STATEMENT OF EMERGENCY

907 KAR 1:160E

(1) This emergency administrative regulation is being promulgated to add goods and services to the consumer-directed option consistent with KRS 205.5606 and with a waiver approved by the Centers for Medicare and Medicaid Services (CMS).

(2) This action must be taken on an emergency basis to comply with KRS 205.5606.

(3) This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler.

(4) The ordinary administrative regulation is identical to this emergency administrative regulation.

_____
Ernie Fletcher
Governor

_____
Mark D. Birdwhistell, Secretary
Cabinet for Health and Family Services

CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Long Term Care and Community Alternatives

(Emergency Amendment)

907 KAR 1:160E. Home and community based waiver services.

RELATES TO: KRS 205.520(3), 205.5605, 205.5606, 205.5607, 205.635, 42 C.F.R. 440.180

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.5606, 42 C.F.R. 440.180, 42 U.S.C. 1396a, b, d, n

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet to comply with any requirement that may be imposed, or opportunity presented, by federal law for the provision of medical assistance to Kentucky's indigent citizenry. KRS 205.5606(1) requires the cabinet to promulgate administrative regulations to establish a consumer-directed services program to provide an option for the home and community based services waiver. This administrative regulation establishes the provisions for home and community based waiver services, including a consumer directed services option pursuant to KRS 205.5606.

Section 1. Definitions. (1) "ADHC" means adult day health care.

(2) "ADHC center" means an adult day health care center licensed in accordance

with 902 KAR 20:066, Operation and services; adult day health care programs.

(3) "ADHC services" means health-related services provided on a regularly-scheduled basis that ensure optimal functioning of an HCB recipient who does not require twenty-four (24) hour care in an institutional setting.

(4) "Advanced registered nurse practitioner" or "ARNP" means a person who acts within his or her scope of practice and is licensed in accordance with KRS 314.042.

(5) "Assessment team" means a team which:

(a) Conducts assessment or reassessment services; and

(b) Consists of:

1. Two (2) registered nurses; or

2. One (1) registered nurse and one (1) of the following:

a. A social worker;

b. A certified psychologist with autonomous functioning;

c. A licensed psychological practitioner;

d. A licensed marriage and family therapist; or

e. A licensed professional clinical counselor.

(6) "Blended services" means a nonduplicative combination of HCB waiver services identified in Section 5 of this administrative regulation and CDO services identified in Section 6 of this administrative regulation provided pursuant to a recipient's approved plan of care.

(7) "Budget allowance" is defined by KRS 205.5605(1).

(8) "Certified psychologist with autonomous functioning" or "licensed psychological practitioner" means a person licensed pursuant to KRS Chapter 319.

(9) "Communicable disease" means a disease that is transmitted:

(a) Through direct contact with an infected individual;

(b) Indirectly through an organism that carries disease-causing microorganisms from one (1) host to another or a bacteriophage, a plasmid, or another agent that transfers genetic material from one (1) location to another; or

(c) Indirectly by a bacteriophage, a plasmid, or another agent that transfers genetic material from one (1) location to another.

(10) "Consumer" is defined by KRS 205.5605(2).

(11) "Consumer-directed option" or "CDO" means an option established by KRS 205.5606 within the home- and community-based services waiver that allows recipients to:

(a) Assist with the design of their programs;

(b) Choose their providers of services; and

(c) Direct the delivery of services to meet their needs.

(12) "Covered services and supports" is defined by KRS 205.5605(3).

(13) "DCBS" means the Department for Community Based Services.

(14) "Department" means the Department for Medicaid Services or its designee.

(15) "Electronic signature" is defined by KRS 369.102(8).

(16) "HCB recipient" means an individual who:

(a) Is a recipient as defined by KRS 205.8451(9);

(b) Meets the NF level of care criteria established in 907 KAR 1:022<u>, Nursing facility services and intermediate care facility for individuals with mental retardation or a developmental disability services</u>; and

(c) Meets the eligibility criteria for HCB waiver services established in Section 4 of this administrative regulation.

(17) "Home and community based waiver services" or "HCB waiver services" means home and community based waiver services for individuals who meet the requirements of Section 4 of this administrative regulation.

(18) "Home and community support services" means nonresidential and nonmedical home and community based services and supports that:

(a) Meet the consumer's needs; and

(b) Constitute a cost-effective use of funds.

(19) "Home health agency" means an agency that is:

(a) Licensed in accordance with 902 KAR 20:081, Operation and services; home health agencies; and

(b) Medicare and Medicaid certified.

(20) "Licensed marriage and family therapist" or "LMFT" is defined by KRS 335.300(2).

(21) "Licensed practical nurse" or "LPN" means a person who:

(a) Meets the definition of KRS 314.011(9); and

(b) Works under the supervision of a registered nurse.

(22) "Licensed professional clinical counselor" or "LPCC" is defined by KRS 335.500(3)

(23) "NF" means nursing facility.

(24) "NF level of care" means a high intensity or low intensity patient status determination made by the department in accordance with 907 KAR 1:022, Nursing facility ser-

vices and intermediate care facility for individuals with mental retardation or a developmental disability services.

(25) "Normal baby sitting" means general care provided to a child which includes custody, control, and supervision.

(26) "Occupational therapist" is defined by KRS 319A.010(3).

(27) "Occupational therapist assistant" is defined by KRS 319A.010(4).

(28) "Patient liability" means the financial amount an individual is required to contribute toward cost of care in order to maintain Medicaid eligibility.

(29) "Physical therapist" is defined by KRS 327.010(2).

(30) "Physical therapist assistant" means a skilled health care worker who:

(a) Is certified by the Kentucky Board of Physical Therapy; and

(b) Performs physical therapy and related duties as assigned by the supervising physical therapist.

(31) "Physician assistant" or "PA" is defined by KRS 311.840(3).

(32) "Plan of care" or "POC" means a written individualized plan developed by an HCB recipient or an HCB recipient's legal representative, case manager, or other individual designated by the HCB recipient.

(33) "Plan of treatment" means a care plan used by an ADHC center.

(34) "Registered nurse" or "RN" means a person who:

(a) Meets the definition established in KRS 314.011(5); and

(b) Has one (1) year or more experience as a professional nurse.

(35) "Representative" is defined by KRS 205.5605(6).

(36) "Sex crime" is defined by KRS 17.165(1).

(37) "Social worker" means a person with a bachelor's degree in social work, sociology, or a related field.

(38) "Speech-language pathologist" is defined by KRS 334A.020(3).

(39) "Support broker" means an individual chosen by a consumer from an agency designated by the department to:

(a) Provide training, technical assistance, and support to a consumer; and

(b) Assist a consumer in any other aspects of CDO.

(40) "Support spending plan" means a plan for a consumer that identifies the:

(a) CDO services requested;

(b) Employee name;

(c) Hourly wage;

(d) Hours per month;

(e) Monthly pay;

(f) Taxes; and

(g) Budget allowance.

(41) "Violent crime" is defined by KRS 17:165(3).

Section 2. Provider Participation. (1) In order to provide HCB waiver services, excluding consumer directed option services, a provider shall be a home health agency or ADHC center that provides services:

(a) Directly; or

(b) Indirectly through a subcontractor.

(2) An out-of-state provider shall comply with the requirements of this administrative regulation.

(3) A provider shall:

(a) Comply with the following administrative regulations and program requirements:

1. 902 KAR 20:081, Operations and services; home health agencies;

2. 907 KAR 1:671, Conditions of Medicaid provider participation; withholding overpayments, administrative appeal process, and sanctions;

3. 907 KAR 1:672, Provider enrollment, disclosure, and documentation for Medicaid participation;

4. 907 KAR 1:673, Claims processing;

5. The Department for Medicaid Services Home and Community Based Waiver Services Manual; and

6. The Department for Medicaid Services Adult Day Health Care Services Manual;

(b) Not enroll an HCB recipient for whom the provider cannot provide HCB waiver services;

(c) Be permitted to accept or not accept an HCB recipient;

(d) Implement a procedure to ensure that the following is reported:

1. Abuse, neglect, or exploitation of an HCB recipient in accordance with KRS Chapters 209 or 620;

2. A slip or fall;

3. A transportation incident;

4. Improper administration of medication;

5. A medical complication; or

6. An incident caused by the recipient, including:

a. Verbal or physical abuse of staff or other recipients;

b. Destruction or damage of property; or

c. Recipient self-abuse;

(e) Ensure a copy of each incident reported in accordance with paragraph (d) of this subsection is maintained in a central file subject to review by the department;

(f) Implement a process for communicating the incident, the outcome, and the prevention plan to:

1. An HCB recipient, family member, or his responsible party; and

2. The attending physician, PA, or ARNP;

(g) Maintain documentation of any communication provided in accordance with subsection (f) of this section. The documentation shall be:

1. Recorded in the HCB recipient's case record; and

2. Signed and dated by the staff member making the entry;

(h) Implement a procedure that ensures the reporting of a recipient or any interested party's [~~a~~] complaint against the provider or its personnel;

(i) Ensure that a copy of each complaint reported is maintained in a central file subject to review by the department;

(j) Implement a process for communicating a complaint, the resulting outcome, and related prevention plan to:

1. The HCB recipient, family member, or the HCB recipient's responsible party; and

2. The attending physician, PA, or ARNP if appropriate;

(k) Maintain documentation of any communication provided in accordance with subsection (j) of this section. The documentation shall be:

1. Recorded in the HCB recipient's case record; and

2. Signed and dated by the staff member making the entry;

(l) [~~to the department;~~

~~(i)~~] Inform a recipient or any interested party in writing of the provider's:

1. Hours of operation; and

2. Policies and procedures;

(m) [~~(j)~~] Not permit a staff member who has contracted a communicable disease to provide a service to an HCB recipient until the condition is determined to no longer be contagious; and

(n) [~~(k)~~] Ensure that a staff member who provides direct services:

1. Demonstrates the ability to:

a. Read;

b. Write;

c. Understand and carry out instructions;

d. Keep simple records; and

e. Interact with an HCB recipient when providing an HCB waiver service;

2. Be trained by an HCB waiver provider;

3. Be supervised by an RN at least every other month.

Section 3. Maintenance of Records. (1) An HCB waiver provider shall maintain:

(a) A clinical record for each HCB recipient. The clinical record shall contain the following:

1. Pertinent medical, nursing, and social history;

2. A comprehensive assessment entered on form MAP-351 and signed by the:

a. Assessment team; and

b. Department;

3. A completed MAP 109-HCBW;

4. A copy of the MAP-350 signed by the recipient or his legal representative at the time of application or reapplication and each recertification thereafter;

5. The name of the case manager;

6. Documentation of all level of care determinations;

7. All documentation related to prior authorizations, including requests, approvals and denials;

8. Documentation of each contact with, or on behalf of, an HCB recipient;

9. [~~7.~~] Documentation that the HCB recipient receiving ADHC services was provided a copy of the ADHC center's posted hours of operation;

10. Documentation that the recipient or legal representative was informed of the procedure for reporting complaints; and

11. [~~8.~~] Documentation of each service provided that shall include:

a. The date the service was provided;

b. The duration of the service;

c. The arrival and departure time of the provider, excluding travel time, if the service was provided at the HCB recipient's home;

d. Itemization of each personal care or homemaking service delivered;

e. The HCB recipient's arrival and departure time, excluding travel time, if the service was provided at the ADHC center;

f. Progress notes which shall include documentation of changes, responses and treatments utilized to evaluate the HCB recipient's needs; and

g. The signature of the service provider; and

(b) Fiscal reports, service records, and incident reports regarding services provided. These reports shall be retained:

1. At least six (6) years from the date that a covered service is provided; or

2. For a minor three (3) years after the recipient reaches the age of majority under state law, whichever is longest.

(2) Upon request, an HCB provider shall make information regarding service and financial records available to the:

(a) Department;

(b) Cabinet for Health and Family Services, Office of Inspector General or its designee;

(c) Department for Health and Human Services or its designee;

(d) General Accounting Office or its designee;

(e) Office of the Auditor of Public Accounts or its designee; or

(f) Office of the Attorney General or its designee.

Section 4. HCB Recipient Eligibility Determinations and Redeterminations. (1) An HCB waiver service shall be provided to a Medicaid eligible HCB recipient who:

(a) Is determined by the department to meet NF level of care requirements; and

(b) Would, without waiver services, be admitted by a physician's order to an NF.

(2) The department shall perform an NF level of care determination for each HCB recipient at least once every twelve (12) months or more often if necessary.

(3) An HCB waiver service shall not be provided to an individual who:

(a) Does not require a service other than:

1. A minor home adaptation;

2. Case management; or

3. A minor home adaptation and case management;

(b) Is an inpatient of:

1. A hospital;

2. An NF; or

3. An intermediate care facility for an individual with mental retardation or a developmental disability;

(c) Is a resident of a licensed personal care home; or

(d) Is receiving services from another Medicaid home and community based services waiver program.

(4) An HCB waiver provider shall:

(a) Inform an HCB recipient or his legal representative of the choice to receive:

1. HCB waiver services; or

2. Institutional services; and

(b) Require an HCB recipient to sign a MAP-350 form at the time of application or reapplication and at each recertification to document that the individual was informed of the choice to receive HCB waiver or institutional services.

(5) An eligible HCB recipient or the recipient's legal representative shall select a participating HCB waiver provider from which the recipient wishes to receive HCB waiver services.

(6) The department may exclude from the HCB waiver program an individual for whom the aggregate cost of HCB waiver services would reasonably be expected to ex-

ceed the cost of NF services.

(7) An HCB waiver provider shall use a MAP-24 to notify the local DCBS office and the department of an HCB recipient's:

(a) Termination from the HCB waiver program; or

(b)1. Admission to an NF for less than sixty (60) consecutive days; and

2. Return to the HCB waiver program from an NF within sixty (60) consecutive days.

Section 5. Covered Services. (1) An HCB waiver service shall:

(a) Be prior authorized by the department to ensure that the service or modification of the service already meets the needs of the HCB recipient;

(b) Be provided pursuant to a plan of care or, for a CDO service, pursuant to a plan of care and support spending plan;

(c) Except for a CDO service, not be provided by a member of the HCB recipient’s family. A CDO service may be provided by an HCB recipient's family member; and

(d) Shall be accessed within sixty (60) days of the date of prior authorization.

(2) To request prior authorization, a provider shall submit a completed MAP 10, MAP 109, and MAP 351 to the department.

(3) Covered HCB services shall include:

(a) A comprehensive assessment which shall:

1. Identify an HCB recipient’s needs and the services that the HCB recipient or the recipient's family cannot manage or arrange for on the recipient's behalf;

2. Evaluate an HCB recipient’s physical health, mental health, social supports, and environment;

3. Be requested by an individual seeking HCB waiver services or the individual's fam-

ily, legal representative, physician, physician assistant, or ARNP;

4. Be conducted by an assessment team within seven (7) calendar days of receipt of the request for assessment; and

5. Include at least one (1) face-to-face home visit by a member of the assessment team with the HCB recipient and, if appropriate, the recipient's family;

(b) A reassessment service which shall:

1. Determine the continuing need for HCB waiver services and, if appropriate, CDO services;

2. Be performed at least every twelve (12) months;

3. Be conducted using the same procedures used in an assessment service;

4. Not be retroactive; and

5. Be initiated by an HCB waiver provider or support broker who shall:

a. Notify the department no more than three (3) weeks prior to the expiration of the current level of care certification to ensure that certification is consecutive; and

b. Not be reimbursed for a service provided during a period that an HCB recipient is not covered by a valid level of care certification;

(c) A case management service which shall:

1. Consist of coordinating the delivery of direct and indirect services to an HCB recipient;

2. Be provided by a case manager who shall:

a. Be an RN, LPN, social worker, certified psychologist with autonomous functioning, licensed psychological practitioner, LMFT, or an LPCC;

b. Arrange for a service but not provide a service directly;

c. Contact the HCB recipient monthly by telephone or through a face-to-face visit at the HCB recipient's residence or in the ADHC center, with a minimum of one (1) face-to-face visit between the case manager and the recipient every other month; and

d. Assure that service delivery is in accordance with an HCB recipient's plan of care;

3. Not include a group conference; and

4. Include development of a plan of care that shall:

a. Be completed on the MAP 109;

b. Reflect the needs of the HCB recipient;

c. List goals, interventions, and outcomes;

d. Specify services needed;

e. Determine the amount, frequency, and duration of services;

f. Provide for reassessment at least every twelve (12) months;

g. Be developed and signed by the assessment team, case manager, and HCB recipient or his family; and

h. Be submitted to the department no later than thirty (30) calendar days after receiving the department's verbal approval of NF level of care;

(d) A homemaker service which shall consist of general household activities and shall be provided:

1. By staff pursuant to Section 2(3)(m) and (n)[~~(j) and (k)~~]of this administrative regulation; and

2. To an HCB recipient:

a. Who is functionally unable, but would normally perform age-appropriate homemaker tasks; and

b. If the caregiver regularly responsible for homemaker activities is temporarily absent or functionally unable to manage the homemaking activities;

(e) A personal care service which shall consist of age-appropriate medically-oriented services and be provided:

1. By staff pursuant to Section 2(3)(m) and (n)[~~(j) and (k)~~] of this administrative regulation; and

2. To an HCB recipient:

a. Who does not need highly skilled or technical care;

b. For whom services are essential to the recipient's health and welfare and not for the recipient's family; and

c. Who needs assistance with age-appropriate activities of daily living;

(f) An attendant care service which shall consist of hands-on care that is:

1. Provided by staff pursuant to Section 2(3)(m) and (n)[~~(j) and (k)~~]of this administrative regulation to an HCB recipient who:

a. Is medically stable but functionally dependent and requires care or supervision twenty-four (24) hours per day; and

b. Has a family member or other primary caretaker who is employed and not able to provide care during working hours;

[~~c. Prior to being eligible for the HCB Waiver Program in accordance with Section 4 of this administrative regulation, was able to care for him or herself;~~]

2. Not of a general housekeeping nature; and

3. Not provided to an HCB recipient who is receiving any of the following HCB waiver services:

a. Personal care;

b. Homemaker; or

c. ADHC;

(g) A respite care service which shall be short term care based on the absence or need for relief of the primary caretaker and be:

1. Provided by staff pursuant to Section 2(3)(m) and (n) [~~(j) and (k)~~]of this administrative regulation who provide services at a level that appropriately and safely meets the medical needs of the HCB recipient in the following settings:

a. An HCB recipient's place of residence; or

b. An ADHC center during posted hours of operation;

2. Provided to an HCB recipient who has care needs beyond normal baby sitting; and

3. Used no less than every six (6) months;

4. Provided in accordance with 902 KAR 20:066, Operation and services; adult day health care programs, Section 2(1)(b)10.a. through c ., if provided to a child under age 21 (twenty-one) in an ADHC center;

(h) A minor home adaptation service which shall be a physical adaptation to a home that is necessary to ensure the health, welfare, and safety of an HCB recipient and which shall:

1. Meet all applicable safety and local building codes;

2. Relate strictly to the HCB recipient's disability and needs;

3. Exclude an adaptation or improvement to a home that has no direct medical or remedial benefit to the HCB recipient; and

4. Be submitted on form MAP-95 for prior authorization; or

(i) An ADHC service which shall:

1. Except for an HCB recipient approved for an ADHC service prior to May 1, 2003, be provided to an HCB recipient who is at least twenty-one (21) years of age;

2. Include the following basic services and necessities provided to Medicaid waiver recipients during the posted hours of operation:

a. Skilled nursing services provided by an RN or LPN, including ostomy care, urinary catheter care, decubitus care, tube feeding, venipuncture, insulin injections, tracheotomy care, or medical monitoring;

b. Meal service corresponding with hours of operation with a minimum of one (1) meal per day and therapeutic diets as required;

c. Snacks;

d. Supervision by an RN;

e. Age and diagnosis appropriate daily activities; and

f. Routine services that meet the daily personal and health care needs of an HCB recipient, including:

(i) Monitoring of vital signs;

(ii) Assistance with activities of daily living; and

(iii) Monitoring and supervision of self-administered medications, therapeutic programs, and incidental supplies and equipment needed for use by an HCB recipient;

3. Include developing, implementing and maintaining nursing policies for nursing or medical procedures performed in the ADHC center.

4. [~~3.~~] Include ancillary services in accordance with 907 KAR 1:023, Review and approval of selected therapies as ancillary services in nursing facilities, if ordered by a

physician, PA, or ARNP in an HCB recipient's ADHC plan of treatment. Ancillary services shall:

a. Consist of evaluations or reevaluations for the purpose of developing a plan which shall be carried out by the HCB recipient or ADHC center staff;

b. Be reasonable and necessary for the HCB recipient's condition;

c. Be rehabilitative in nature;

d. Include physical therapy provided by a physical therapist or physical therapist assistant, occupational therapy provided by an occupational therapist or occupational therapist assistant, or speech therapy provided by a speech-language pathologist; and

e. Comply with the physical, occupational, and speech therapy requirements established in Technical Criteria for Reviewing Ancillary Services for Adults;

5. [~~4.~~] Include respite care services pursuant to paragraph (g) of this subsection;

6. [~~5.~~] Be provided to an HCB recipient by the health team in an ADHC center which may include:

a. A physician;

b. A physician assistant;

c. An ARNP;

d. An RN;

e. An LPN;

f. An activities director;

g. A physical therapist;

h. A physical therapist assistant;

i. An occupational therapist;

j. An occupational therapist assistant;

k.. A speech pathologist;

l. A social worker;

m. A nutritionist;

n. A health aide;

o. An LPCC;

p. An LMFT;

q. A certified psychologist with autonomous functioning; or

r. A licensed psychological practitioner; and

7. [~~6.~~] Be provided pursuant to a plan of treatment. The plan of treatment shall:

(i) Be developed and signed by each member of the plan of treatment team which shall include the recipient or a legal representative of the recipient;

(ii) Include pertinent diagnoses, mental status, services required, frequency of visits to the ADHC center, prognosis, rehabilitation potential, functional limitation, activities permitted, nutritional requirements, medication, treatment, safety measures to protect against injury, instructions for timely discharge, and other pertinent information; and

(iii) Be developed annually from information on the MAP 351 [~~reviewed annually~~] and revised as needed[~~; and~~

~~b. The plan of treatment team shall:~~

~~(i) Include the recipient or a legal representative of the recipient; and~~

~~(ii) Submit a current copy of the plan of treatment to the department annually or following any revision~~].

(4) Modification of an ancillary therapy service or an ADHC unit of service shall re-

quire prior authorization as follows:

(a) Prior authorization shall:

1. Be requested by an RN or designated ADHC center staff; and

2. Require submission of a revised MAP 109 and an order signed by a physician, physician assistant, or ARNP;

(b) An RN or designated ADHC center staff shall forward a copy of the documents required in paragraph (a) of this subsection to the HCB case manager or the consumer's support broker for inclusion in the HCB recipient's case records within ten (10) working days of the prior authorization request; and

(c) Upon approval or denial of a prior authorization request, the department shall provide written notification to the HCB agency, the ADHC center, and the HCB recipient.

Section 6. Consumer Directed Option. (1) Covered services and supports provided to an HCB recipient participating in CDO shall include:

(a) A home and community support service which shall:

1. Be available only under the consumer directed option;

2. Be provided in the consumer's home or in the community;

3. Be based upon therapeutic goals and not diversional in nature; <u>and</u>

4. Not be provided to an individual if the same or similar service is being provided to the individual via non-CDO HCB services<u>; or</u>

<u>(b) Goods and services which shall:</u>

<u>1. Be individualized;</u>

<u>2. Be utilized to reduce the need for personal care or to enhance independence within the home or community of the recipient;</u>

3. Not include experimental goods or services; and

4. Not include chemical or physical restraints.

(2) To be covered, a CDO service shall be specified in the plan of care.

(3) Reimbursement for a CDO service shall not exceed the department's allowed reimbursement for the same or similar service provided in a non-CDO HCB setting.

(4) A consumer, including a married consumer, shall choose providers and a consumer's choice shall be reflected or documented in the plan of care.

(5) A consumer may designate a representative to act on the consumer's behalf. The CDO representative shall:

(a) Be twenty-one (21) years of age or older;

(b) Not be monetarily compensated for acting as the CDO representative or providing a CDO service; and

(c) Be appointed by the consumer on a MAP 2000 form.

(6) A consumer may voluntarily terminate CDO services by completing a MAP 2000 and submitting it to the support broker.

(7) The department shall immediately terminate a consumer from CDO services if:

(a) Imminent danger to the consumer's health, safety, or welfare exists; or

(b) The consumer fails to pay patient liability.

(8) The department may terminate a consumer from CDO services if it determines that the consumer's CDO provider has not adhered to the plan of care.

(9) Prior to a consumer's termination from CDO services, the support broker shall:

(a) Notify the assessment or reassessment service provider of potential termination;

(b) Assist the consumer in developing a resolution and prevention plan;

(c) Allow at least thirty (30) but no more than ninety (90) days for the consumer to resolve the issue, develop and implement a prevention plan or designate a CDO representative;

(d) Complete, and submit to the department, a MAP 2000 terminating the consumer from CDO services if the consumer fails to meet the requirements in paragraph (c) of this subsection; and

(e) Assist the consumer in transitioning back to traditional HCB services.

(10) Upon an involuntary termination of CDO services, the department shall:

(a) Notify a consumer in writing of its decision to terminate the consumer's CDO participation; and

(b) Except in a case where a consumer failed to pay patient liability, inform the consumer of the right to appeal the department's decision in accordance with Section 8 of this administrative regulation.

(11) A CDO provider shall:

(a) Be selected by the consumer;

(b) Submit a completed Kentucky Consumer Directed Option Employee Provider Contract to the support broker;

(c) Be eighteen (18) years of age or older;

(d) Be a citizen of the United States with a valid Social Security number or possess a valid work permit if not a U.S. citizen;

(e) Be able to communicate effectively with the consumer, consumer representative or family;

(f) Be able to understand and carry out instructions;

(g) Be able to keep records as required by the consumer;

(h) Submit to a criminal background check;

(i) Submit to a check of the nurse aide abuse registry maintained in accordance with 906 KAR 1:100, Nurse aid abuse registry, home health aide abuse registry, and hearing procedures, and not be found on the registry;

(j) Not have pled guilty or been convicted of committing a sex crime or violent crime as defined in KRS 17.165(1) through (3);

(k) Complete training on the reporting of abuse, neglect or exploitation in accordance with KRS 209.030 or 620.030 and on the needs of the consumer;

(l) Be approved by the department;

(m) Maintain and submit timesheets documenting hours worked; and

(n) Be a friend, spouse, parent, family member, other relative, employee of a provider agency or other person hired by the consumer.

(12) A parent, parents combined or a spouse shall not provide more than forty (40) hours of services in a calendar week (Sunday through Saturday) regardless of the number of children who receive waiver services.

(13)(a) The department shall establish a budget for a consumer based on the individual's historical costs minus five (5) percent to cover costs associated with administering the consumer directed option. If no historical cost exists for the consumer, the consumer's budget shall equal the average per capita historical costs of HCB recipients minus five (5) percent.

(b) Cost of services authorized by the department for the individual's prior year plan of care but not utilized may be added to the budget if necessary to meet the individual's

needs.

(c) The department shall adjust a consumer's budget based on the consumer's needs and in accordance with paragraphs (d) and (e) of this subsection.

(d) A consumer's budget shall not be adjusted to a level higher than established in paragraph (a) of this subsection unless:

1. The consumer's support broker requests an adjustment to a level higher than established in paragraph (a) of this subsection; and

2. The department approves the adjustment.

(e) The department shall consider the following factors in determining whether to allow for a budget adjustment:

1. If the proposed services are necessary to prevent imminent institutionalization;

2. The cost effectiveness of the proposed services; and

3. Protection of the consumer's health, safety and welfare.

<u>(f) A consumer's budget shall not exceed the average per capita cost of services provided to individuals in an NF.</u>

(14) Unless approved by the department pursuant to subsection (13)(b) through (e) of this section, if a CDO service is expanded to a point in which expansion necessitates a budget allowance increase, the entire service shall only be covered via a traditional (non-CDO) waiver service provider.

(15) A support broker shall:

(a) Provide any needed assistance to a consumer with any aspect of CDO or blended services;

(b) Be available to a consumer twenty-four (24) hours per day, seven (7) days per

week;

(c) Comply with all applicable federal and state laws and requirements;

(d) Continually monitor a consumer's health, safety and welfare; and

(e) Complete or revise a plan of care using person-centered planning principles.

(16)(a) For a CDO participant, a support broker may conduct an assessment or reassessment; and

(b) A CDO assessment or reassessment performed by a support broker shall comply with the assessment or reassessment provisions established in Section 5(2) of this administrative regulation.

Section 7. Use of Electronic Signatures. (1) The creation, transmission, storage, and other use of electronic signatures and documents shall comply with the requirements established in KRS 369.101 to 369.120.

(2) A home health provider that chooses to use electronic signatures shall:

(a) Develop and implement a written security policy that shall:

1. Be adhered to by each of the provider's employees, officers, agents, and contractors;

2. Identify each electronic signature for which an individual has access; and

3. Ensure that each electronic signature is created, transmitted, and stored in a secure fashion;

(b) Develop a consent form that shall:

1. Be completed and executed by each individual using an electronic signature;

2. Attest to the signature's authenticity; and

3. Include a statement indicating that the individual has been notified of his responsi-

bility in allowing the use of the electronic signature; and

(c) Provide the department with:

1. A copy of the provider's electronic signature policy;

2. The signed consent form; and

3. The original filed signature immediately upon request.

Section 8. Appeal Rights. An appeal of a department determination regarding NF level of care or services to an HCB recipient or a consumer shall be in accordance with 907 KAR 1:563.

Section 9. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "Department for Medicaid Services Adult Day Health Care Services Manual", May 2005 edition;

(b) "Department for Medicaid Services Home and Community Based Waiver Services Manual", September 2006 edition;

(c) "Person Centered Planning: Guiding Principles", March 2005 edition;

(d) "Technical Criteria for Reviewing Ancillary Services for Adults", November 2003 edition;

(e) "MAP-24, The Commonwealth of Kentucky, Cabinet for Health and Family Services, Department for Community Based Services Memorandum", February 2001 edition;

(f) "MAP-95 Request for Equipment Form" June 2007 [~~September 2002~~] edition;

(g) "MAP 109, Plan of Care/Prior Authorization for HCB Waiver Services", March 2007 edition;

(h) "MAP-350, Long Term Care Facilities and Home and Community Based Program Certification Form", January 2000 edition; and

(i) "MAP-351, The Department for Medicaid Services, Medicaid Waiver Assessment", March 2007 edition:

(j) "MAP 2000, Initiation/Termination of Consumer Directed Option (CDO)", March 2007, edition; and

(k) "MAP-10, Waiver Services", March 2007 edition.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m.

907 KAR 1:160E

REVIEWED:

Date	Shawn M. Crouch, Commissioner Department for Medicaid Services

APPROVED:

Date	Mark D. Birdwhistell, Secretary Cabinet for Health and Family Services

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 1:160E
Cabinet for Health and Family Services
Department for Medicaid Services
Agency Contact Person: Stuart Owen (502) 564-6204 or Shelley Adams (502) 564-5560

(1) Provide a brief summary of:
(a) What this administrative regulation does: This administrative regulation establishes the provisions for home and community based waiver services.
(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the provisions for the home and community based waiver services.
(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing the provisions for the home and community based waiver services.
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the statutes by establishing the provisions for the home and community based waiver services.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: This amendment adds goods and services to the consumer directed option; clarifies various policies such as documentation requirements, respite hours, respite for children; and alters consumer directed option (CDO) budget caps consistent with the other two (2) programs offering CDO.
(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to add goods and services to the consumer-directed option established by KRS 205.5606, to clarify various policies and to cap CDO budgets consistent with the caps in other programs offering CDO. The CDO expansion is necessary to provide more options for consumers consistent with KRS 205.5606.
(c) How the amendment conforms to the content of the authorizing statutes: This amendment conforms to the content of KRS 205.2605 and 205.5606 by adding goods and services to the consumer-directed option.
(d) How the amendment will assist in the effective administration of the statutes: This amendment assists in the effective administration of the statutes by adding goods and services to the consumer-directed option accordance with KRS 205.5605 and 5606.

(3) List the type and number of individuals, businesses, organizations, or state and

local government affected by this administrative regulation: This administrative regulation will affect Medicaid's home and community based waiver recipients. Currently, there are approximately 13,000 members enrolled in the home and community based waiver program.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: Providers will have to develop and maintain complaint reporting and documentation processes and will have to document level of care determinations and prior authorizations in an individual's record as a result of this amendment.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). The amendments are not expected to impose any cost on the regulated entities.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). The amendments are expected to generate enhanced health care outcomes as well as options for recipients.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: The Department for Medicaid Services (DMS) anticipates additional costs as the consumer directed option is expanding to include goods and services; however, the specific amount of costs is indeterminable at this time. DMS does not anticipate costs exceeding funds available within the current budget.

(b) On a continuing basis: DMS anticipates additional costs as the consumer directed option is expanding to goods and services; however, the specific amount of costs is indeterminable at this time. DMS does not anticipate costs exceeding funds available within the current budget.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under the Social Security Act, Title XIX and matching funds of general fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: Neither an increase in fees nor funding will be necessary to implement this administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation does not establish

or increase any fees.

(9) Tiering: Is tiering applied? (Explain why tiering was or was not used)
Tiering was not appropriate in this administrative regulation because the administrative regulation applies equally to all those individuals or entities regulated by it. Disparate treatment of any person or entity subject to this administrative regulation could raise questions of arbitrary action on the part of the agency. The “equal protection” and “due process” clauses of the Fourteenth Amendment of the U.S. Constitution may be implicated as well as Sections 2 and 3 of the Kentucky Constitution.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Reg NO: 907 KAR 1:160E Contact Person: Stuart Owen (502) 564-6204 or Shelley Adams (502) 564-5560

1. Does this administrative regulation relate to any program, service, or requirements of a state or local government (including cities, counties, fire departments or school districts)?

   Yes _X__ No ____
   If yes, complete 2-4.

2. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? This amendment will affect each Medicaid home and community based waiver recipient who opts to participate in the consumer directed option program.

3. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. This amendment is required by KRS 205.5605 and 205.5606.

4. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

   (a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? This amendment will not generate revenue for state or local government during the first year of program administration.

   (b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? This amendment will not generate revenue for state or local government during subsequent years of program administration.

   (c) How much will it cost to administer this program for the first year? The Department for Medicaid Services (DMS) anticipates additional costs as the consumer directed option is expanding to include goods and services; however, the specific amount of costs is indeterminable at this time. DMS does not anticipate costs exceeding funds available within the current budget.

   (d) How much will it cost to administer this program for subsequent years? DMS anticipates additional costs as the consumer directed option is expanding to include goods and services; however, the specific amount of costs is indeterminable at this time. DMS does not anticipate costs exceeding funds

available within the current budget..

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-): ____

Expenditures (+/-): ____

Other Explanation: No additional expenditures are necessary to implement this amendment.

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

907 KAR 1:160E, Home and community based waiver services

Summary of Material Incorporated by Reference

(1) The only form being amended is the “MAP-95, Request for Equipment Form”, Commonwealth of Kentucky, Cabinet for Health and Family Services, Department for Medicaid Services,”. The September 2002 edition is being replaced by the June 2007 edition. Changes include adding “support broker” next to “case manager”, no longer requiring manufacturer’s suggested list price of an item, no longer requiring a trade name, manufacturer’s name, or model number for an item and deleting the request for rental information. This form serves as a prior authorization tool for minor home adaptations and contains one (1) page.

(2) The following material incorporated by reference is not being amended at this time:
(a) "Department for Medicaid Services Adult Day Health Care Services Manual", May 2005 edition;
(b) "Department for Medicaid Services Home and Community Based Waiver Services Manual", September 2006 edition;
(c) "Person Centered Planning: Guiding Principles", March 2005 edition;
(d) "Technical Criteria for Reviewing Ancillary Services for Adults", November 2003 edition;
(e) "MAP-24, The Commonwealth of Kentucky, Cabinet for Health and Family Services, Department for Community Based Services Memorandum", February 2001 edition;
(f) "MAP-95 Request for Equipment Form" September 2002 edition;
(g) "MAP 109, Plan of Care/Prior Authorization for HCB Waiver Services", March 2007 edition;
(h) "MAP-350, Long Term Care Facilities and Home and Community Based Program Certification Form", January 2000 edition; and
(i) "MAP-351, The Department for Medicaid Services, Medicaid Waiver Assessment", March 2007 edition:
(j) "MAP 2000, Initiation/Termination of Consumer Directed Option (CDO)", March 2007, edition; and
(k) "MAP-10, Waiver Services", March 2007 edition.

A total of one hundred sixty (160) pages is incorporated into this administrative regulation by reference.