters degreed professional; HS Degree or Equiv; 2000 hrs experience with population; state curriculum as applicable
Intermittent Intensive Medical Care							X	No changes other than include state curriculum would be specific to the population served (not limited to TA).
Medical Respite Care							X	No changes
Medication Reminder		X	X	X				No changes
Nursing Evaluation Visit		X						No changes
Occupational Therapy				X				Eliminate 40 hours of disability specific education requirement.
Oral Health Services		X						No changes

Service	Current Waivers IDD	FE	PD	TBI	SED	AU	TA	Provider Qualification Changes Recommended
Parent Support & Training					X	X		No changes other than preference for experience with the specific population (not just SED).
Personal/Attendant Care/Personal Assistants/Supportive Home Care	X	X	X	X	X		X	18 years of age or high school diploma supervised by licensed facility plus disability specific training consistent with policy requirements (as relates to relationship).*

Personal Emergency Response/Medical Alert Rental	X	X	X	X				Remove the CDDO affiliation requirement.
Physical Therapy				X				Eliminate 40 hours of education requirement.
Professional Resource Family					X			No changes
Residential Supports	X							No changes
Respite/Short Term/Overnight	X				X	X		18 years of age; supervised by licensed entity (not limited to CMHC supervision) and state curriculum for autism if serving that population.
Sleep Cycle Support	X	X	X	X				18 years of age, high school diploma supervised by licensed facility plus disability specific training consistent with policy requirements (as relates to relationship).
Specialized Medical Care	X						X	No changes
Speech & Language Therapy/Interpersonal Communication Therapy				X		X		Licensed speech therapist; 40 hours of training related to population served
Supported Employment	X							18 years of age, high school diploma supervised by licensed facility plus certification for supported employment (examples: Certified Employment Support Professional. ACRE Certified Support Specialist, etc.).
Transitional Living Skills				X				18 years of age, high school diploma supervised by licensed facility plus certification in transitional living skills specific to disability
Wellness Monitoring	X	X						LPN with specialized training under the supervision of RN (consistent with nurse practice act).

Wraparound Facilitation					X			No changes other than broaden training requirement to include other disabilities.
Supports Broker								BA/BS or work experience/combination with training requirement specific to disability/age population
Self-Directed - Services								No changes

*Consensus was not reached on the age limit for this service and this might be an area for further stakeholder discussions.

IV. Policy and Regulation

A. Establish an Operational Council to assist with a detailed regulation/policy review and development of specific recommendations to operationalize the integrated waiver. *State response: We do not believe there need to be two advisory groups related to policies.*

B. Establish a clear timeline for interim steps for collaboration between the Operational Council, KDADS and KDHE to ensure adequate time for thorough review and drafting of revisions or development of new regulations and policy as needed with a contingency plan to push back the target implementation date as necessary. *State response: The State will make every effort to allow time for policy and regulation review; however, the State Executive and Legislative branches, as well as the Centers for Medicare and Medicaid (CMS) retain the ultimate decision-making authority regarding the implementation date for waiver integration.*

C. KDADS and KDHE should immediately establish a Policy Advisory Council to include stakeholders representing systems responsible for delivery of waiver programs. This advisory council will assist State staff in the development/revision of current policy needed to support the 1915(c) waivers in place and would continue under an integrated waiver. *State response: We agree. KDADS is in the process of soliciting representatives for the policy advisory council.*

D. The State should develop a specific plan for communication regarding regulation and policy. Regulations and policies should be easily located by end users and should be clear, concise and accessible; this should include a single access point to find the same information for all waiver populations. Regulations and policies should be understandable to those impacted by them and involved in the public review and comment. The State should use plain language and various methods; the State should not rely on only on its website or internet access as a means of posting to the public for review and comment (consider use of social media). *State response: We agree policies should be easy to understand and locate. KDADS will work with the policy*

advisory council on suggestions of improvement.

E. Collaborate with stakeholders to write an integrated waiver program manual (like Autism and SED waivers) and develop a basic set of policies to further operationalize aspects of the program manual. *State response: We agree.*

F. The following topics should be addressed through regulation and/or policy for transition to an integrated waiver:
   - Program Oversight/Administration (process for manual development, regular reviews and updates; compliance for consistent application of all policies across populations and locations throughout the state)
   - Eligibility (criteria, functional assessment, exceptions, assessor qualifications/training).
   - Access (to funding or specific services, exceptions due to crisis or priority populations)
   - Waiting List
   - Transitions (multi-eligibility, benefits packages/services)
   - Person Centered Support Planning (PCSP) and service delivery
   - Conflict of Interest avoidance
   - Grievance/Appeal/Conflict Resolution regarding beneficiary Rights & Responsibilities
   - Rights & Responsibilities of Persons Served (including all settings)
   - Critical Incidents & Freedom from Abuse, Neglect & Exploitation
   - Gatekeeping
   - Quality Assurance/Continuous Quality Improvement/Program Integrity
   - Prompt Payment
   - Self-Direction
   - Data Integrity and Management

State response: As the Waiver Integration project moves along, there will be discussions and work related to policy. All KDADS policies related to Medicaid programs will follow the Medicaid policy process and include topics relevant to the services, populations served and providers.

G. All regulations and/or policies for the 1115 Integrated Waiver should preserve 1915 (c) Waiver Protections/Assurances including:

   - Administrative Authority, including but not limited to ADA, DDRA, Article 63 and Article 64
   - Number of Waiver Participants
   - Health and Welfare to include Medicaid Entitlement Language
   - Access to Services
   - Level of Care Assurances
   - Service Plan
   - Continuity-of-care period during the transition to the integrated waiver

State response: No Medicaid waiver can waive ADA requirements or other federal statutes and regulations that are outside the Medicaid program. We will make every effort to continue all the assurances that the 1915(c) waivers contain. Please note that there is no entitlement to HCBS. People who are eligible for Medicaid are entitled to all medically necessary State Plan services and children in the Medicaid program are entitled to early periodic screening, diagnosis and treatment (EPSDT) which allows coverage for medically necessary services that the State Plan could cover. EPSDT is not an entitlement to HCBS.

V. Education, Training and Communications

A. General

1. Clearly define success
   State response: We believe our 1115 demonstration amendment will do this.

2. The state agencies and MCOs should work to improve management information systems and transparency, especially communication of data and measurable outcomes.
   State response: Current 1115 demonstration quarterly and annual reports, along with the Medical Assistance Reports (MAR) detail utilization information, along with outcomes data.

3. Continue to bring state staff and all stakeholders together (including providers, MCOs, advocates, and consumers) to communicate, collaborate, and work together.
   State response: We agree and will continue to work with stakeholders.

B. Communication

1. Make sure all documents use both person-first language and plain language at the sixth-grade level.
   State response: We agree.

2. Fix Inconsistent Notices of Action
   State response: We agree that we need to ensure that Notices of Action are clear and consistent.
   i. NOAs sometimes have incorrect due-process information.

   ii. Clarify inconsistent information as it relates to the two-prongs of eligibility (financial and functional eligibility).

3. Have consistent communication with consumers about client obligation and establish consistent collection practices across the state.
   State response: KDADS, KDHE, and the MCOs are currently evaluating this

process to ensure appropriate notifications to providers and consumers regarding client obligations.

4. Regular, planned communication-both verbal and written.
   State response: We agree.

5. Improve the process to store and change addresses
   State response: We are currently evaluating this process via WISE 2.0 and look forward to suggestions.

6. Quickly reduce uncertainty.
   State response: We hope that our convening the WISE Workgroup and public meetings we have held and will hold will help to reduce uncertainty; however, as we try to be transparent, that often means we share incomplete information since program design and policy are not completely determined.

C. Education/Training

1. Utilize the State universities.
   State response: As there is funding we will partner with state universities to help with education and training.

2. Utilize peer to peer training.
   State response: We agree we should try to use peer to peer training when we can, especially to help consumers understand Waiver Integration.

3. Utilize the train-the-trainer model.
   State response: We agree that this model can be useful and we will consider it where it is appropriate.

4. Utilize a wide variety of mediums to provide the training and education.
   State response: We agree.

D. Provider Training:

1. We recommend there be a process through which all providers would be required to receive a waiver integration certificate before they can provide services.
   State response: This could be problematic if the intent is for every staff person in an agency to take this training, particularly in who should be responsible for policing the requirement. We agree that such training could be developed and offered, but believe it should be voluntary.

2. Clearly communicate there are multiple eligibility steps to go through and where consumers are in that process.
   State response: The state has been offering eligibility training to providers and encouraging them to attend to understand the steps. The Medicaid Waivers

training currently being offered touches on both the financial and functional eligibility that must be met for access to HCBS.

3. Be sure to educate providers about resources to help consumer answer questions.
   State response: We agree and hope that all stakeholders will help with this.

4. MCO staff needs more education about all of the benefit plans and the services available. There needs to be a more unified, consistent message on what is allowed and not allowed as well as where ultimate authority rests.
   State response: We agree and note that a large number of MCO staff have registered for Medicaid Waivers training and attended other Medicaid training.

5. Clarify for providers as to how each population qualifies for the benefit plan.
   State response: We agree that this needs to be done as we head into implementation.

6. Provide more standardization in training for direct care/personal care workers for agency-directed services.
   State response: While we agree that everyone can benefit from more training, we are reluctant to mandate additional training that will have to be paid for by the State either directly or through increased reimbursement rates when there is no new money for this initiative.

7. Provide more education of DCF Adult and Protective Services workers, Child Protection workers, and the child welfare providers of the services available in the benefit plans. Provide generalized training to them on the benefits and services.
   State response: We agree and note that many of these staff have registered for Medicaid Waivers training. Other Medicaid Training topics are also offered to them twice yearly.

8. Ensure that the goal of helping people to become more independent remains a prominent component of the program.
   State response: We agree and have included this in our guiding principles for the Waiver Integration project.

9. We are also recommending there be a basic series of trainings most providers should have and these could include the following:

   a. Health and Safety
   b. Basic First Aid
   c. CPR
   d. Basic 101 Medicaid training
   e. HIPAA
   f. Abuse, Neglect, and Exploitation
   g. Basic Person-Centered support planning/person first “thinking skills”
   h. Basic medication side effects

State response: While we agree that everyone can benefit from more training, we are reluctant to mandate additional training that will have to be paid for by the State either directly or through increased reimbursement rates when there is no new money for this initiative.

Conclusion

The next step in the process is to provide these recommendations to the broader stakeholder network. After gathering comments on the recommendations, state staff will determine the need for additional work group meetings and the topics requiring discussion.