

# Application for a §1915(c) Home and Community-Based Services Waiver

## PURPOSE OF THE HCBS WAIVER PROGRAM

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The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

## Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

### 1. Major Changes

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Describe any significant changes to the approved waiver that are being made in this renewal application:

The Commonwealth of Kentucky is actively reviewing all of the 1915c waivers and it is anticipated there will be additional changes to the waiver at a later date.

For that reason, the Commonwealth is making minimal changes for this submission. Changes to the waiver are limited to implementing necessary changes for the Home and Community Based Services (HCBS) Federal final rules and combining or deleting underutilized services. All services provided under the current Michelle P. Waiver will be available in some form. No waiver participant will lose services due to this transition.

The following services are removed from this renewal due to underutilization: shared living and community guide.

The following services can be obtained through the state plan, other Medicaid or state general fund options: transportation, community transition, and vehicle adaptation.

The following services were combined under behavior supports: consultative clinical and therapeutic services, person centered coaching, and natural supports training.

Personal assistance can be obtained through personal care, attendant care and homemaker.

Current submitted changes include the provision of conflict-free case management, person centered service planning and waiver setting requirements consistent with the HCBS Federal final rules. This submission also outlines a more effective and comprehensive Continuous Quality Improvement (CQI) plan stressing the cycle of information sharing, action steps and remediation.

All services provided under the current Michelle P. Waiver will be available in some form. No waiver participant will lose services due to this transition.

## Application for a §1915(c) Home and Community-Based Services Waiver

### 1. Request Information (1 of 3)

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- A. The **State of Kentucky** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).
- B. **Program Title** (*optional - this title will be used to locate this waiver in the finder*):  
**Michelle P. waiver**
- C. **Type of Request: renewal**  
**Requested Approval Period:** (*For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.*)  
 3 years  5 years  
  
**Original Base Waiver Number: KY.0475**  
**Draft ID: KY.007.02.00**
- D. **Type of Waiver** (*select only one*):

Regular Waiver E. **Proposed Effective Date:** (mm/dd/yy)

04/01/17

**1. Request Information (2 of 3)**

F. **Level(s) of Care.** This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

 **Hospital**

Select applicable level of care

 **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:



 **Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160**
 **Nursing Facility**

Select applicable level of care

 **Nursing Facility as defined in 42 CFR §440.40 and 42 CFR §440.155**

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:



 **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**
 **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:



**1. Request Information (3 of 3)**

G. **Concurrent Operation with Other Programs.** This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

 **Not applicable**
 **Applicable**

Check the applicable authority or authorities:

 **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**
 **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:



Specify the §1915(b) authorities under which this program operates (*check each that applies*):
 **§1915(b)(1) (mandated enrollment to managed care)**
 **§1915(b)(2) (central broker)**
 **§1915(b)(3) (employ cost savings to furnish additional services)**
 **§1915(b)(4) (selective contracting/limit number of providers)**
 **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:



 **A program authorized under §1915(i) of the Act.**
 **A program authorized under §1915(j) of the Act.**
 **A program authorized under §1115 of the Act.**

Specify the program:




**H. Dual Eligibility for Medicaid and Medicare.**

Check if applicable:

- This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

**2. Brief Waiver Description**

**Brief Waiver Description.** *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Kentucky Michelle P. Medicaid Waiver (MPW) program offers individualized community based services to individuals who have intellectual or developmental disabilities and would otherwise need institutional services from an ICF/IID, and to support individuals who transition from ICF/IID institutional services to the community. Services are delivered with respect, and are designed to ensure individuals are safe in the community and are afforded choices. These services and supports will create a positive culture that promotes person centered thinking through communication, respect, and choice.

**GOALS**

The MPW Program goals: 1) People receiving waiver services are safe, healthy, and respected in their community; 2) People receiving waiver services live in the community with effective, individualized assistance; and 3) People receiving waiver services enjoy living and working in their community.

**OBJECTIVES**

The MPW Program objectives are to:

- 1) identify individual needs by implementing a comprehensive evaluation utilizing the MAP 351 assessment tool in order to assist in the person centered service planning process leading to development of the person centered service plan.
- 2) Ensure home and community based services are comprehensive alternatives to institutional services by providing positive assistive supports as needed to identify and eliminate barriers that create crisis situations.
- 3) Improve information, access and utilization of employment related supports for participants.
- 4) Enhance provider competency and continuity of care through training, technical assistance.

**ORGANIZATIONAL STRUCTURE**

This waiver is operated by the Department for Behavioral Health and Developmental and Intellectual Disabilities as the operating agency for the Kentucky Department for Medicaid Services.

**SERVICE DELIVERY METHODS**

The MPW offers statewide availability of traditional services and participant-directed services. Participants can choose all traditional, all participant-directed, or a combination (blend) of traditional and participant-directed services.

**3. Components of the Waiver Request**

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the State provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):
 

**Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*

**No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*
- F. Participant Rights.** Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy.** Appendix H contains the Quality Improvement Strategy for this waiver.

- I. Financial Accountability.** Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** Appendix J contains the State's demonstration that the waiver is cost-neutral.

#### 4. Waiver(s) Requested

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- A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.
- B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):
- Not Applicable
- No
- Yes
- C. Statewideness.** Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act (*select one*):
- No
- Yes

If yes, specify the waiver of statewideness that is requested (*check each that applies*):

- Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.  
*Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*
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- Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in Appendix E available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.  
*Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:*
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#### 5. Assurances

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In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
- As specified in Appendix C, adequate standards for all types of providers that provide services under this waiver;
  - Assurance that the standards of any State licensure or certification requirements specified in Appendix C are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
  - Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in Appendix C.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in Appendix I.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in Appendix B.
- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in Appendix B, the individual (or, legal representative, if applicable) is:
- Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

## 6. Additional Requirements

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*Note: Item 6-I must be completed.*

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver:  
The state secures public input on changes to the waiver by announcing input opportunities to self-advocates, families, advocates, and providers through a variety of methods, including email notifications and public meetings. Stakeholder meetings were held on March 23, 2016, April 8 and 19, 2016 to solicit suggestions for this waiver renewal. All comments and suggestions were considered by the Department. Since that time, an administration change has spurred discussions regarding broader changes to all of the 1915c waivers. Additional meetings with stakeholders are on-going regarding these changes. In addition to these stakeholder meetings, the current waiver renewal was posted for public comment in November 2016 and the public comment period remained open for 30 days. This public notice was posted on the DMS webpage and in newspapers with instructions on how to submit public comments via email or US Postal mail. Additionally, there was information posted about how to request a paper copy of the full waiver renewal, and DMS complied with these requests when received.
- J. Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.
- K. Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

## 7. Contact Person(s)

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- A.** The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

**Last Name:**

Anderson

**First Name:**

Deborah

**Title:**

Director

**Agency:**

The Department for Medicaid Services

**Address:**

275 East Main Street

**Address 2:**

Mail Stop 6W-A

**City:**

Frankfort

**State:**

Kentucky

**Zip:**

40621

**Phone:**

(502) 564-7540

Ext: 2122

TTY

**Fax:**

**E-mail:**

**B.** If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

**Last Name:**

**First Name:**

**Title:**

**Agency:**

**Address:**

**Address 2:**

**City:**

**State:** **Kentucky**

**Zip:**

**Phone:**  **Ext:**   **TTY**

**Fax:**

**E-mail:**

## 8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are **readily** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

**Signature:**

State Medicaid Director or Designee

**Submission Date:**

**Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.**

**Last Name:**

<b>First Name:</b>	<input type="text" value="Steve"/>
<b>Title:</b>	<input type="text" value="Commissioner"/>
<b>Agency:</b>	<input type="text" value="Department for Medicaid Services"/>
<b>Address:</b>	<input type="text" value="275 East Main Street"/>
<b>Address 2:</b>	<input type="text"/>
<b>City:</b>	<input type="text" value="Frankfort"/>
<b>State:</b>	<b>Kentucky</b>
<b>Zip:</b>	<input type="text" value="40601"/>
<b>Phone:</b>	<input type="text" value="(502) 564-4321"/> Ext: <input type="text"/> <input type="checkbox"/> TTY
<b>Fax:</b>	<input type="text" value="(502) 564-3852"/>
<b>E-mail:</b>	<input type="text" value="Steve.Miller@ky.gov"/>

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**Attachments**

**Attachment #1: Transition Plan**

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- Replacing an approved waiver with this waiver.
- Combining waivers.
- Splitting one waiver into two waivers.
- Eliminating a service.
- Adding or decreasing an individual cost limit pertaining to eligibility.
- Adding or decreasing limits to a service or a set of services, as specified in Appendix C.
- Reducing the unduplicated count of participants (Factor C).
- Adding new, or decreasing, a limitation on the number of participants served at any point in time.
- Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915 (c) or another Medicaid authority.
- Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

Availability of Current Waiver Services

All services provided under the current MPW will be available in some form in the waiver renewal.

Transition Process

As previously stated, participants receiving services under the current approved waiver will not lose services due to the changes in the proposed waiver renewal.

Assessments/reassessments and Person Centered Service Plans (PCSP) will be completed according to the participant's level of care (LOC) date.

PCSP's are developed assessing each participant's needs, including ongoing and new care needs, identified through the assessment/reassessment process. All participants will have access to the services in the new waiver and these will be considered based on each participant's needs.

Through the transition process, all participants will have access to services in the current approved waiver. Conflict free case management

services will be phased-in as the participant reaches his level of care month. Case Managers will inform each waiver participant of his/her rights to a Fair Hearing, as specified in Appendix F-1. DMS will monitor the implementation of the phase-in plan for new-service delivery.

#### Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

*Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.*

*To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.*

*Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.*

*Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.*

#### Home and Community-Based Settings Waiver Transition Plan

The Michelle P. waiver-specific transition plan was submitted on August 28, 2014. The initial Kentucky statewide transition plan was submitted to CMS on December 19, 2014. Kentucky has since conducted additional assessments of providers, submitting a revised statewide transition plan to CMS on December 18, 2015. This version of the statewide transition plan includes counts of both providers and settings in each compliance category. The submission of this renewal is consistent with the content of the statewide transition plan. As this waiver does not include residential services, the only provider settings where MPW participants receive services are day settings and/or provider offices.

Settings that will require heightened scrutiny will be sent to CMS beginning in January, 2017. Kentucky is currently conducting on-site visits of providers who are designated as category 4, presumed not to be home and community-based, and completed these visits in August, 2016. Provider settings will be required to be compliant with the federal home and community-based settings requirements, except for the rules specific to integration and location, which will take effect upon the completion of Kentucky's revised MPW regulation. Kentucky state staff will monitor the provider settings to ensure compliance with the regulation during annual reviews. Provider settings must be compliant with the rules specific to integration and location in 2019, which is consistent with Kentucky's statewide transition plan.

#### Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

#### Appendix A: Waiver Administration and Operation

**1. State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

- The waiver is operated by the State Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one*):

- The Medical Assistance Unit.**

Specify the unit name:

*(Do not complete item A-2)*

- Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

*(Complete item A-2-a).*

- The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

**The Department for Behavioral Health, Developmental and Intellectual Disabilities.**

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

## Appendix A: Waiver Administration and Operation

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### 2. Oversight of Performance.

- a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

**As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.**

- b. Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance: The Medicaid agency continually assesses the performance of the operational agency through analysis of data obtained through second-line reviews of clinical records, provider certifications, incident reporting and investigations. The Medicaid agency reviews all reports submitted by the operational agency to identify any training or clarification related to waiver policy. Training and policy clarifications are routinely provided to the operating agency to ensure continuing adherence with waiver requirements.

## Appendix A: Waiver Administration and Operation

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- 3. Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

- Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:* DMS contracts with the Department for Aging and Independent Living (DAIL), the Department of Behavioral Health, Developmental and Intellectual Disabilities (DBHDID), the Department for Community Based Services (DCBS), the Community Mental Health Center's (CMHC's), and the Fiscal Agent (FA) who contracts with the Quality Improvement Organization (QIO).

The contracted QIO will determine level of care, prior authorize requests for services and approve the Person Centered Service Plans. DMS contracts with a non-governmental fiscal agent for processing and payment of provider claims. DMS contracts with DAIL to provide supports for participants choosing to participate in self direction of non-medical waiver services.

In addition, DMS contracts with the DBHDID to certify non-licensed waiver providers and assist with quality assurance with these providers.

DMS contracts with DCBS to determine medicaid eligibility.

- No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

## Appendix A: Waiver Administration and Operation

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- 4. Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

- Not applicable**

- Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

- Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

*Specify the nature of these agencies and complete items A-5 and A-6:*

- Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

*Specify the nature of these entities and complete items A-5 and A-6:*

### Appendix A: Waiver Administration and Operation

- 5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:  
 The Department for Medicaid Services (DMS) is responsible for assessing the performance of the contracted entities providing Quality Improvement Organization (QIO) functions, the fiscal agent, the Department for Aging and Independent Living (DAIL), Community Mental Health Centers (CMHC's), and the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID).

### Appendix A: Waiver Administration and Operation

- 6. Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:  
 DMS assesses the performance of the contracted agencies continually through policy clarification, post payment auditing processes, monthly, quarterly, and yearly reporting.

### Appendix A: Waiver Administration and Operation

- 7. Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):  
 In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

**Appendix A: Waiver Administration and Operation**

**Quality Improvement: Administrative Authority of the Single State Medicaid Agency**

As a distinct component of the State’s quality improvement strategy, provide information in the following fields to detail the State’s methods for discovery and remediation.

**a. Methods for Discovery: Administrative Authority**

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

**i. Performance Measures**

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

--First line monitoring activities and reviews of the MPW program providers by DMS, DBHDID, Department for Independent Living (DAIL), and QIO shall be conducted according to an on-going provider schedule. N = Number of activities and reviews conducted according to the ongoing provider schedule. D = Number of activities and reviews conducted.

Data Source (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

**Reports per FA/QIO systems.**

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: FA/QIO. MWMA when being fully used.	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify: FA/QIO	<input checked="" type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

--The quality, appropriateness of services provided and compliance with reimbursement requirements shall be reviewed for each participant in the review sample. N = The number of participant records reviewed in review sample to determine quality, appropriateness of services provided and compliance with reimbursement requirements. D = Number of participant records reviewed.

**Data Source (Select one):**

**Provider performance monitoring**

If 'Other' is selected, specify:

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> <b>Other</b> Specify: FA/QIO. MWMA when being fully used.	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify:	

	<input style="width: 90%;" type="text"/>	
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**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: FA/QIO. MWMA when being fully used.	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

**Performance Measure:**

--Findings shall be reported to the provider to include identified deficiencies and a request for a Corrective Action Plan (CAP) when applicable. N = Number of findings reported to provider to include identified deficiencies and a request for CAP when applicable. D = Number of findings reported to provider.

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 100%;" type="text"/>
<input checked="" type="checkbox"/> Other Specify: FA/QIO. MWMA when being fully used.	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%;" type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: FA/QIO. MWMA when being fully used.	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

--Findings of reviews conducted by QIO shall be reported to DMS, including deficiencies identified and recommendation for a CAP as applicable for follow-up by DMS. N = Number of findings of reviews conducted by QIO and reported to DMS, including deficiencies identified and recommendation for CAP as applicable. D = Number of findings of reviews conducted by QIO.

**Data Source (Select one):**

**Provider performance monitoring**

If 'Other' is selected, specify:

**FA/QIO system(s) for reports, provides to DMS for processing. CAP is requested per QIO, DMS follows up and ensures provider compliance.**

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: FA/QIO. MWMA when being fully used.	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify: FA/QIO. MWMA when being fully used.	<input checked="" type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

--The Fiscal Agent shall submit monthly, quarterly and annual reports to DMS containing statistical and summation data related to LOC determinations, prior authorization of services, other information requested as related to participants. N=Number of scheduled reports submitted containing statistical/summation data re to LOC, PA of services, pertinent information. D=Number of reports submitted.

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**FA, QIO, MWMA (when fully utilized) system(s) for the reports.**

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> <b>Other</b> Specify: FA/QIO, MWMA when being fully used.	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> <b>Other</b> Specify: FA/QIO, MWMA when being fully used.	<input checked="" type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

--Percent of required reports provided to DMS within the required timeframes by program providers, (DBHDID, QIO, DAIL). N= Number of required reports provided to DMS within the required timeframes by program providers. D=Number of required reports provided to DMS by program providers.

**Data Source (Select one):**

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

**Each agency database for reports.**

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> <b>Other</b> Specify: FA/QIO	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify: FA/QIO	<input checked="" type="checkbox"/> <b>Annually</b>

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

**b. Methods for Remediation/Fixing Individual Problems**

i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

DMS contracts with the Fiscal Agent who in turn contracts with the QIO for medical necessity review. Identified problems are researched and addressed by the DMS and the Fiscal Agent through the use of Utilization Management Reports that are generated on a monthly basis. DMS and the fiscal agent meet on a regular basis to review and identify issues/problems related to the level of care, person centered service plan and prior authorization of services. DMS monitors the Fiscal Agent to ensure that contract objectives and goals for LOC are met as appropriate. Should problems be identified, a collaborative plan is developed to resolve the issue/problem. Should the Fiscal Agent not meet the requirements, a corrective action plan is required and/or a recoupment of funds could occur.

ii. **Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify: QIO	<input checked="" type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

- No**
- Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

**Appendix B: Participant Access and Eligibility**

**B-1: Specification of the Waiver Target Group(s)**

a. **Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301 (b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input type="checkbox"/> Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged			<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)			
	<input type="checkbox"/>	Disabled (Other)			
<input type="checkbox"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input checked="" type="checkbox"/> Intellectual Disability or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism			<input type="checkbox"/>
	<input checked="" type="checkbox"/>	Developmental Disability	0		<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/>	Intellectual Disability	0		<input checked="" type="checkbox"/>
<input type="checkbox"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness			
	<input type="checkbox"/>	Serious Emotional Disturbance			

b. **Additional Criteria.** The State further specifies its target group(s) as follows:

c. **Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

- Not applicable. There is no maximum age limit**
- The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

## Appendix B: Participant Access and Eligibility

### B-2: Individual Cost Limit (1 of 2)

a. **Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*). Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

The limit specified by the State is (*select one*)

- A level higher than 100% of the institutional average.**

Specify the percentage:

- Other**

Specify:

- Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. *Complete Items B-2-b and B-2-c.*

The cost limit specified by the State is (select one):

- The following dollar amount:**

Specify dollar amount:

**The dollar amount (select one)**

- Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

- May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**

- The following percentage that is less than 100% of the institutional average:**

Specify percent:

- Other:**

Specify:

## Appendix B: Participant Access and Eligibility

### B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

- b. Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

- c. Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

- The participant is referred to another waiver that can accommodate the individual's needs.**
- Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

**Other safeguard(s)**

Specify:

**Appendix B: Participant Access and Eligibility**

**B-3: Number of Individuals Served (1 of 4)**

**a. Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	10500
Year 2	10500
Year 3	10500
Year 4	10500
Year 5	10500

**b. Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

- The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

**Appendix B: Participant Access and Eligibility**

**B-3: Number of Individuals Served (2 of 4)**

**c. Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- Not applicable. The state does not reserve capacity.**
- The State reserves capacity for the following purpose(s).**

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (3 of 4)

- d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):

- The waiver is not subject to a phase-in or a phase-out schedule.
- The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

- e. **Allocation of Waiver Capacity.**

*Select one:*

- Waiver capacity is allocated/managed on a statewide basis.
- Waiver capacity is allocated to local/regional non-state entities.

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

- f. **Selection of Entrants to the Waiver.** Specify the policies that apply to the selection of individuals for entrance to the waiver:

As long as capacity exists, eligible applicants will be selected for waiver entrance based on the date of their waiver application.

Applicants will apply on Medicaid Waiver Management Application (MWMA) and are pre-screened. The participant meeting the pre-screening requirements is added to the MPW waiting list.

There will not be an emergency status that will allow applicants to move ahead of other applicants to gain entry into the waiver.

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served - Attachment #1 (4 of 4)

**Answers provided in Appendix B-3-d indicate that you do not need to complete this section.**

## Appendix B: Participant Access and Eligibility

### B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a (*select one*):

- §1634 State
- SSI Criteria State
- 209(b) State

2. **Miller Trust State.**

Indicate whether the State is a Miller Trust State (*select one*):

- No
- Yes

- b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

***Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)***

- Low income families with children as provided in §1931 of the Act
- SSI recipients
- Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
- Optional State supplement recipients
- Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

- 100% of the Federal poverty level (FPL)
- % of FPL, which is lower than 100% of FPL.

Specify percentage:

- Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
- Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
- Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
- Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
- Medically needy in 209(b) States (42 CFR §435.330)
- Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)
- Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

Specify:

The federal regulatory citation(s) for the eligibility group(s) that are covered under the state's Medicaid plan proposes to include:

42 CFR 435.110, Parents and other caretaker relatives,

42 CFR 435.116, Pregnant women, and

42 CFR 435.118, Children.

---

**Special home and community-based waiver group under 42 CFR §435.217** Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed

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- No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.
- Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.

Select one and complete Appendix B-5.

- All individuals in the special home and community-based waiver group under 42 CFR §435.217
- Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217

Check each that applies:

- A special income level equal to:

Select one:

- 300% of the SSI Federal Benefit Rate (FBR)
- A percentage of FBR, which is lower than 300% (42 CFR §435.236)

Specify percentage:

- A dollar amount which is lower than 300%.

Specify dollar amount:

- Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
- Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
- Medically needy without spend down in 209(b) States (42 CFR §435.330)
- Aged and disabled individuals who have income at:

Select one:

- 100% of FPL
- % of FPL, which is lower than 100%.

Specify percentage amount:

- Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

Specify:

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

- a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

- Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses spousal post-eligibility rules under §1924 of the Act.

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (select one).

- Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.

In the case of a participant with a community spouse, the State elects to (select one):

- Use spousal post-eligibility rules under §1924 of the Act.  
(Complete Item B-5-b (SSI State) and Item B-5-d)
- Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)  
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)
- Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.  
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

- b. Regular Post-Eligibility Treatment of Income: SSI State.**

The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

- i. Allowance for the needs of the waiver participant (select one):**

- The following standard included under the State plan

Select one:

- SSI standard
- Optional State supplement standard
- Medically needy income standard
- The special income level for institutionalized persons

(select one):

- 300% of the SSI Federal Benefit Rate (FBR)
- A percentage of the FBR, which is less than 300%

Specify the percentage:

- A dollar amount which is less than 300%.

Specify dollar amount:

- A percentage of the Federal poverty level

Specify percentage:

- Other standard included under the State Plan

Specify:

^  
v

- The following dollar amount

Specify dollar amount:  If this amount changes, this item will be revised.

- The following formula is used to determine the needs allowance:

Specify:

SSI standard plus SSI general exclusion

- Other

Specify:

^  
v

**ii. Allowance for the spouse only (select one):**

- Not Applicable
- The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:

Specify:

^  
v

Specify the amount of the allowance (select one):

- SSI standard
- Optional State supplement standard
- Medically needy income standard
- The following dollar amount:

Specify dollar amount:  If this amount changes, this item will be revised.

- The amount is determined using the following formula:

Specify:

iii. **Allowance for the family** (*select one*):

- Not Applicable (see instructions)  
 AFDC need standard  
 Medically needy income standard  
 The following dollar amount:

Specify dollar amount:  The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

- The amount is determined using the following formula:

Specify:

- Other

Specify:

iv. **Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:**

- a. Health insurance premiums, deductibles and co-insurance charges  
 b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- Not Applicable (see instructions) *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*  
 The State does not establish reasonable limits.  
 The State establishes the following reasonable limits

Specify:

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (3 of 7)

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.*

**c. Regular Post-Eligibility Treatment of Income: 209(B) State.**

**Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.**

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (4 of 7)

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.*

**d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules**

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

**i. Allowance for the personal needs of the waiver participant**

(select one):

- SSI standard
- Optional State supplement standard
- Medically needy income standard
- The special income level for institutionalized persons
- A percentage of the Federal poverty level

Specify percentage:

- The following dollar amount:

Specify dollar amount:  If this amount changes, this item will be revised

- The following formula is used to determine the needs allowance:

*Specify formula:*

SSI Standard plus the \$20 General Exclusion

- Other

*Specify:*

**ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.**

Select one:

- Allowance is the same
- Allowance is different.

*Explanation of difference:*

**iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:**

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- Not Applicable (see instructions) *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- The State does not establish reasonable limits.
- The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (5 of 7)

*Note: The following selections apply for the five-year period beginning January 1, 2014.*

e. **Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.**

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. **Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.**

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. **Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.**

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

## Appendix B: Participant Access and Eligibility

### B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

- a. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. **Minimum number of services.**

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is:

ii. **Frequency of services.** The State requires (select one):

- The provision of waiver services at least monthly**  
 **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

- b. **Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (*select one*):

- Directly by the Medicaid agency**  
 **By the operating agency specified in Appendix A**  
 **By an entity under contract with the Medicaid agency.**

Specify the entity:

DMS contracts with Community Mental Health Centers (CMHC) throughout the state to complete evaluations and reevaluations for the MPW program.

- Other**  
Specify:

- c. Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Bachelor's Degree, or higher, in human service field, from an accredited college or university; OR  
Bachelor's degree in any other field from an accredited college or university, with at least one(1) year experience in the field of disabilities; OR Registered Nurse currently licensed as defined in KRS 314.011(5), and who has one (1) year or more experience as a Registered Nurse.

- d. Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The applicants Level of Care (LOC) is developed utilizing the MAP 351 assessment tool.

Level of care criteria used to evaluate and reevaluate waiver eligibility:

- (1) An individual shall be determined to have met the Michelle P. waiver service level of care criteria if the individual:

(a) Requires physical or environmental management or rehabilitation and:

1. Has a developmental disability or significantly sub-average intellectual functioning;
2. Requires a protected environment while overcoming the effects of a developmental disability or sub

-average intellectual functioning while:

- a. Learning fundamental living skills;
- b. Obtaining educational experiences which will be useful in self-supporting activities; or
- c. Increasing awareness of his or her environment; or
3. Has a primary psychiatric diagnosis if:
  - a. The individual possesses care needs listed in subparagraph 1 or 2 of this paragraph;
  - b. The individual's mental care needs are adequately handled in an ICF-IID; and
  - c. The individual does not require psychiatric inpatient treatment; or

(b) Has a developmental disability and meets the:

1. High-intensity nursing care patient status criteria pursuant to 907 KAR 1:022, Section 4(2); or
2. Low-intensity nursing care patient status criteria pursuant to 907 KAR 1:022, Section 4(3).

(2) An individual who does not require a planned program of active treatment to attain or maintain an optimal level of functioning shall not meet the Michelle P. waiver service level of care criteria.

(3) The department shall not determine that an individual fails to meet the Michelle P. waiver service level of care criteria solely due to the individual's age, length of stay in an institution, or history of previous institutionalization if the individual meets the criteria established in subsection (1) of this section.

Intellectual disability means an individual has:

- (a) Significantly sub-average intellectual functioning;
- (b) An intelligence quotient of seventy (70) or below;
- (c) Concurrent deficits or impairments in present adaptive functioning in at least two (2) of the following areas:
  1. Communication;
  2. Self-care;
  3. Home living;
  4. Social or interpersonal skills;
  5. Use of community resources;
  6. Self-direction;
  7. Functional academic skills;
  8. Work;
  9. Leisure; or
  10. Health and safety; and
- (d) Had an onset prior to eighteen (18) years of age.

Developmental disability means a severe, chronic disability that:

- (a) Is attributable to:
  1. Cerebral palsy or epilepsy; or
  2. Any other condition, excluding mental illness, closely related to an intellectual disability resulting in impairment of general intellectual functioning or adaptive behavior similar to that of an individual with an intellectual disability and which

requires treatment or services similar to those required by persons with an intellectual disability;

- (b) Is manifested prior to the individual's 22nd birthday;
- (c) Is likely to continue indefinitely; and
- (d) Results in substantial functional limitations in three (3) or more of the following areas of major life activity:
  1. Self-care;
  2. Understanding and use of language;
  3. Learning;
  4. Mobility;
  5. Self-direction; or
  6. Capacity for independent living.

State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency, including the instrument/tool utilized.

- e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):

- The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

The QIO utilizes the assessment tool to review and determine level of care for individuals in the community and is not appropriate or used for institutional level of care determination.

The tool used for institutional care does not reflect the person's community, home or environmental support systems. The MAP-351 reflects all criteria for Level of Care determination, but also reflects the person-centered supports needed to stay in their home.

- f. **Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

All applicants must have an order stating that, without community supports, the individual would require institutional care. The contracted entity will assess members applying for the waiver upon completion of this assessment. DMS staff will forward of the information to the QIO to review authorization.

The reevaluation process utilizes the same assessment tool.

- g. **Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):

- Every three months**
- Every six months**
- Every twelve months**
- Other schedule**

*Specify the other schedule:*

- h. **Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations (*select one*):

- The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- The qualifications are different.**

*Specify the qualifications:*

- i. **Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care (*specify*):

The State of Kentucky requires that re-evaluations be performed at least every 12 months, or more often as needed due to significant change.

The QIO staff will use this information to evaluate if the consumer meets Level of Care (LOC) for admittance to an Intermediate

Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

An approved waiver segment, determined by the QIO, is in effect for one year, or until significant change requires reassessment.

If the waiver segment is not updated at least annually, the provider of services will not be paid.

- j. Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Written documentation of the evaluations and reevaluations shall be maintained by the Case Manager and provider agencies.

All records shall be maintained a minimum of six (6) years.

## Appendix B: Evaluation/Reevaluation of Level of Care

### Quality Improvement: Level of Care

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

#### a. Methods for Discovery: Level of Care Assurance/Sub-assurances

*The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.*

##### i. Sub-Assurances:

- a. *Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.*

#### Performance Measures

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

#### Performance Measure:

--Percent of applicants who had a level of care assessment. N = Total number of level of care eligibility determination packets returned. D = Total number of level of care determinations.

Data Source (Select one):

**Provider performance monitoring**

If 'Other' is selected, specify:

**FA/QIO, and MWMA provide information to DMS. DMS assesses compliance and compiles date.**

Responsible Party for data collection/generation( <i>check each that applies</i> ):	Frequency of data collection/generation( <i>check each that applies</i> ):	Sampling Approach( <i>check each that applies</i> ):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: FA/QIO. MWMA when being fully used.	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify: FA/QIO. MWMA when being fully used.	<input type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

b. *Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.*

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**--Percent of waiver participants whose level of care was reevaluated within 12 months of their initial LOC evaluation or of their last annual LOC evaluation. N= Total number of participants who had a LOC redetermination within 12 months D= Total number of MPW LOC redeterminations completed.**

**Data Source (Select one):**

**Provider performance monitoring**

If 'Other' is selected, specify:

**FA/QIO, MWMA**

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>

<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample Confidence Interval</b> = <input type="text"/>
<input checked="" type="checkbox"/> <b>Other</b> Specify: FA/QIO, MWMA	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify: FA/QIO, MWMA	<input checked="" type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

- c. **Sub-assurance:** *The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.*

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**--Percent of waiver participants whose LOC eligibility was based on accurate application of policy resulting in accurate LOC determinations. N= Number of randomly selected waiver participants whose LOC eligibility was done appropriately and according to policy. D= Number of LOC eligibility reviewed for randomly selected waiver participants.**

**Data Source (Select one):**  
**Record reviews, on-site**  
 If 'Other' is selected, specify:  
**MWMA, FA/QIO**

Responsible Party for data collection/generation( <i>check each that applies</i> ):	Frequency of data collection/generation( <i>check each that applies</i> ):	Sampling Approach( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: MWMA, FA/QIO	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: MWMA, FA/QIO	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

–Percentage of waiver applicants who had a level of care assessment which met the criteria for the waiver. N= Total number and percentage of applicants who had a level of care evaluation which met the criteria for the waiver. D= Total number of waiver applicants level of care completed and submitted.

**Data Source (Select one):**  
**Record reviews, off-site**  
 If 'Other' is selected, specify:  
**Database provided by FA/QIO, MWMA.**

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: FA/QIO MWMA	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: QIO	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: FA/QIO, MWMA	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

DMS addresses problems as discovered through the use of utilization management reports which are generated by the fiscal agent and the QIO for evaluation/reevaluation. These reports show number of new participants who received LOC prior to services being provided, shows number of timely reevaluations, and forms/instruments completed as required by the state. DMS will meet with the fiscal agent and/or the provider to identify and remediate the problem.

- ii. **Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

<b>Responsible Party</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify: FA/QIO, MWMA	<input checked="" type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

**No**

**Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

DMS will ensure integration of supporting agencies and Fiscal Agent, collaborating to develop reports that detail progress toward meeting this performance measure. DMS will work with support agencies to ensure processes and instruments are applied appropriately and according to the approved description to determine the initial participant level of care. DMS will evaluate understanding and compliance and will provide corrective action as indicated. Responsible parties will be supporting agencies, fiscal agent and DMS.

**Appendix B: Participant Access and Eligibility****B-7: Freedom of Choice**

**Freedom of Choice.** As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and
- ii. given the choice of either institutional or home and community-based services.

- a. Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

All waiver members are informed of their choice of institutional care or waiver programs and available services, including all available waiver providers by participating Case Management waiver providers.

This information is provided at the initial evaluation and at each reevaluation and documented on the assessment tool, MAP 531-Freedom of Choice and Case Management Conflict Exemption, or the MAP 350-“Long Term Care Facilities and Home and Community Based Program Certification Form”. Both the MAP 531 and the MAP 350 will be uploaded to the Medicaid Waiver Management Application (MWMA) system.

Written copies of the signed form are retained in the participant's chart and maintained by the Case Management provider. The freedom of choice form is completed annually or when a participant changes case management providers.

- b. Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Copies are maintained by the Providers and the case management agency. The freedom of choice documentation is maintained in MWMA.

## Appendix B: Participant Access and Eligibility

### B-8: Access to Services by Limited English Proficiency Persons

**Access to Services by Limited English Proficient Persons.** Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

All Kentucky Medicaid providers are required to provide effective language access services to Medicaid participants who are limited in their English proficiency (LEP). Specific procedures for assuring LEP access may vary by provider, but are required to address assessment of the language needs of participants served by the provider, provision of interpreter services at no cost to the participants, and staff training.

As indicated in Appendix A, Waiver Administration and Operation, of this application, the Department for Medicaid Services (DMS) contracts with several state and contracted entities to perform waiver administrative functions, including level of care determination and prior authorization of services, processing and payment of provider claims, and fiscal intermediary services. In addition, the Department for Community Based Services, a governmental unit within the Cabinet for Health and Family Services, determines technical and financial eligibility for Medicaid services. All of these entities are required, through contract, to comply with Federal standards regarding the provision of language services to improve access to their programs and activities for persons who are limited in their English proficiency. Contractors' language services must be consistent with Federal requirements, include a method of identifying LEP individuals, and provide language assistance measures including interpretation and translation, staff training, providing notice to LEP persons, and monitoring compliance and updating procedures.

The Cabinet for Health and Family Services has established a Language Access Section to assist all Cabinet organizational units, including DMS, in effectively communicating with LEP individuals, as well as complying with Federal requirements. The Language Access Section has qualified interpreters on staff, maintains a listing of qualified interpreters for use by CHFS units and contractors throughout the state, contracts with a telephone interpretation service for use by CHFS units and contractors when appropriate, provides translation services for essential program forms and documents, establishes policies and procedures applicable to CHFS, and provides technical assistance to CHFS units as needed. Procedures employed by individual departments and units, including DMS, include posting multi-lingual signs in waiting areas to explain that interpreters will be provided at no cost; using "I Speak" cards or a telephone language identification service to help identify the primary language of LEP individuals at first contact; recording the primary language of each LEP individual served; providing interpretation services at no cost to the individual served; staff training; and monitoring of staff offices and contractors.

Provider procedures for assuring LEP access are ensured through routine interaction and monitoring. When the State learns of an individual needing assistance, staff consult with the individual, case manager and the service provider to determine the type of assistance needed and may require additional activities on the part of the provider to ensure the appropriate translation services are available to the individual.

## Appendix C: Participant Services

### C-1: Summary of Services Covered (1 of 2)

- a. **Waiver Services Summary.** List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service		
Statutory Service	Adult Day Health		
Statutory Service	Adult Day Training		
Statutory Service	Case Management		
Statutory Service	Community Living Supports		
Statutory Service	Homemaker		
Statutory Service	Personal Care		
Statutory Service	Respite		
Statutory Service	Supported Employment		
Extended State Plan Service	Occupational Therapy		
Extended State Plan Service	Physical Therapy		
Extended State Plan Service	Speech Therapy		
Supports for Participant Direction	Community Day Supports		
Supports for Participant Direction	Financial Management Services		
Supports for Participant Direction	Goods and Services		
Supports for Participant Direction	Home and Community Services		
Supports for Participant Direction	Support Broker		
Other Service	Attendant Care		
Other Service	Behavioral Supports		

Service Type	Service
Other Service	Environmental and Minor Home Adaptations

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Statutory Service

**Service:**

Adult Day Health

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

**Category 1:**

04 Day Services

**Sub-Category 1:**

04050 adult day health

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

Adult day health care (ADHC) services include basic and ancillary services for waiver members who are twenty-one (21) years or older. Basic services include skilled nursing services; one meal per day, snacks, RN supervision, regularly scheduled daily activities, crisis service, routine personal and healthcare needs and equipment essential to the provision of the ADHC services. Transportation is not covered under the ADHC element. All ADHC services are prior authorized. ADHC is not available in the participant directed services option.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

A unit of service is 15 minutes. Limit of 160 units per week in combination with other services, excluding Case Management and Respite.

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E
- Provider managed

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person
- Relative

Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	All Medicaid approved providers

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type: Statutory Service**  
**Service Name: Adult Day Health**

**Provider Category:**

Agency

**Provider Type:**

All Medicaid approved providers

**Provider Qualifications**

**License (specify):**

Office of the Inspector General

**Certificate (specify):**

Dept. for Behavioral Health, Developmental and Intellectual Disabilities

**Other Standard (specify):**

As specified in 907 KAR 1:160 and program services manual

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Office of Inspector General

**Frequency of Verification:**

Annually or more frequently if necessary

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Statutory Service

**Service:**

Day Habilitation

**Alternate Service Title (if any):**

Adult Day Training

**HCBS Taxonomy:**

**Category 1:**

04 Day Services

**Sub-Category 1:**

04020 day habilitation

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

▼

▼

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

**Service Definition (Scope):**

Adult Day Training services are intended to support the participation of individuals in daily, meaningful, routines of the community, which for adults may include work-like settings that do not meet the definition of supported employment. ADT services stress training in the activities of daily living, self-advocacy, adaptive and social skills and are age and culturally appropriate. The training, activities, and routines established shall not be diversional in nature but rather, shall be meaningful to the person, shall provide an appropriate level of variation and interest, and shall assist the person to achieve personally chosen outcomes which are documented in the Person Centered Service Plan (PCSC).

ADT services can be provided at a fixed location, or in community settings. Services provided in a fixed location are typically provided on a regularly scheduled basis, no more than five days per week. The hours must be spent in training and program activities and must be based on the individual's Person Centered Service Plan (PCSP). Support services lead to the acquisition, improvement, and/or retention of skills and abilities to prepare the person for work and/or community access or transition from school to adult responsibilities and community integration.

ADT may be provided as an adjunct to other services included on a person's support plan. For example: a person may receive supported employment or other services for part of a day or week and ADT services at a different time of the day or week. ADT services will only be billable for the time that the person actually received the service. ADT may also include group approaches to work related training that occur in community settings (mobile work crews, enclaves, entrepreneurial models) OR ADT may include dispersing of an individual throughout an integrated work setting with people without disabilities. Any person receiving ADT services that are performing productive work that benefits the organization, or would have to be performed by someone else if not performed by the person, must be paid. People who are working must be paid commensurate with members of the general work force doing similar work per wage and hour regulations of the U.S. Department of Labor.

In addition to work-related training, ADT may include involvement in community based activities that assist the person in increasing his/her ability to access community resources and being involved with other members of the general population. ADT can be used to provide access to community-based activities that cannot be provided by natural or other unpaid supports, and is defined as activities designed to result in increased ability to access community resources without paid supports. These services may not supplant educational services available under the IDEA (20 U.S.C. 1401 et seq.).

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Limit of 160 units per week in combination with other services, excluding Case Management and Respite.

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E
- Provider managed

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Qualified Day Training Staff
Agency	Certified or licensed agency employing qualified staff

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type:** Statutory Service  
**Service Name:** Adult Day Training

**Provider Category:**

Individual ▼

**Provider Type:**

Qualified Day Training Staff

**Provider Qualifications****License (specify):****Certificate (specify):****Other Standard (specify):**

1. Is eighteen (18) years or older; and Has a high school diploma or GED; is or is at least twenty-one (21) years old; and
2. Meets all applicable personnel and training requirements;
3. Has a valid Social Security number or a valid work permit if not a citizen of the U.S.; and
4. Has the ability to: a) communicate effectively with the person/family; b) understand and carry out instructions; c) perform required documentation.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Case Manager

**Frequency of Verification:**

Prior to service delivery

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Adult Day Training****Provider Category:**Agency **Provider Type:**

Certified or licensed agency employing qualified staff

**Provider Qualifications****License (specify):****Certificate (specify):**

Dept. for Behavioral Health, Developmental and Intellectual Disabilities

**Other Standard (specify):**

Certified providers meet all applicable DMS standards for a waiver provider agency; employs staff with the following qualifications:

1. Is eighteen (18) years or older; and Has a high school diploma or GED; or is at least twenty-one (21) years old; and
2. Meets all applicable DMS personnel and training requirements;
3. Has a valid Social Security number or a valid work permit if not a citizen of the U.S.; and
4. Has the ability to: a) communicate effectively with the person/family; b) understand and carry out instructions; c) perform required documentation.

Supervisory staff must also have 2 years experience in supporting persons with disabilities and complete a supervisory training curriculum approved by DMS.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

DMS - certified providers

OIG-licensed providers

**Frequency of Verification:**

Prior to service delivery and every two years thereafter.

**Appendix C: Participant Services****C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Statutory Service ▼

**Service:**

Case Management ▼

**Alternate Service Title (if any):**

**HCBS Taxonomy:****Category 1:**

01 Case Management ▼

**Sub-Category 1:**

01010 case management ▼

**Category 2:**

▼

**Sub-Category 2:**

▼

**Category 3:**

▼

**Sub-Category 3:**

▼

**Category 4:**

▼

**Sub-Category 4:**

▼

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

**Service Definition (Scope):**

Case Management involves working with the member and others identified by the member, such as family members, in developing a Plan of Care under the traditional model of waiver service delivery. Utilizing person centered processes, case management assists in identifying and implementing support strategies. Support strategies will incorporate the principles of empowerment, community inclusion, health and safety assurances, and the use of informal supports. Case managers will work closely with the individual to assure ongoing satisfaction with the process and outcomes of supports, services and available resources.

Case management means face to face and related contacts to make arrangements for activities which assure: the desires and needs of the member are determined; the supports and services desired and needed by the member are identified and implemented; housing and employment issues are addressed; social networks are developed; appointments and meetings are scheduled; a person-centered approach to planning is provided; informal and community supports are utilized; the quality of supports and services as well as the health and safety of the individual are monitored; income benefits are maximized based on needed activities are documented; and plans of supports/services are reviewed at such intervals as are indicated during planning. Case Management will be coordination, planning and monitoring process and not include direct services. Case management will be conflict free. Agencies providing case management services may not provide other services to the member. All case management services shall be prior authorized.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Case Management is provided one monthly unit.

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E**
- Provider managed**

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person**
- Relative**

Legal Guardian

**Provider Specifications:**

<b>Provider Category</b>	<b>Provider Type Title</b>
Agency	Licensed and certified Medicaid providers

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type: Statutory Service**  
**Service Name: Case Management**

**Provider Category:**

Agency

**Provider Type:**

Licensed and certified Medicaid providers

**Provider Qualifications**

**License (specify):**

Office of Inspector General

**Certificate (specify):**

Department for Behavioral Health, Developmental and Intellectual Disabilities

**Other Standard (specify):**

Must meet all personnel and training requirements per 907 KAR 1:835 Section 6(c)1-6, and Section 9.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Office of Inspector General (OIG)

Department for Behavioral Health, Developmental and Intellectual Disabilities

**Frequency of Verification:**

Initially and annually thereafter

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Statutory Service

**Service:**

Day Habilitation

**Alternate Service Title (if any):**

Community Living Supports

**HCBS Taxonomy:**

**Category 1:**

08 Home-Based Services

**Sub-Category 1:**

08040 companion

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

▼

▼

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

**Service Definition (Scope):**

Community living supports, which shall:

1. Be provided to facilitate independence and promote integration into the community for a participant residing in his or her own home or in his or her family's home;
2. Be supports and assistance that shall be related to chosen outcomes, not be diversional in nature, and may include:
  - a. Routine household tasks and maintenance;
  - b. Activities of daily living;
  - c. Personal hygiene;
  - d. Shopping;
  - e. Money management;
  - f. Medication management;
  - g. Socialization;
  - h. Relationship building;
  - i. Leisure choices;
  - j. Participation in community activities;
  - k. Therapeutic goals; or
3. Not replace other work or day activities;
4. Be provided on a one-on-one basis;
5. Not be provided at an adult day training or children's day habilitation site;
6. Be documented in the MWMA by:
  - a. A time and attendance record, which shall include:
    - (i) The date of the service;
    - (ii) The beginning and ending time of the service; and
    - (iii) The signature, date of signature, and title of the individual providing the service; and
  - b. A detailed monthly summary note, which shall include:
    - (i) The month, day, and year for the time period each note covers;
    - (ii) Progression, regression, and maintenance toward outcomes identified in the person-centered service plan; and
    - (iii) The signature, date of signature, and title of the individual preparing the summary note; and
7. Be limited to sixteen (16) hours per day alone or in combination with adult day training and supported employment.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Community Living Supports is limited to 160 units per week, excluding Case Management and Respite.

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E**
- Provider managed**

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person**
- Relative**
- Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Certified waiver provider

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type: Statutory Service**

**Service Name: Community Living Supports**

**Provider Category:**

Agency ▼

**Provider Type:**

Certified waiver provider

**Provider Qualifications****License (specify):****Certificate (specify):**

Dept. for Behavioral Health, Developmental and Intellectual Disabilities

**Other Standard (specify):****Verification of Provider Qualifications****Entity Responsible for Verification:**

Dept. for Behavioral Health, Developmental and Intellectual Disabilities

**Frequency of Verification:**

Initially and annually thereafter

**Appendix C: Participant Services****C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:****Service:****Alternate Service Title (if any):****HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

**Service Definition (Scope):**

Homemaker services consist of general household activities such as meal preparation and routine household care. Provided by direct-care staff, to a participant who is functionally unable, but would normally perform age-appropriate homemaker tasks.

Service is provided when the caregiver regularly responsible for homemaker activities is temporarily absent or functionally unable to manage the homemaking activities.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

160 units per week in combination with other services, excluding Case Management and Respite.

**Service Delivery Method** (check each that applies):

- Participant-directed as specified in Appendix E  
 Provider managed

**Specify whether the service may be provided by** (check each that applies):

- Legally Responsible Person  
 Relative  
 Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Home Health Agency, ADHC and Certified Waiver Provider.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**

**Service Name: Homemaker**

**Provider Category:**

Agency

**Provider Type:**

Home Health Agency, ADHC and Certified Waiver Provider.

**Provider Qualifications**

**License** (specify):

902 KAR 20:081, 902 KAR 20:066, KRS 334.020

**Certificate** (specify):

**Other Standard** (specify):

Meets all applicable DMS standards for a waiver provider agency;

1. Is eighteen (18) years or older; and Has a high school diploma or GED; or

Is at least twenty-one (21) years old; and able to communicate with a recipient in a manner that the recipient or recipient's legal representative or family member can understand;

2. Meets all applicable personnel and training requirements;

3. Has a valid Social Security number or a valid work permit if not a citizen of the U.S.;

4. Has the ability to: a) communicate effectively with the person/family; b) understand and carry out instructions; c) perform required documentation; and

5. Is managed by the provider's supervisory staff.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Dept. for Behavioral Health, Developmental and Intellectual Disabilities for certified

Office of Inspector General for Licensed

**Frequency of Verification:**

Prior to service delivery, annually thereafter

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Statutory Service ▼

**Service:**

Personal Care ▼

**Alternate Service Title (if any):**

**HCBS Taxonomy:****Category 1:**

08 Home-Based Services ▼

**Sub-Category 1:**

08030 personal care ▼

**Category 2:**
 ▼
**Sub-Category 2:**
 ▼
**Category 3:**
 ▼
**Sub-Category 3:**
 ▼
**Category 4:**
 ▼
**Sub-Category 4:**
 ▼

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

**Service Definition (Scope):**

Personal Care services enable waiver participants to accomplish tasks that they normally would do for themselves if they did not have a disability. This assistance may include hands-on assistance (actually performing a task for the person), reminding, observing, guiding, and/or training a waiver participant in ADLs (such as bathing, dressing, toileting, transferring, maintaining continence) and IADLs (more complex life activities such as personal hygiene, light housework, laundry, meal planning and preparation, transportation, grocery shopping, using the telephone, money management, and medication administration). This service may also include assisting the waiver participant in managing his/her medical care including making medical appointments. May accompany waiver participant to/from medical appointments, but may not bill while participant is being treated by a medical professional. Transportation to access community services, activities and appointments, other than State plan services, is included in the rate.

Personal Care services take place in the waiver participant's home, and in the community as appropriate to the individual's need.

Personal Care services are available only to a waiver participant who lives in his/her own residence or in his/her family residence.

Without these services, the individual is at risk of needing ICF/IID services. Personal Care services are not available to individuals under the age of 21 when medically necessary personal care services are covered by EPSDT. Personal Care services may not supplant educational services available under the IDEA (20 U.S.C. 1401 et seq.).

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Limit of 160 units per week in combination with other services, excluding Case Management and Respite.

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E**
- Provider managed**

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person**
- Relative**
- Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Home Health Agency
Agency	Adult Day Health Care
Agency	Private Duty Nursing Agencies

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Personal Care****Provider Category:**

Agency

**Provider Type:**

Home Health Agency

**Provider Qualifications****License (specify):**

902 KAR20:066

**Certificate (specify):**

**Other Standard (specify):**

Meets all applicable DMS standards for a waiver provider agency;

Meets all applicable standards for a waiver provider agency;

Employs staff with the following qualifications:

1. Is eighteen (18) years or older; and has a high school diploma or GED; or Is at least twenty-one (21) years old; and

2. Meets all applicable DMS personnel and training requirements;

3. Has a valid Social Security number or a valid work permit if not a citizen of the U.S.;

4. Has the ability to: a) communicate effectively with the individual/family; b) understand and carry out instructions; c) perform required documentation.

Supervisory staff must also have 2 years experience in supporting individuals with DD and complete a supervisory training curriculum approved by DMS.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Office of Inspector General

**Frequency of Verification:**

Initially and annually thereafter

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Personal Care****Provider Category:**

Agency

**Provider Type:**

Adult Day Health Care

**Provider Qualifications****License (specify):**

License 902 KAR20:066

**Certificate (specify):**

**Other Standard (specify):**

Meets all applicable DMS standards for a waiver provider agency;

Employs staff with the following qualifications:

1. Is eighteen (18) years or older; and Has a high school diploma or GED; or

- Is at least twenty-one (21) years old; and
- 2.Meets all applicable DMS personnel and training requirements;
  - 3.Has a valid Social Security number or a valid work permit if not a citizen of the U.S.;
  - 4.Has the ability to: a) communicate effectively with the person/family; b) understand and carry out instruction
  - c) perform required documentation; and
  5. Driver must be at least 18 years of age, hold a valid, Class C State of Kentucky driver's license, have no major traffic violations, and have current mandatory insurance.
- Supervisory staff must also have 2 years experience in supporting persons with ID and complete a supervisory training curriculum approved by DMS.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

OIG

**Frequency of Verification:**

Initially and annually

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Personal Care****Provider Category:**Agency **Provider Type:**

Private Duty Nursing Agencies

**Provider Qualifications****License (specify):**

902 KAR20:370

**Certificate (specify):****Other Standard (specify):**

Employs staff with the following qualifications:

- 1.Is eighteen (18) years or older; and Has a high school diploma or GED; or
- Is at least twenty-one (21) years old; and
- 2.Meets all applicable DMS personnel and training requirements;
- 3.Has a valid Social Security number or a valid work permit if not a citizen of the U.S.;
- 4.Has the ability to: a) communicate effectively with the person/family; b) understand and carry out instruction
- c) perform required documentation; and

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Office of Inspector General

**Frequency of Verification:**

Initially and annually thereafter

**Appendix C: Participant Services****C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**Statutory Service **Service:**Respite **Alternate Service Title (if any):**

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

Respite Services are provided to the individual living in his/her own or family's home who are unable to independently care for themselves. Respite services are provided on a short term basis due to the absence of or need for relief of the primary caregiver.

Respite may be provided in a variety of settings including the individual's own home, a private residence or other MPW certified or licensed setting. Receipt of respite care does not preclude an individual from receiving other services on the same day. For example, a participant may receive day services (such as supported employment, day training, personal assistance, community access, etc.) on the same day as he/she receives respite care as long as the services are not provided at the same time.

These services may not supplant educational services available under the IDEA (20 U.S.C. 1401 et seq.).

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Limited up to \$4000.00 per level of care year.

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E
- Provider managed

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Certified or Licensed Agency that employs qualified Respite Staff
Individual	Qualified Respite Staff

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

Service Type: Statutory Service

**Service Name: Respite**

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**Provider Category:**Agency **Provider Type:**

Certified or Licensed Agency that employs qualified Respite Staff

**Provider Qualifications****License (specify):**

Licensed Adult Day Health Care 902 KAR 20:066

Home Health Agency 902 KAR 20:081

**Certificate (specify):**

Certified waiver provider

**Other Standard (specify):**

Certified providers staff: 1.Is eighteen (18) years or older; and Has a high school diploma or GED; or

Is at least twenty-one (21) years old; and

2.Meets all applicable DMS personnel and training requirements;

3.Has a valid Social Security number or a valid work permit if not a citizen of the U.S.;

4.Has the ability to: a) communicate effectively with the person/family; b) understand and carry out instructions;c) perform required documentation

**Verification of Provider Qualifications****Entity Responsible for Verification:**

BHDID - certified providers

OIG- licensed providers

**Frequency of Verification:**

Annually - licensed providers

Initially and at least annually thereafter-certified providers

**Appendix C: Participant Services**

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**C-1/C-3: Provider Specifications for Service**

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**Service Type: Statutory Service****Service Name: Respite**

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**Provider Category:**Individual **Provider Type:**

Qualified Respite Staff

**Provider Qualifications****License (specify):****Certificate (specify):****Other Standard (specify):**

1.Is eighteen (18) years or older; and Has a high school diploma or GED; or

Is at least twenty-one (21) years old; and

2.Meets all applicable DDID personnel and training requirements;

3.Has a valid Social Security number or a valid work permit if not a citizen of the U.S.;

4.Has the ability to: a) communicate effectively with the person/family; b) understand and carry out instructions; c) perform required documentation

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Support Broker

**Frequency of Verification:**

Prior to service delivery

**Appendix C: Participant Services**

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**C-1/C-3: Service Specification**

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State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Statutory Service

**Service:**

Supported Employment

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

**Category 1:**

03 Supported Employment

**Sub-Category 1:**

03021 ongoing supported employment, individual

**Category 2:**

03 Supported Employment

**Sub-Category 2:**

03022 ongoing supported employment, group

**Category 3:**

03 Supported Employment

**Sub-Category 3:**

03010 job development

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

**Service Definition (Scope):**

Supported employment is paid, competitive employment at or above minimum wage for a MPW recipient who has demonstrated an inability to gain and maintain traditional employment. Intensive, ongoing support for a participant to maintain paid employment in which an individual without a disability is employed. SE must be provided by a staff person who has completed supported employment training curriculum conducted by staff of the cabinet or designee.

Supported Employment occurs in a variety of integrated business environments. Phases of Supported Employment include: Job Development, Job Acquisition, Successful Placement and Long Term Follow up. Supported employment is a one to one service that shall be person specific.

These services may not supplant educational services available under the IDEA (20 U.S.C. 1401 et seq.).

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Supported Employment is limited to 160 units per week in combination with other services, excluding Case Management and Respite.

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E**
- Provider managed**

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person**
- Relative**
- Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title

Provider Category	Provider Type Title
Agency	Certified Agency employing qualified Supported Employment Staff

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type: Statutory Service**  
**Service Name: Supported Employment**

**Provider Category:**

Agency

**Provider Type:**

Certified Agency employing qualified Supported Employment Staff

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

DBHDID certified provider

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Dept. for Behavioral Health, Developmental and Intellectual Disabilities

**Frequency of Verification:**

Initially and at least annually thereafter.

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Extended State Plan Service

**Service Title:**

Occupational Therapy

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

**Service Definition (Scope):**

Occupational Therapy Services are provided by a licensed occupational therapist or certified occupational therapist assistant, and by order of a physician. Occupational Therapy Services cover evaluation and therapeutic services that are not otherwise covered by Medicaid State Plan services. These services address the occupational therapy needs of the participant that result from his or her developmental disability as well as development of a home treatment/support plan with training and technical assistance provided on-site to improve the ability of paid and unpaid caregivers to carry out therapeutic interventions. Occupational therapy facilitates maximum independence by establishing life skills with an emphasis on safety and environmental adaption to improve quality of life and increase meaning and purpose in daily living and community integration. Occupational Therapy promotes fine motor skills, coordination, sensory integration, and/or facilitate the use of adaptive equipment or other assistive technology. Specific services include occupational therapy evaluation of the individual and/or environment, therapeutic activities to improve functional performance, sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, and participant/family education. Services may be delivered in the individual's home and in the community as described in the service plan. Attendance is expected at Person Centered Planning meeting which is not a separate billable service.

Occupational Therapy services must be prior authorized. If a service is available to a recipient under the State plan or could be furnished as an expanded EPSDT benefit under the provisions of § 1905(r), it may not be covered as a waiver service for waiver participants under age 21.

Services provided by an occupational therapy assistant must be supervised by a licensed occupational therapist.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Limited to 160 units per week in combination with other services, excluding Case Management and Respite.

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E**
- Provider managed**

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person**
- Relative**
- Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Adult Day Health Care
Agency	Home Health Agency
Individual	Certified waiver providers

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Extended State Plan Service**

**Service Name: Occupational Therapy**

**Provider Category:**

Individual ▾

**Provider Type:**

Adult Day Health Care

**Provider Qualifications**

**License (specify):**

902 KAR 20:066

**Certificate (specify):**

**Other Standard (specify):**

^  
v

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Office of Inspector General

**Frequency of Verification:**

Annually or more frequently if necessary

**Appendix C: Participant Services**

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**C-1/C-3: Provider Specifications for Service**

---

**Service Type: Extended State Plan Service**

**Service Name: Occupational Therapy**

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**Provider Category:**

Agency v

**Provider Type:**

Home Health Agency

**Provider Qualifications**

**License (specify):**

902 KAR 20:081

**Certificate (specify):**

^  
v

**Other Standard (specify):**

^  
v

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Office of Inspector General

**Frequency of Verification:**

Annually or more frequently if necessary

**Appendix C: Participant Services**

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**C-1/C-3: Provider Specifications for Service**

---

**Service Type: Extended State Plan Service**

**Service Name: Occupational Therapy**

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**Provider Category:**

Individual v

**Provider Type:**

Certified waiver providers

**Provider Qualifications**

**License (specify):**

^  
v

**Certificate (specify):**

Certified at least annually by operating agency

**Other Standard (specify):**

^  
v

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDID

**Frequency of Verification:**

annually

**Appendix C: Participant Services****C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

**Service Title:**

Physical Therapy

**HCBS Taxonomy:****Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**


Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

**Service Definition (Scope):**

Physical Therapy services are provided by a licensed physical therapist or certified physical therapy assistant, and by order of a physician. Physical Therapy Services cover evaluation and therapeutic services that are not otherwise covered under Medicaid State Plan services.

These services address physical therapy needs that result from a participant's developmental disability. Physical Therapy Services facilitate independent functioning and/or prevent progressive disabilities. Covered services include: physical therapy evaluation, therapeutic procedures, therapeutic exercises to increase range of motion and flexibility, participant/family education and assessment of an individual's environment. Services also include development of a home treatment/support plan with training and technical assistance provided on-site to improve the ability of paid and unpaid caregivers to carry out therapeutic interventions. Services may be delivered in the individual's home and in the community as described in the service plan. Attendance is expected at Person Centered Planning meeting which is not a separate billable service.

Physical Therapy Services must be prior authorized. If a service is available to a recipient under the State plan or could be furnished as an expanded EPSDT benefit under the provisions of § 1905(r), it may not be covered as a waiver service for waiver participants under age 21.

Services provided by a physical therapist assistant must be supervised by a licensed physical therapist.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Limited to 160 units per week in combination with other services, excluding Case Management and Respite.

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E**
- Provider managed**

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person**

- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Adult Day Health Care
Individual	certified waiver providers
Agency	Home Health Agency

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type:** Extended State Plan Service  
**Service Name:** Physical Therapy

**Provider Category:**

Agency

**Provider Type:**

Adult Day Health Care

**Provider Qualifications**

**License (specify):**

902 KAR 20:066

**Certificate (specify):**

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Office of Inspector General

**Frequency of Verification:**

Annually and more frequently if necessary

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type:** Extended State Plan Service  
**Service Name:** Physical Therapy

**Provider Category:**

Individual

**Provider Type:**

certified waiver providers

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

DBHDID certified

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDID

**Frequency of Verification:**

Annually or more necessary if needed

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type:** Extended State Plan Service  
**Service Name:** Physical Therapy

**Provider Category:**

Agency

**Provider Type:**

Home Health Agency

**Provider Qualifications**

**License (specify):**

902 KAR 20:081

**Certificate (specify):**

**Other Standard (specify):**

All standards identified in program regulations and service manual

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Office of Inspector General

**Frequency of Verification:**

Annually or more frequently if needed

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Extended State Plan Service

**Service Title:**

Speech Therapy

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

Speech and Language Therapy Services cover evaluation and therapeutic services that are not otherwise covered by Medicaid State Plan services. Evaluation of the individual and their living and working environments may be conducted.

These services address the speech and language needs of the participant that result from his or her developmental disability. Speech and Language Therapy Services preserve abilities for independent function in communication, motor and swallowing functions, facilitate use of assistive technology, and/or prevent regression. Specific services include speech and language therapy evaluation, individual treatment of voice, communication, and/or auditory processing, therapeutic services for the use of speech-device, including programming and modification, and participant/family education. Services also include development of a home treatment/support plan with training and technical assistance provided on-site to improve the ability of paid and unpaid caregivers to carry out therapeutic interventions.

Speech and Language Therapy Services are provided by a licensed speech and language pathologist and by order of a physician. Services may be delivered in the individual’s home and in the community as described in the service plan. Attendance is expected at Person Centered Planning meeting which is not a separate billable service.

Speech and Language Therapy Services must be prior authorized. If a service is available to a recipient under the State plan or could be furnished as an expanded EPSDT benefit under the provisions of § 1905(r), it may not be covered as a waiver service for waiver participants under age 21.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Limited to 160 units per week in combination with other services, excluding Case Management and Respite.

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E
- Provider managed

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Certified provider agency
Agency	Home Health
Agency	Adult Day Health Care

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type:** Extended State Plan Service  
**Service Name:** Speech Therapy

**Provider Category:**

Agency ▼

**Provider Type:**

Certified provider agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

As certified by DBHDID

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDID

**Frequency of Verification:**

Annually or more frequently if necessary

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type:** Extended State Plan Service

**Service Name:** Speech Therapy

**Provider Category:**

Agency 

**Provider Type:**

Home Health

**Provider Qualifications**

**License (specify):**

902 KAR 20:081

**Certificate (specify):**



**Other Standard (specify):**



**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Office of Inspector General

**Frequency of Verification:**

Annually or more frequently if necessary

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type:** Extended State Plan Service

**Service Name:** Speech Therapy

**Provider Category:**

Agency 

**Provider Type:**

Adult Day Health Care

**Provider Qualifications**

**License (specify):**

902 KAR 20:066

**Certificate (specify):**



**Other Standard (specify):**



**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Office of Inspector General

**Frequency of Verification:**

Annually or more frequently if necessary

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Supports for Participant Direction 

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

**Support for Participant Direction:**Other Supports for Participant Direction **Alternate Service Title (if any):**

Community Day Supports

**HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

**Service Definition (Scope):**

1. Be provided to facilitate independence and promote integration into the community for a participant residing in his or her own home or in his or her family's home;
2. Be supports and assistance that shall be related to chosen outcomes, not be diversional in nature, and may include:
  - a. Routine household tasks and maintenance;
  - b. Activities of daily living;
  - c. Personal hygiene;
  - d. Shopping;
  - e. Money management;
  - f. Medication management;
  - g. Socialization;
  - h. Relationship building;
  - i. Leisure choices;
  - j. Participation in community activities;
  - k. Therapeutic goals; or
1. Nonmedical care not requiring nurse or physician intervention;
3. Not replace other work or day activities;
4. Be provided on a one-on-one basis;
5. Not be provided at an adult day training or children's day habilitation site;

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Limited to 160 units per week in combination with other services, excluding Case Management and Respite.

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E**
- Provider managed**

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person**
- Relative**

Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	qualified communitiy day support employee

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type: Supports for Participant Direction**  
**Service Name: Community Day Supports**

**Provider Category:**

Individual

**Provider Type:**

qualified communitiy day support employee

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Meets all DMS regulatory requirements

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Support Broker

**Frequency of Verification:**

Annually or more frequently if necessary

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

**Support for Participant Direction:**

Financial Management Services

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

**Category 1:**

12 Services Supporting Self-Direction

**Sub-Category 1:**

12010 financial management services in support of self-directi

**Category 2:**

**Sub-Category 2:**

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

Financial management includes

1. Managing, directing, or dispersing a participant’s funds identified in the participant’s approved PDS budget;
2. Include payroll processing associated with the individuals hired by a participant or participant’s representative;
3. Include withholding local, state, and federal taxes and making payments to appropriate tax authorities on behalf of a participant;
4. Be performed by an entity:
  - a. Enrolled as a Medicaid provider in accordance with 907 KAR 1:672; and
  - b. With at least two (2) years of experience working with individuals possessing the same or similar level of care needs as those referenced in Section 5 of this administrative regulation;
5. Include preparing fiscal accounting and expenditure reports for:
  - a. A participant or participant’s representative; and
  - b. The department.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Fiscal Management is defined as a fifteen (15) minute unit and limited to eight (8) units per member per calendar month. Financial management services are limited to members who opt to participant direct some or all of their non-medical services and apply only to participant directed services.

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E
- Provider managed

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Area Developmental District
Agency	Community Mental Health Centers (CMHC)

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type: Supports for Participant Direction**

**Service Name: Financial Management Services**

**Provider Category:**

Agency

**Provider Type:**

Area Developmental District

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Both federal and state statutory authority, independent board of directors

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Department for Aging and Independent Living

**Frequency of Verification:**

Initially and annually thereafter

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type: Supports for Participant Direction**

**Service Name: Financial Management Services**

**Provider Category:**

**Provider Type:**

Community Mental Health Centers (CMHC)

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

KY statue and regulation 907 KAR Chapter 2

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Dept. for Behavioral Health, Developmental and Intellectual Disabilities

**Frequency of Verification:**

Initially and annually thereafter.

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

**Support for Participant Direction:**

**Alternate Service Title (if any):**

Goods and Services

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

Goods and Services are services, equipment or supplies that are individualized to the person or their representative who chooses to Self Direct their services. Goods and services may be utilized to reduce the need for personal care or to enhance independence within the home or community of the person. These services address an identified need in the Person Centered Service Plan/Support Spending Plan (including improving and maintaining the participant’s opportunities for full membership in the community) and meet the following requirements: the item or service would decrease the need for other Medicaid services; AND/OR promote inclusion in the community; AND/OR increase the participant’s safety in the home environment; AND, the participant does not have the funds to purchase the item or service or the item or service is not available through another source.

Individual Directed Goods and Services are purchased from the participant-directed budget and must be prior authorized. Experimental or prohibited treatments are excluded.

The specific goods and services provided must be clearly linked to a participant need that has been identified through a specialized assessment, established in the Support Spending Plan and documented in the participant’s POC. Goods and services purchased under this coverage may not circumvent other restrictions on waiver services, including the prohibition against claiming for the costs of room and board.

The participant or representative must submit a request to the Case Manager for the goods or service to be purchased that will include the supplier/vendor name and identifying information and the cost of the service/goods. A paid invoice or receipts that provide clear evidence of the purchase must be on file in the participant’s records to support all goods and services purchased. Authorization for these services requires Case Manager documentation that specifies how the Goods and Services meet the above-specified criteria for these services.

An individual serving as the representative of a waiver participant for whom the goods and service are being purchased is not eligible to be a provider of Individual Directed Goods and Services. The Financial Manager, a Medicaid enrolled provider, makes direct payments to the specified vendor.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Individuals shall not receive goods and services through both traditional and participant directed services option.

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E
- Provider managed

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Agency/store
Agency	Home Health Agency
Agency	Adult Day Health Care Center

**Appendix C: Participant Services**

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### C-1/C-3: Provider Specifications for Service

---

**Service Type: Supports for Participant Direction**  
**Service Name: Goods and Services**

---

**Provider Category:**

Individual ▾

**Provider Type:**

Agency/store

**Provider Qualifications****License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

907 KAR 1:835

Have an applicable business license for goods or services provided.

Understands and agrees to comply with the self-directed services and goods delivery requirements.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Support Broker

**Frequency of Verification:**

Prior to service delivery and based on participant purchase.

### Appendix C: Participant Services

#### C-1/C-3: Provider Specifications for Service

---

**Service Type: Supports for Participant Direction**  
**Service Name: Goods and Services**

---

**Provider Category:**

Agency ▾

**Provider Type:**

Home Health Agency

**Provider Qualifications****License (specify):**

OIG per 902 KAR 20:081 which provides licensure requirements for the operation of and services provided by home health agencies.

**Certificate (specify):**

**Other Standard (specify):**

As specified in 907 KAR 1:160 which establishes the provisions for home and community based waiver services, including a participant directed service option pursuant to KRS 205.5606.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Office of the Inspector General

**Frequency of Verification:**

Annually or more frequently as necessary.

### Appendix C: Participant Services

#### C-1/C-3: Provider Specifications for Service

---

**Service Type: Supports for Participant Direction**  
**Service Name: Goods and Services**

---

**Provider Category:**

Agency ▾

**Provider Type:**

Adult Day Health Care Center

**Provider Qualifications**

**License (specify):**

Office of the Inspector General as regulated by 902 KAR 20:066: Operations and services: adult day health care programs.

**Certificate (specify):**

**Other Standard (specify):**

As specified in 907 KAR 1:160 which establishes the provisions for home and community based waiver services, including a participant directed services option pursuant to KRS 205.5606.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Office of the Inspector General

**Frequency of Verification:**

Annually or more often as necessary

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

**Support for Participant Direction:**

**Alternate Service Title (if any):**

Home and Community Services

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

A home and community support service, which shall:

1. Be available only as participant-directed services;

- 2. Be provided in the participant’s home or in the community;
  - 3. Be based upon therapeutic goals and not be diversional in nature;
  - 4. Not be provided to an individual if the same or similar service is being provided to the individual via non-PDS Michelle
- P. waiver services; and
- 5. Include:
    - a. Assistance, support, or training in activities including meal preparation, laundry, or routine household care or maintenance;
    - b. Activities of daily living including bathing, eating, dressing, personal hygiene, shopping, or the use of money;
    - c. Reminding, observing, or monitoring of medications;
    - d. Nonmedical care that does not require a nurse or physician intervention;
    - e. Respite; or
    - f. Socialization, relationship building, leisure choice, or participation in generic community activities;

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Limited to 160 units per week in combination with other services, excluding Case Management and Respite.

**Service Delivery Method** *(check each that applies):*

- Participant-directed as specified in Appendix E**
- Provider managed**

**Specify whether the service may be provided by** *(check each that applies):*

- Legally Responsible Person**
- Relative**
- Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type: Supports for Participant Direction**  
**Service Name: Home and Community Services**

**Provider Category:**

Individual ▾

**Provider Type:**

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*

Qualified home and community services employee

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Support Broker

**Frequency of Verification:**

Annually or more frequently if necessary

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Supports for Participant Direction ▼

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

**Support for Participant Direction:**

Information and Assistance in Support of Participant Direction ▼

**Alternate Service Title (if any):**

Support Broker

**HCBS Taxonomy:**

**Category 1:**

▼

**Sub-Category 1:**

▼

**Category 2:**

▼

**Sub-Category 2:**

▼

**Category 3:**

▼

**Sub-Category 3:**

▼

**Category 4:**

▼

**Sub-Category 4:**

▼

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

**Service Definition (Scope):**

Support Brokerage is required for all members choosing to access participant directed opportunities or choose to receive a blend of services under the traditional and participant directed option. Functions of support brokerage include providing information regarding alternatives to make informed choice; care planning which includes assisting with the development and revision of the Plan of Care (POC) utilizing the person centered planning process and guiding principles; monitoring the member's POC and satisfaction with and quality of service provision; assisting with locating services and negotiating rates; offer assistance to the participant regarding hiring, training, scheduling and terminating employees; development of and monitoring of the participant's emergency back up plan which may include arranging for the provision of emergency services if necessary; establish participant's request for benefit total based on need, utilization and existing service limitations; conduct quarterly reviews of participant's spending; and completing all necessary paperwork. Additionally, activities such as providing technical assistance regarding managing the member's budget, spending and records management to participants and employees shall be included under this service. Support Brokerage shall be available twenty-four (24) hours per day, seven (7) days per week.

The Support Broker shall perform all the above and all case management activities for individuals receiving a blended package of services through traditional waiver service providers and participant directed opportunities. The support brokerage entity is responsible for interfacing with providers under the traditional service delivery model to ensure a smooth transition if a member elects to participant direct services or if the member is receiving services under both service delivery models. The support brokerage entity must work closely with the financial management services entity to ensure payment for service provision is within the scope of the member's Plan of Care (POC) and prior authorization limits. The support brokerage entity shall be independent of other service provision.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Monthly

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E**
- Provider managed**

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person  
 Relative  
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Area Agencies on Aging and Independent Living
Agency	Community Mental Health Centers

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction

Service Name: Support Broker

Provider Category:

Agency ▼

Provider Type:

Area Agencies on Aging and Independent Living

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Area Agencies on Aging and Independent Living are defined in 910 KAR 1:220:

Section 1. Definitions. (1) "Area development district" means one (1) of the fifteen (15) regional planning and development agencies with which the Office of Aging Services contracts for the local delivery of aging services.

(2) "Area agency on aging" means that local agency designated under the provisions of Title III of the Older Americans Act to administer funds received under that title for a given planning and service area.

AAAIL as defined in Section 1321.33 of the Older American's Act which refers to the designation of area agencies

Specified in 907 KAR 1:160 which establishes the provisions for home and community based waiver services, including a consumer directed services option pursuant to KRS 205.5606 and annual training requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

DAIL

Frequency of Verification:

Annually

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction

Service Name: Support Broker

Provider Category:

Agency ▼

Provider Type:

Community Mental Health Centers

Provider Qualifications

License (specify):

**Certificate** *(specify):*

**Other Standard** *(specify):*

KY statute and regulation 907 KAR Chapter 2

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDID

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Attendant Care

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition** *(Scope):*

Hands-on care provided by direct care staff to a participant who is medically stable but functionally dependent and requires care or supervision 24 hours per day and has a family member or other primary caretaker who is employed and not able to provide care during working hours. Care is not of a general housekeeping nature and is not provided to a participant who is receiving any of the following MPW services, Personal Care, Homemaker, ADHC, ADT, CLS, or Supported Employment.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Limited to 160 units per week in combination with other services, excluding Case Management and Respite.

**Service Delivery Method** *(check each that applies):*

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified waiver provider
Agency	Home Health Agency
Agency	Adult Day Health Care Center

### Appendix C: Participant Services

#### C-1/C-3: Provider Specifications for Service

Service Type: Other Service  
 Service Name: Attendant Care

Provider Category:

Agency

Provider Type:

Certified waiver provider

Provider Qualifications

License (specify):

Certificate (specify):

Meets all applicable DMS regulatory requirements

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Dept. for Behavioral Health, Developmental and Intellectual Disabilities

Frequency of Verification:

Annually or more frequently if necessary

### Appendix C: Participant Services

#### C-1/C-3: Provider Specifications for Service

Service Type: Other Service  
 Service Name: Attendant Care

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License (specify):

Office of Inspector General per 902 KAR 20:081 which provides licensure requirements for the operation of and services provided by home health agencies.

Certificate (specify):

Other Standard (specify):

As specified in 907 KAR 1:160 which establishes the provisions for home and community based waiver services including participant directed services otion pursuant to KRS 205.5606.All standards identified in program regulations. Must meet all personnel and training requirements

**Verification of Provider Qualifications****Entity Responsible for Verification:**

OIG

**Frequency of Verification:**

Annually or more frequently if necessary

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Attendant Care****Provider Category:**Agency **Provider Type:**

Adult Day Health Care Center

**Provider Qualifications****License (specify):**

Office of the Inspector General as regulated by 902 KAR 20:066: Operation and services; adult day health care programs.

**Certificate (specify):****Other Standard (specify):**

Meets all applicable standards for a waiver provider agency.

Employs staff with the following qualifications:

- 1) Is at least 18 years of age or older;
- 2) Has a high school diploma or GED;
- 3) Has a valid Social Security number or a valid work permit if not a citizen of the U.S.;
- 4) Has the ability to communicate effectively with the person/family;
- 5) Has the ability to understand and carry out instructions; and
- 6) Has the ability to perform required documentation
- 7) Has completed initial DAILE approved Attendant Care Health Certification Training and maintained Annual Certification.

Supervisor must have two years experience in supporting elderly or disabled individuals.

Must have 24/7 access to a registered nurse for consultation.

As specified in 907 KAR 1:160 which establishes the provisions for home and community based waiver services, including a consumer directed services option pursuant to KRS 205.5606.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

OIG

**Frequency of Verification:**

At least annually and more frequently if necessary

**Appendix C: Participant Services****C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**Other Service 

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Behavioral Supports

**HCBS Taxonomy:**

**Category 1:**

10 Other Mental Health and Behavioral Services ▼

**Sub-Category 1:**

10090 other mental health and behavioral services ▼

**Category 2:**

▼

**Sub-Category 2:**

▼

**Category 3:**

▼

**Sub-Category 3:**

▼

**Category 4:**

▼

**Sub-Category 4:**

▼

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

Positive Behavior Supports is comprised of behavior supports, consultative clinical and therapeutic services and person centered coaching. These services are combined to be provided through Positive Behavior Supports (PBS) for the individual with significant, intensive challenges which interfere with activities of daily living, social interaction, work or volunteer situations.

These services are derived from the utilization of data collected during the functional assessment of behavior. The functional assessment is the basis for the development of the positive behavior support plan. The goal of the plan is the acquisition or maintenance of skills for community living and behavioral intervention for the reduction of maladaptive behaviors.

The plan is intended to be implemented across service settings and by individuals assisting the person in meeting his or her dreams or goals. Intervention modalities described in the plan must relate to the identified behavioral needs of the individual, and specific criteria for remediation of the behavior must be established and specified in the plan. The need for the plan shall be evaluated and revisions made as needed and at least annually. It is expected that the need for this service will be reduced over time as an individuals skills develop. Prior authorization is required for PBS services.

These services are provided by professionals with at least a Master's Degree in behavioral science and one (1) year of experience in behavioral programming, in addition to two (2) years of direct experience with individuals with intellectual or developmental disabilities. These services may not supplant educational services available under the IDEA (20 U.S.C. 1401 et seq.)

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Limit of 160 units per week in combination with other services, excluding Case Management and Respite.

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E
- Provider managed

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Licensed or Certified Medicaid Provider

**Appendix C: Participant Services**

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### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**  
**Service Name: Behavioral Supports**

**Provider Category:**

Agency ▼

**Provider Type:**

Licensed or Certified Medicaid Provider

**Provider Qualifications**

**License (specify):**

902 KAR 20:066

**Certificate (specify):**

**Other Standard (specify):**

All standards identified in program regulations and services manual. Services are provided by professionals with at least a Master's Degree in behavioral science and one (1) year of experience in behavioral programming AND two (2) years of direct services experience with individuals with intellectual or developmental disabilities.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Office of Inspector General

**Frequency of Verification:**

Initially and annually thereafter

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service ▼

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Environmental and Minor Home Adaptations

**HCBS Taxonomy:**

**Category 1:**

14 Equipment, Technology, and Modifications ▼

**Sub-Category 1:**

14020 home and/or vehicle accessibility adaptations ▼

**Category 2:**

▼

**Sub-Category 2:**

▼

**Category 3:**

▼

**Sub-Category 3:**

▼

**Category 4:**

▼

**Sub-Category 4:**

▼

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.

- Service is not included in the approved waiver.

**Service Definition (Scope):**

Environmental and Minor Home Adaptation services consist of adaptations which are designed to enable individuals to interact more independently with their environment, thus enhancing their quality of life and reducing their dependence on physical support from others. Environmental and Minor Home Services consist of physical adaptations to the waiver participant's or family's home which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and without which, the waiver participant would require institutionalization.

Such adaptations consist of the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver participant, but exclude those adaptations or improvements to the home which are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, central air conditioning, etc.

Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). All services shall be provided in accordance with applicable state and local building codes.

Environmental Accessibility Adaptation services will not be approved for homes that are provider owned.

Environmental Accessibility Adaptation services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Person Centered Service Plan (PCSP) development and with any revisions. Environmental Accessibility Adaptation services are not available in the participant directed services option.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

limit up to \$500.00 per level of care year

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E
- Provider managed

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Licensed or Certified Medicaid Provider

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type: Other Service**

**Service Name: Environmental and Minor Home Adaptations**

**Provider Category:**

Agency

**Provider Type:**

Licensed or Certified Medicaid Provider

**Provider Qualifications**

**License (specify):**

902 KAR 20:066

**Certificate (specify):**

**Other Standard (specify):**

Insured and licensed in state of KY

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

OIG or DMS

**Frequency of Verification:**

Initially and annually thereafter

## Appendix C: Participant Services

### C-1: Summary of Services Covered (2 of 2)

**b. Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

**Not applicable** - Case management is not furnished as a distinct activity to waiver participants.

**Applicable** - Case management is furnished as a distinct activity to waiver participants.

*Check each that applies:*

**As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*

**As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

**As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*

**As an administrative activity.** *Complete item C-1-c.*

**c. Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

## Appendix C: Participant Services

### C-2: General Service Specifications (1 of 3)

**a. Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (*select one*):

**No. Criminal history and/or background investigations are not required.**

**Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

All employees of enrolled waiver providers and employees of participants enrolled in Participant Directed Services (PDS) are required to submit to a state criminal background check. DMS or DBHDID conduct initial certification and at least every two years thereafter of all waiver providers. During the provider certification, employee records are reviewed to verify compliance with the criminal history check requirement. Licensed providers are inspected annually by the Office of Inspector General (OIG) and employee records are reviewed to ensure compliance.

**b. Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (*select one*):

**No. The State does not conduct abuse registry screening.**

**Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

All employees of the waiver providers and employees of participants directing non-medical waiver services are required to submit to screening through state registries which are the Child Abuse and Neglect (CAN) registry, the Caregiver Misconduct registry maintained by the Department for Community Based Services (DCBS), and the Nurse Aide Registry maintained by the Kentucky Board of Nursing (KBN).

DMS and DHDID conduct initial certifications and recertifications of all waiver providers, conducting audits every other year. During the recertification, employee records are reviewed to ensure that mandatory registry screenings have been completed.

Licensed providers are inspected annually by the Office of Inspector General and employee records are reviewed to ensure compliance.

## Appendix C: Participant Services

### C-2: General Service Specifications (2 of 3)

**c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:***

- No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

## Appendix C: Participant Services

### C-2: General Service Specifications (3 of 3)

**d. Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

- No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

Payment for the Participant Directed Services (PDS) may be issued to legally responsible individuals for providing a service similar to personal care. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological, adoptive, foster or step) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant.

This service is available only through participant directed opportunities and only in specified extraordinary circumstances. In order for a legally responsible individual to provide paid services the services must be extraordinary, exceeding the range of activities that a legally responsible individual would ordinarily provide in the household on behalf of a person without a disability of the same age, and which are necessary to assure health and welfare of the person and avoid institutionalization. A legally responsible individual may not be approved to provide more than forty (40) hours per week of paid services.

This service is available only through Participant Directed Services and only in specified extraordinary circumstances. The participant chooses a legally responsible individual to provide this service. The participant's choice is documented in the client file and retained by the Case Manager.

Documentation of services provided shall be submitted to the support broker. The participant/representative shall sign the employee's timesheet, verifying the accuracy of the time reported. The support broker is responsible for monitoring service provision

**e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

- The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

The participant or the representative as the employer is responsible for monitoring services and signing appropriate timesheets. The services and timesheets are also monitored by the support broker. Once the support broker has reviewed the timesheet for filling it out appropriately it is then sent to the fiscal manager for payment.

- Other policy.**

Specify:

- f. Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Provider enrollment is continuous and open to any willing and qualified individual or entity. A potential provider may make application by contacting Provider Enrollment through a toll-free phone number on the Department for Medicaid Services (DMS) website, completing the application process and obtaining an agency license or certification. These provider enrollment forms, along with new provider information are also accessible through Internet web access.

The Division of Developmental and Intellectual Disabilities (DBHDID) also has information for providers on their website and provides orientation training for new waiver providers six times a year, and potential providers are required to attend this training. Once the orientation process is complete, provider enrollment information is forwarded to the state Medicaid agency, provider enrollment branch, to complete the process of enrollment as a State Medicaid provider.

The Division of Developmental and Intellectual Disabilities of DBHDID provides orientation training for new waiver providers six times a year, and potential providers are required to attend this training. Once the orientation process is complete, provider enrollment information is forwarded to the state Medicaid agency, provider enrollment branch, to complete the process of enrollment as a State Medicaid provider.

## Appendix C: Participant Services

### Quality Improvement: Qualified Providers

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

#### a. Methods for Discovery: Qualified Providers

*The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.*

##### i. Sub-Assurances:

- a. Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.**

##### Performance Measures

*For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

##### Performance Measure:

**--Percent of waiver providers with corrective action plans completed within the required time frame. N = Number of providers reviewed, with documented corrective action plans submitted within the required time frame. D = Number of waiver providers reviewed.**

**Data Source (Select one):**  
**Operating agency performance monitoring**  
 If 'Other' is selected, specify:

Responsible Party for data collection/generation( <i>check each that applies</i> ):	Frequency of data collection/generation( <i>check each that applies</i> ):	Sampling Approach( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: QIO, MWMA	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: QIO, MWMA	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

--Percent of providers who meet regulatory certification requirements prior to provision of waiver services. N= Number of providers who met regulatory requirements at certification review. D= Number of ongoing waiver providers.

**Data Source (Select one):**  
**Provider performance monitoring**  
 If 'Other' is selected, specify:

Responsible Party for data collection/generation( <i>check each that applies</i> ):	Frequency of data collection/generation( <i>check each that applies</i> ):	Sampling Approach( <i>check each that applies</i> ):

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: QIO,OIG, MWMA	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: OIG, OIG, MWMA	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

Percent of providers whose approved corrective action plans which have been implemented successfully. N = Number of providers with approved CAP which are implemented successfully . D = Number of providers with approved CAP.

**Data Source (Select one):**

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample

		Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> <b>Other</b> Specify: OIG, QIO, MWMA	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify: OIG, QIO, MWMA	<input checked="" type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

Percent of providers with no repeat citations at recertification time. N = Number of providers with no repeat citations. D = Total number of providers.

**Data Source (Select one):**

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

OIG

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> <b>Other</b>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b>

Specify: OIG, QIO, MWMA		Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify: OIG, QIO, MWMA	<input checked="" type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

Percent of OIG licensed providers that meet OIG licensing requirements at certification review (KRS 216.520). N = Number of providers meeting OIG licensure requirement during certification review. D = Total number of providers reviewed for certification.

**Data Source (Select one):**

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> <b>Other</b> Specify: OIG, QIO, MWMA	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify:

	<input type="checkbox"/> <b>Other</b> Specify:	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify: OIG, QIO, MWMA	<input checked="" type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify:

**Performance Measure:**

Percentage of providers that obtained background investigations on all new employees prior to rendering services. N = Number of providers that obtained background investigations on new employees prior to rendering services. D = Total number of providers with new employees.

**Data Source (Select one):**

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval =
<input checked="" type="checkbox"/> <b>Other</b> Specify: OIG, QIO	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify:
	<input type="checkbox"/> <b>Other</b> Specify:	

	<input type="text"/>
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**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: OIG, QIO	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

Percentage of provider agencies who completed required mandatory training prior to enrollment. N = Number of provider agencies that have completed all required training prior to enrollment. D = Number of all provider agencies.

**Data Source (Select one):**

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

**Each operating agency gathers and reports.**

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: OIG	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Source (Select one):**