TEAM KENTUCKY®

CABINET FOR HEALTH AND FAMILY SERVICES

Medicaid Stakeholder Forum

July 18, 2024

- Welcome
- Public Health Emergency Unwinding Update
- New Federal Rules and Acts
- School-Based Services
- Reentry Services Update
- Medicaid Equity Initiatives
- Quality Initiatives Update
- Strategic Planning

Public Health Emergency (PHE)

The Secretary for the Department of Health and Human Services declared a PHE on January 31, 2020, due to COVID-19, that ended on May 11, 2023

The PHE allowed states several flexibilities by:

- Triggering a variety of federal emergency powers
- Temporarily waiving certain Medicaid and Children's Health Insurance Program (CHIP) requirements
- Permitting continuous coverage with 6.2% enhanced Federal Medical Assistance Percentage (FMAP)

PHE flexibilities ended on May 11, 2023*

The Consolidated Appropriations Act 2023 separated continuous coverage from the PHE effective **March 31, 2023** and phases out the enhanced FMAP through December 31, 2023

Upon PHE expiration

- ✓ End PHE flexibilities
- ✓ Resume temporarily waived requirements and conditions
- ✓ Permanently integrate specific flexibilities into state plan or waivers

*Per CMS Guidance released in May 2024, PHE flexibilities are extended through June 30, 2024.

PHE Unwinding Today

- Last PHE renewals for adults have been initiated with a due date of May 31.
- Ongoing annual renewals for non-PHE cases resumed in April with a due date of May 31.
- Ongoing flexibilities in place through June 2025.
- Certain Appendix K flexibilities made permanent in waivers effective May 1.
- April, May, and June renewals in 90-day Reconsideration Period.
- CMS monthly and updated reporting ongoing.

Month	Total	Approvals	Terminations
May	73999	42989	30968
Jun	79,382	45,723	33,633
Jul	54,485	35,344	19,100
Aug	53,294	35,735	17,430
Sep	103,804	87,735	16,067
Oct	155,421	121,632	33,774
Nov	73,544	53,189	20,338
Dec	41,104	34,306	6,795
Jan	79,658	75,827	3,830
Feb	75,497	65,990	9,507
Mar	96,473	74,192	22,236
Apr	122,967	69,102	7,290
May*	82,890	43,966	898

Unwinding Report Updates Posted

Original CMS Monthly Reports

	Individual Renewals	Medicaid Approvals	Medicaid Terminations	Pending
May	80,673	37,182	34,124	2,698
Jun	82,606	37,364	35,971	1,883
Jul	54,975	27,044	20,344	1,325
Aug	54,344	28,296	18,662	1,069
Sept	150,985	81,144	16,617	16
Oct	155,003	92,524	12,780	15
Nov	31,863	22,888	1,508	38
Dec	30,705	28,889	1,244	2
Jan	79,053	67,748	10,899	22
Feb	93,004	64,789	10,128	1
Mar	97,962	70,358	7,932	72

90-Day Processing Period

2,659 processed
1868 processed
1,287 processed
1064 processed
14 processed
7 processed
33 processed
2 processed
22 processed
1 processed
72 processed

Updated CMS Monthly Reports*

	Individual Renewals	Medicaid Approvals	Medicaid Terminations	Pending
May	80,673	38,552	35,413	39
Jun	82,606	38,236	36,967	15
Jul	54,975	27,775	20,900	38
Aug	54,344	28,853	19,169	5
Sept	150,985	81,156	16,169	2
Oct	155,003	92,528	12,783	8
Nov	31,863	22,900	1,529	5
Dec	30,705	28,891	1,244	0
Jan	79,053	67,758	10,911	0
Feb	93,004	64,780	10,128	0
Mar	97,962	70,404	7,958	0

*Per CMS' Medicaid and Children's Health Insurance Program Eligibility and Enrollment Data Specifications for Reporting During Unwinding, Updated October 2023, Version 3.

KY Medicaid Renewals* and Reinstatements

Individuals procedurally terminated on their renewal due date are given 90 days to respond and provide requested information. If they are determined eligible, coverage is **reinstated** back to their termination date. Months that are still within the 90-day window and are still processing reinstatements are included below.

	Individual Renewals	Medicaid Approvals	Medicaid Terminations	Pending	Extended	Reinstatements as of 07/15/24
April	103,265	70,170	15,887	226	16,982	3,628
May	94,705	51,534	37,461	816	4,894	3,269
June	58,959	41,336	13,187	1	4,435	213

*Numbers are based on CMS Reports.

KY PHE Website Resources

https://medicaidunwinding.ky.gov

- Stakeholder Session Information
- KY PHE Reports
- FAQs
- Medicaid Member Information
- Medicaid Provider Information
- Communication Materials

1 Update your information in kynect!

To update your mailing address, phone number, email, and other contact information:

Visit kynect.ky.gov

-or-

Call kynect at 855-4kynect (855) 459-6328

2 Please Respond!

If you received a Medicaid Renewal Packet or Request for Information please respond.

Even if circumstances have changed we still need to hear from you!

Coverage can be reinstated if you missed your due date and are still eligible.

3 Get free local help!

Free help with your benefit application is available.

A kynector can help you!

Find a kynector - Get Local Help

4 No longer qualify for Medicaid?

If you no longer qualify for Medicaid, you can still get help from kynect!
You may be eligible to enroll in a Qualified Health Plan with Financial Assistance to help pay for premiums, co-pays and more.

A licensed insurance agent can help you at no cost to you!

Find an Insurance Agent - Get Local Help

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New Federal Rules and Acts: Shaping the Future of the Medicaid Program

MEDICAID ADVISORY COMMITTEE AND BENEFICIARY ADVISORY COUNCIL

HOME AND COMMUNITY BASED SERVICES (HCBS) AND NURSING FACILITY SERVICES

RATE TRANSPARENCY

Restructuring Advisory Councils: Elevating Member and Stakeholder Voices

Medicaid Advisory Committee (MAC) + Beneficiary Advisory Council (BAC)

- Expand the scope and use of States' MACs
- Rename the Medicaid Advisory Committee.
- Require States to establish a BAC
- Establish minimum requirements for Medicaid beneficiary representation on the MAC.
- Promote transparency and accountability between the State and interested parties by making information on the MAC and BAC activities publicly available.

Payment Analysis & Transparency

Fee-for-Service

Replaces the Access Monitoring Review plan with new requirements to publicly post rates and conduct a comparative analysis with Medicare every two years. Medicaid must:

- Publish all FFS rates and methodologies (including bundled rates), stratify rates by certain variables, and list when rates were last updated
- Conduct an analysis that compares Medicaid to Medicare rates for primary care, OB/GYN, and outpatient mental health and SUD
- Disclose rates for personal care, home health aide, homemaker and habilitation to CMS

CMS may withhold FFP for non-compliance

Goes into effect July 1, 2026

Managed Care

Requires managed care plans to submit the following payment analysis to the Medicaid agency. Medicaid must review the analysis, send it to CMS, and publicly post it. It must include:

- Comparison of plan's rates to Medicare for primary care, outpatient mental health and SUD, and OB/GYN services
- Comparison of plan's rates for homemaker, home health aide, personal care, and habilitation services to FFS Medicaid rate

These payments are excluded: FQHCs, RHCs, and for services for which the plan is not the primary payer

Goes into effect for rating periods on or after July 9, 2026

Rate Restructuring

- Replaces current Access Monitoring Review Plan process with a **two-tiered approach for any SPA which reduces or restructures a FFS rate**.
  - For SPAs that **meet each of the following requirements,** CMS will not require further analysis to accompany the SPA submission:
    - Does not exceed a 4% reduction for the service in a single state fiscal year
    - The service, after reduction or restructuring, is at least 80% of a comparable Medicare service
    - The state meaningfully addresses any concerns raised in public notice and comment
  - **If any of these three requirements are not met**, CMS requires additional analysis with the SPA submission:
    - Summary of proposed payment change, including rationale and cumulative effect of changes on aggregate FFS spend in impacted categories of services
    - Documentation of current and historical trends in access for impacted service for the 3 years preceding the SPA submission date, using quantitative and qualitative information
    - Summaries of, and responses to, any access to care concerns or complaints from beneficiaries, providers, or interested parties

Compliance Date: Effective date of the rule **(July 9, 2024)**

Direct Care Worker Compensation

- CMS finalizes a requirement for **80% of Medicaid payments for specified home-and-community-based services to** be spent on compensation for direct care workers (DCWs) starting **July 9, 2030**
    - Personal care, home health, homemaker, and habilitation services
    - Includes nurses, nursing assistants, direct support professionals, personal care attendants, home health aides, and clinical supervisors.
    - Includes other individuals paid to provide services to address Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs), behavioral supports, employment supports, and other services to promote community integration
- Annual reporting requirement on percentage of Medicaid payments spent on DCW compensation starting **July 9, 2028**
    - Report separately by service
    - Within each service, report self-directed services and facility-related costs separately
- One-time reporting requirement on readiness to collect data on percentage of Medicaid payments spent on DCW compensation by **July 9, 2027**

DCW Compensation: Exemptions

NEW FROM PROPOSED RULE: CMS finalizes two options for Medicaid agencies to adjust or exempt the 80% DCW compensation requirement for certain providers. States may use one or both options.

Option 1

Small Provider Minimum Performance Level

- State may set a compensation percentage below 80% for small providers.
- Criteria for small provider identification must be developed through a transparent process with public comment. Criteria must be approved by CMS.
- State must submit a plan to CMS for trajectory for small providers to meet 80% standard “within a reasonable period of time”.

Option 2 2

Hardship exemption

- State may create a hardship exemption from the 80% standard for providers facing extraordinary circumstances preventing compliance.
- Exemption criteria must be developed through a transparent process with public comment and be approved by CMS.
- States must submit a plan to CMS for reducing exempted providers “within a reasonable period of time”.

Nursing Facility Staffing Ratios

- CMS finalized a rule requiring a total nurse staffing standard of **3.48 hours per resident day (HPRD)** by **May 11, 2026** for urban NFs and **May 10, 2027** for rural NFs
  - Must include at least 0.55 HPRD of direct Registered Nurse (RN) care and 2.45 HPRD of direct nurse aide (NA) care. Nursing staff-specific ratios here must be in place by **May 10, 2027** for urban NFs and by **May 10, 2029** for rural NFs
  - Any combination of nurse staff (RNs, Licensed Practical Nurses, Licensed Vocational Nurses, or nurse aides) to account for remaining 0.48 HPRD
- 24/7 on-site RN requirement (by **May 11, 2026** for urban NFs; **May 10, 2027** for rural)
- Limited hardship exemptions available for both of these requirements, assuming good faith effort made:
  - Facilities in a geographic area with limited nursing staff availability (at least 20% below national average) exempt from 3.48 HPRD requirement
  - Facilities in geographic area with limited RN availability (at least 20% below national average) exempt from 0.55 HPRD of RN care and 24/7 RN requirement
  - Facilities in geographic area with limited NA availability (at least 20% below national average) exempt from 2.45 HPRD of NA care

Institutional Payment Transparency

Separately in the minimum staffing rule, CMS finalizes new payment transparency requirements for Medicaid institutional services (nursing facilities, intermediate care facilities [ICFs] for I/DD) taking effect on **May 10, 2028.**

These require Medicaid programs to publicly report on an accessible website and to CMS:

- Percentage of Medicaid payments made to NFs and ICFs spent on compensation for direct care workers and support staff in both fee-for-service and managed care delivery systems
- Direct care workers includes nursing staff and clinical staff; support staff include janitorial staff, drivers, housekeepers, etc.)
- Travel costs, training costs, and personal protective equipment costs **are not included** in the definition of compensation

School-Based Services Grant Award Overview

Grant Overview

Background
Through the Bipartisan Safer Communities Act (BSCA) the Centers for Medicare & Medicaid Services (CMS) awarded DMS a $2.5 million school-based Medicaid service enhancement cooperative agreement.

Project Duration
The period of performance is 36 months with three 12-month payment increments.

Award Highlight
DMS was one of three awardees within the enhancement category in a national bid open to all state Medicaid agencies.

Partnership
The grant application was based upon partnership between the Kentucky Lieutenant Governor's Office, Department for Medicaid Services, Department of Education, and Department for Behavioral Health, Developmental, and Intellectual Disabilities.

Grant Funding Categories

Enhancement

States that have yet to expand the coverage of and billing for Medicaid and CHIP services provided in schools beyond that which is provided pursuant to a student's Individualized Education Plan (IEP)/Individualized Family Service Plan (IFSP).

Expansion

States that have expanded the coverage and billing of Medicaid or CHIP services provided in schools beyond what is provided pursuant to a student's IEP/IFSP.

Implementation

States that have expanded the coverage and billing of Medicaid services provided in schools to include any Medicaid- or CHIP-covered service provided regardless of whether that service is provided pursuant to a student's IEP/IFSP, 504 Plan, or any other Medicaid or CHIP enrolled beneficiary.

Kentucky School-Based Services History

2019 State Plan Amendment

- Extended SBS for all children and adolescents enrolled in the Medicaid program.
- Expanded coverage beyond the Individuals with Disabilities and Education Act requirements of Medicaid coverage for IEP/IFSP necessary services.

2020 State Plan Amendment

- Revised the school-based services reimbursement methodology.
- Final reimbursement for school-based services are based on cost reports submitted.
- All qualified providers of non-IEP/IFSP services approved within the Medicaid state plan are paid the same as providers and services outside the school-based setting (same fee schedules).

2024-2027 CMS SBS Enhancement Grant

- Focused on increasing provider and staff capacity to allow for greater access to behavioral health and other healthcare services in school settings.
- Strengthening school-based health care service infrastructure to increase access to behavioral health services through telehealth usage.

SHINE KY Project Goals

Goal 1:

Enhance and strengthen Kentucky's SBS infrastructure to increase access to behavioral and other health care services in school settings through increasing provider and staff capacity by at least 40% within 3 years.

- **Objective 1.1:** Reduce/eliminate provider billing barriers.
- **Objective 1.2**: Increase overall capacity of behavioral health providers in a school setting.
- **Objective 1.3**:Increase availability of reimbursement opportunities to expand behavioral health services across the care continuum.

Goal 2:

Enhance and strengthen Kentucky's SBS infrastructure to increase access to behavioral health care services through availability of telehealth by 25% within 3 years.

- **Objective 2.1:** Develop and implement a telehealth program to support access to behavioral health services and provider education.

School-Based Services Enhancement Strategies

Targeted Clinical & Admin Staff Recruitment

- Directly support for the hiring of clinical and administrative staff within school districts.

Launching the SHINE KY Grant Program

- Initiate a grant program to support local school communities with integration and evaluation of enhanced behavioral health services, providing a model for broader implementation. Expecting $100,000 grants to 7 recipients.

Training & Capacity Building to Increase Awareness of Expanded Access Services & Billing

- Provide additional training to districts and providers regarding covered services, parental consent, and provide specialized training as needed.

Outreach & Community Engagement to Increase Parental Involvement

- Develop and implement targeted outreach to educate students, parents, and school staff as well as expand community engagement efforts.

Enhancing Physical & Technological Infrastructure

- Enhance physical and technological infrastructure within school-based settings including renovations for privacy in behavioral health consultations, and necessary systems, training, and resources.

Supporting Sustainability Planning & Programmatic Evaluation

- Continue comprehensive program evaluation to make informed decisions

Immediate Next Steps: **Needs & Infrastructure Final Assessment**

Initiate the stakeholder input process to inform program and infrastructure needs assessments, and identify gaps and opportunities in Medicaid and CHIP SBS, with a focus on behavioral health and equitable access to care.

Kentucky's Section 1115 Reentry Demonstration

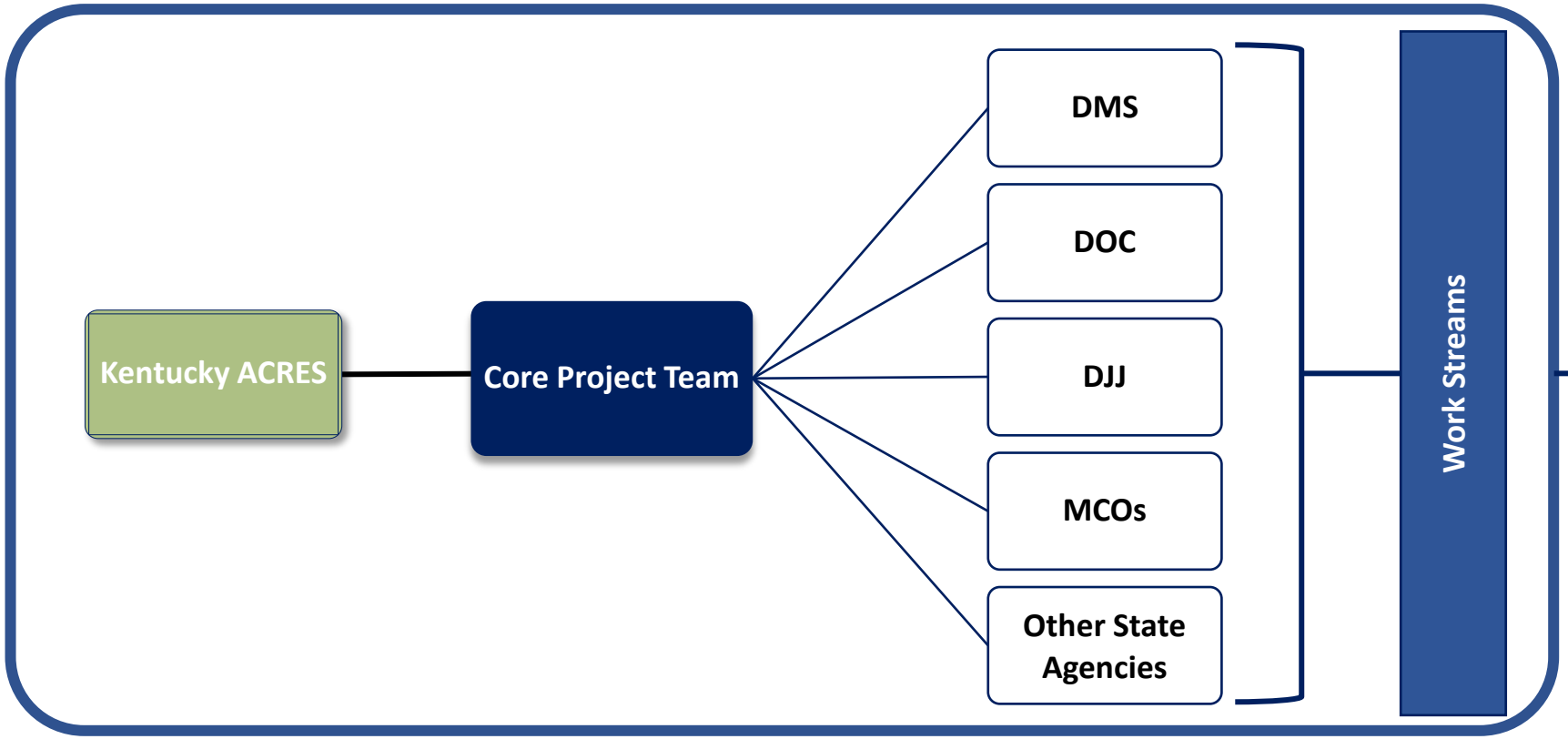
Justice Involved Individuals (JII) are at higher risk for poor health outcomes, injury, and death than the general public.

CMS **approved** Kentucky's 1115 Reentry Demonstration on July 2, 2024.

Provide Medicaid coverage for certain transitional services to JIIs in designated public institution(s), ensuring continuity of health care coverage pre- and post-release, and facilitating linkages to medical, behavioral health and health related social needs upon release.

Reentry Program	Adults	Juveniles
Enrollment & Suspension	• Initiate Medicaid application process for incarcerated individuals. • Begin no later than 60 days before expected release date. • Once enrolled, suspend, not terminate eligibility.	• Initiate Medicaid application process for confined youth. • Begin no later than 60 days before expected release date. • Once enrolled, suspend, not terminate eligibility.
Pre-Release Services Timeframe	60 Days	60 Days
Pre-Release Service Facilities/Locations	14 State Prisons*	DJJ Youth Development Centers* (Youth adjudicated and committed to DJJ custody)
Benefit & Service Package	• Case Management. • Medication Assisted Treatment (MAT) – Requires SUD diagnosis. • 30-day supply of medication.	• Case Management. • Medication Assisted Treatment (MAT) – Requires SUD diagnosis. • 30-day supply of medication.
Service Delivery Methods	In-person and Telehealth	In-person and Telehealth

Reentry Project Oversight



DMS will maintain authority and provide oversight of all activities.

Final approval of demonstration policy will be aligned to CMS Guidance.

Role of Kentucky ACRES

- Provides Executive-level oversight and strategic direction to the project team.
- Ensures alignment of the broader Reentry goals and objectives.

Role of the Core Project Team

- Focused on implementation tasks and project needs.
- Supports policy development and strategy execution.
- Executes strategies according to policy.
- Provides direct oversight of the project work streams.

Health Equity Initiatives

Social Determinants of Health (SDoH) Assessment

Kentucky Benefits | kynect

Purpose:
Allows individuals utilizing the Benefits Exchange system to complete the optional SDoH assessment.

Benefit:
Allows closed-loop referrals for Medicaid members.

4 Managed Care Organizations (MCOs) are onboarded as community partners.

PSN-12 Report

Purpose:
Allows DMS to determine the providers that have not billed for services within 1 year.

Benefit:
Allows the state to better assess true network adequacy for the Medicaid provider network.

Health Risk Assessment

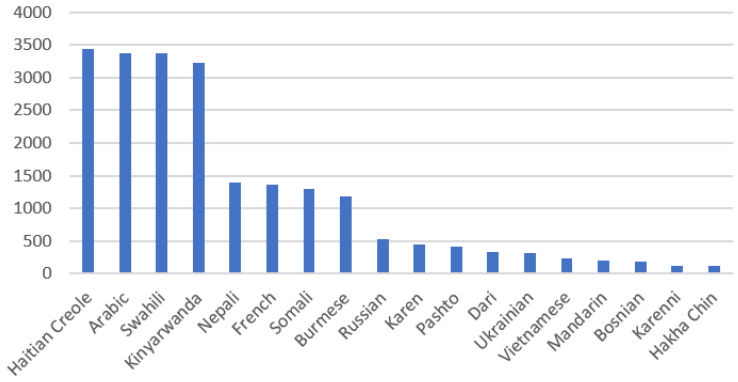
Purpose:
Streamlined HRA process across all MCOs.

Benefit:
Increase member participation.

Collect stratified REaL and SOGI data.

Medicaid Application Update

[Medicaid - How to Apply - Cabinet for Health and Family Services (ky.gov)]



13 Languages	
ENGLISH	UKRAINIAN
SPANISH	VIETNAMESE
FRENCH	ARABIC
KINYARWANDA	BOSNIAN
MANDARIN	BURMESE
NEPALI	HAITIAN CREOLE
SWAHILI	

Quality Initiatives and Programs

- Managed Care Organization Value Based Purchasing Program
- Awarded Continuous Glucose Monitoring Grant
- Medicare Academy: Capacity-Building for Advancing Medicare-Medicaid Integration training program
- The Policy Center for Maternal Mental Health 2024-2025 cohort
- 2027 Medicaid and CHIP Child and Adult Core Set Annual Review Workgroup
- UK/UL 2025 Directed Payment Program
- Hospital Rate Improvement Program
- Quality Focus Studies https://www.chfs.ky.gov/agencies/dms/dpqo/mco-qb/Pages/reports.aspx

DMS Strategic Plan

- Covers next two fiscal years
- Anticipated effective date Jan. 1, 2025
- Goals:
  - Maintain direction of the agency internally
  - Define mission, vision, and values
  - Encourage partners to work with DMS
  - Further define who we are, where we are in our work, and where we want to be
  - Demonstrate public value
  - Provide opportunities for two-way conversations with stakeholders and others

The Kentucky Department for Medicaid Services is conducting a survey of its partners and stakeholders to gather feedback for its strategic plan. We are interested in your opinions. All questions are optional, and the survey is anonymous. You may include your contact information at the end of the survey if you are interested in providing additional feedback.

Questions? Contact DMS strategic plan lead Emily B. Moses at emilyb.moses@ky.gov.

Take the Survey

Questions

Open call for topics of interest!

What would you like to hear more about from the Cabinet?