

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

The Home and Community Based Services Waiver was amended less than a year ago to include the following changes.

- 1) Increase the provider base to ensure choice and access to services throughout the Commonwealth,
- 2) Add additional services including home delivered meals and nursing supports,
- 3) Provide institutional diversion by implementing an independent assessment process,
- 4) Improve quality measures by implementing conflict free case management,
- 5) Expand home modifications and adult day health care services,
- 6) Modify consumer directed options to clarify natural supports, define employee and employer responsibilities,
- 7) Delete support broker services and replace with case manager services,
- 8) Streamline the service array; and
- 9) Amend rates to align this waiver with other 1915c waivers in Kentucky.

We are using the HCBS waiver renewal as an opportunity to fine tune the changes made in the amendment as well as make needed changes to comply with the final rule.

ASSESSMENT:

Based on the intent of the final rule, Kentucky has opted to completely separate service provision, including case management, from the assessment and plan of care process. The Department for Aging and Independent Living (DAIL) will now function as the independent assessment agency conducting all assessments and reassessments and developing or amending the service plan. DAIL will incorporate person centered planning principles in developing plans of care. It is the expectation that the participant, friends and family and providers will all participate in a plan of care meeting to develop the plan. DAIL will hire RNs and MSWs to conduct the assessments and hold the plan of care meetings. In addition, Kentucky is revising the assessment tool used to determine level of care for the waiver. Kentucky has adapted the Wisconsin tool, a validated instrument, to use not only in the waiver but also for all DAIL programs including state funding aging and disability programs and Older Americans Act programs. The tool has been named the Kentucky Home Assessment Tool or K-HAT.

CASE MANAGEMENT:

In the renewal, Kentucky clearly defines conflict free case management to meet regulatory requirements and identifies expected standards and functions each case manager is expected to meet.

SERVICES:

As noted above, Kentucky added nursing supports to the waiver during the previous amendment. Since that time Kentucky Medicaid has increased the availability of private duty nursing in the state plan which diminished the need for nursing supports in the waiver. In addition,

Kentucky will eliminate therapies (OT, PT and Speech) from the waiver as these services are also readily available under the state plan.

Kentucky is adding the personal emergency response system (lifeline) as a service available under Environmental and Minor Home Adaptation Services. Advocates have encouraged the addition of this service over the past few years but funding was not available. Funding from the elimination of nursing supports allowed the addition of this new service.

Goods and Services as a service will now be allowed as both a participant directed service and traditional service.

Finally, Kentucky is redefining participant directed services by further empowering the participant to act as the employer. Kentucky will blend two PDS services into one service called Participant Directed Coordination (PDC). This service combines the duties and functions of a service advisor and fiscal manager into one service that provides program information and guidance, service advice and fiscal management.

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

1. Request Information (1 of 3)

- 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):*
Home and Community Based 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.0144

Waiver Number: KY.0144.R06.00

Draft ID: KY.001.06.00

- D. **Type of Waiver** *(select only one):*

Regular Waiver

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

07/01/15

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 purpose of the HCBS waiver is to prevent institutionalization of aged or disabled individuals by offering effective, individualized services that ensure the health, safety and welfare of participants so they may remain in their own home and community.

Goals

Waiver recipients

- 1) Are safe and healthy while living in the community;
- 2) Receive effective and individualized assistance; and
- 3) Have easy access and choice to waiver services.

Objectives

- 1) Identify individualized needs by implementing an independent assessment process leading to a comprehensive plan of care,
- 2) Ensure home and community based services are comprehensive alternatives to institutional services,
- 3) Improve information, access, and utilization of community based services,
- 4) Enhance provider competency and continuity of care by enhancing certification and training requirements, and;
- 5) Clarify rights and responsibilities of employers and employees in participant directed services.

Organizational Structure

The Department for Aging and Independent Living will serve as the operating entity and independent assessor agency for the waiver through a contract with the Department for Medicaid Services (DMS). DMS exercises administrative discretion in the operation of the waiver and in setting policies, rules and regulations related to the waiver.

Service Delivery Methods

The HCBS waiver offers statewide availability of traditional services and the ability to self-direct non-medical services. Participants can choose either all traditional, all participant-directed, 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

- 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. Statewide.** Indicate whether the State requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):
- No
- Yes

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

- Geographic Limitation.** A waiver of statewide 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:

- Limited Implementation of Participant-Direction.** A waiver of statewide 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:

5. Assurances

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:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. 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,
 3. 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:
1. 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

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 Kentucky HCBS waiver was significantly amended less than one year ago. Since that time providers and advocates have discussed additional changes that should be added to the waiver. As changes have been considered, DAIL staff have utilized a group comprised of self-advocates, families/guardians, advocates, providers, and state university representatives to provide feedback. DAIL staff has also worked with the Area Development Districts, Area Agencies on Aging and Independent Living, Home Health, Adult Day and other providers to consider requested changes and updates. DAIL has utilized conferences and training events to discuss recommendations and receive feedback from various entities.
- Changes that were cost neutral, efficient and effective have been considered and included where appropriate.
- Prior to submission the final draft was provided for public comment and presented to the numerous provider and consumer agencies for feedback. Additional changes were made based on their comments.
- 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)

A. The Medicaid 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:

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:

(502) 564-6930 Ext: 3544 TTY

Fax:

(502) 564-4595

E-mail:

deborah.anderson2@ky.gov

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:

Lee

First Name:

Lisa

Title:

Commissioner

Agency:

Department for Medicaid Services

Address:

275 East Main Street

Address 2:

City:

Frankfort

State:

Kentucky

Zip:

40602

Phone:

(502) 564-4321 Ext: TTY

Fax:

(502) 564-0249

E-mail:

Attachments

Lisa.Lee@ky.gov

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:

All services currently listed in the waiver with the exception of nursing supports, occupational therapy, speech and physical therapy will be available in the renewed waiver. Kentucky Medicaid has increased the number of hours private duty nursing will be available in the state plan which diminished the need for nursing supports in the waiver. In addition, Kentucky will eliminate therapies (OT, PT and Speech) from the waiver as these services are also readily available under the state plan. Waiver participants who need nursing or therapy will be able to access those services through the state plan. Current participants will begin the transition to the amended waiver by July 1, 2015. Providers will be trained regarding the change by May of 2015. Assessors will assist the participants in accessing the needed services through the state plan. No waiver participant will lose services due to this renewal.

Goods and Services has been expanded to include traditional providers and now includes maximum expenditure limits. An exception process is included if needed.

The maximum yearly limit on Environmental and Minor Home Adaptations increased from \$500 to \$2,500 and includes personal emergency response systems as an allowable service.

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.

Kentucky 1915 (c) HCB Waiver Transition Plan

I. Background

On March 17, 2014, updated Home and Community Based Services (HCBS) final rules became effective in the Federal Register for 1915 (c) waivers, 1915(i) state plan services, and 1915(k) community first choice state plan option. As they pertain to 1915(c) waivers, these rules include requirements for several areas of HCBS: all residential and non-residential settings, provider-owned residential settings, person-centered planning process, service plan requirements, and conflict-free case management. The goal of the HCBS final rules is to improve the services rendered to HCBS participants and to maximize the opportunities to receive services in integrated settings and realize the benefits of community living. The Centers for Medicare & Medicaid Services (CMS) is allowing five years (until March 17, 2019) for states and providers to transition into compliance with the all settings and provider-owned settings requirements.

As part of the five year transition period, states must submit transition plans to CMS that document their plan for compliance. The first of these transition plans is a waiver-specific transition plan and is required when a state submits a waiver renewal or amendment. The other required transition plan is a statewide transition plan to bring all 1915(c) waivers into compliance, and is due 120 days after the submission of the first transition plan. The statewide transition plan describes the process to bring all 1915(c) waivers for a state into compliance with the HCBS all settings and provider-owned settings requirements.

II. Introduction

The Commonwealth of Kentucky (KY) Department for Medicaid Services (DMS) operates the Home and Community-Based (HCB)

waiver under the 1915(c) benefit. HCB is a non-residential waiver and includes the option for Participant Directed Services (PDS). HCB participants are individuals who are elderly or disabled and meet nursing facility level of care, but are able to remain in or return to their homes (907 KAR 1:160).

A. Purpose

The purpose of this HCB waiver transition plan is to outline the assessments that DMS has completed, and planned remedial actions to bring this waiver into compliance with the HCB setting final rules. DMS submitted the transition plan specific to the MPW on August 28, 2014 to CMS, which started the 120 day clock to submit the Statewide Transition Plan. The Statewide Transition Plan serves as a guide for transitioning all HCBS waivers into compliance with the all settings and provider-owned settings rules, while this transition plan focuses on the HCB waiver. The goal of the implementation of these requirements is to facilitate the integration and access of waiver participants into the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree as individuals not receiving Medicaid HCBS.

Another objective of this document is to give stakeholders an opportunity to provide input on KY's process to comply with the HCBS final rules. Stakeholders include waiver participants, legal guardians, families, parents, siblings, wives, husbands, advocacy groups, friends, and providers. Throughout this process, one of DMS' goals is to actively engage stakeholders in the implementation of the final rules. For the purposes of this document, if a participant has a legal guardian, the legal guardian is included in all references of the participant.

B. Overview

This Statewide Transition Plan contains the process that DMS is using to evaluate and revise the Kentucky 1915(c) waivers. The first section describes the assessments that were conducted to determine the compliance of each waiver with HCBS final rules at the state level. The assessments focused on two components: policy (regulation and waiver application) and monitoring processes. The second section is the provider assessment, which includes residential and non-residential settings, and the results of provider surveys. After the assessment section, the remedial strategy section is outlined, with a focus on state and provider remedial actions. The state remedial strategy includes four sub-sections: 1) policy, 2) operations, 3) participants, and 4) technology. The provider-level remedial strategy includes the process for settings presumed not to be HCBS as well as suggested sample remedial actions. The fourth and final section of this transition plan includes the process for public comment.

III. Assessment Process – Systemic Review

A. Regulation and Waiver Application Assessment

To evaluate the compliance of the KY HCB waiver with the HCBS final rules, DMS established a regimented process led by a workgroup of staff from three departments representing each waiver from across the Cabinet for Health and Family Services (CHFS). The review included a detailed analysis of the waiver regulation, including manuals incorporated by reference, the application approved by CMS, and related state regulations, such as provider and enrollment regulations, against each requirement of the federal HCBS rule.

The workgroup categorized and color-coded state regulations and applications into three groups: 1) state policy and requirements meet the final rules (green), 2) state policy and requirements have similar language to the final rules, but need to be strengthened (yellow), and 3) state policy and requirements do not specifically address all provisions of final rules, so language needs to be added (red). For group one, no action is required. For group two, language and requirements in state policy have similar language to the final rules, but need to be strengthened. While some operational practices comply with the federal standards, state policies do not fully meet the final rules, and therefore, DMS needs to implement policy changes. For group three, current state policy does not specifically address all provisions of final rules, so language needs to be added. While some operational practices have similar intent to the federal standards, they do not fully meet the final rules and therefore, DMS needs to add additional requirements to policies.

Below is the summary analysis of the HCB waiver operating in KY as it relates to the HCBS final rules. DMS will need to update waiver policies (regulations), operational areas, and monitoring practices to comply with the final rules. Below are only the applicable HCBS final rules or applicable parts of the HCBS final rules. All HCBS final rules that were edited for the purposes of this document are indicated with an*.

HCBS Waiver – Non-residential

Not compliant; minor changes required. State policy and requirements have similar language to the final rules, but need to be strengthened.

- The setting is selected by the individual from among setting options including non-disability specific settings. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, and preferences.*

- Facilitates individual choice regarding services and supports, and who provides them.

Not compliant with the following rules. Federal language and requirements do not currently exist in state policy and requirements and need to be added.

- The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

- Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

- Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

- Home and community-based settings do not include the following: (v) Any other locations that have qualities of an institutional setting, as

determined by the Secretary. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution unless the Secretary determines through heightened scrutiny, based on information presented by the State or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings.*

B. Monitoring Process Assessment

DMS has set monitoring requirements for each of the HCBS waiver providers operating in KY and these monitoring processes will continue while providers comply with the HCBS final rules. The workgroup outlined these monitoring processes, including the oversight process and participant and provider surveying process. Each process was then analyzed to determine the impact of the HCBS final rules and areas requiring revision were identified. Some monitoring tools will need to be updated to incorporate the new federal requirements so that state staff evaluates providers appropriately. If necessary, KY will increase the frequency and percentage of providers selected for review to confirm that state staff effectively track provider compliance. After providers have fully implemented the HCBS final rules, monitoring processes will continue with compliant tools and standards. Below describes the current monitoring/oversight process for each waiver, the participant and/or provider surveys that are conducted, and the areas that will need to be updated to comply with the HCBS final rules. If the department acts regarding a certified waiver provider due to the provider's behavior in one 1915(c) HCBS waiver program, the action regarding the certified waiver provider shall apply in every 1915(c) HCBS waiver program in which the provider is participating. PDS is specifically separated since PDS for all waivers is centrally monitored by state staff through separate waiver monitoring processes.

Current waiver monitoring process:

Current HCB Oversight Process

- Every agency must be licensed as a Home Health agency or Adult Day Health Center
- The DMS contracted Quality Improvement Organization (QIO) agency completes all first line evaluations of HCB providers
- The evaluations are on-site and include quality questions posed to participants (are you treated with respect, are you aware of your case manager, were you given freedom of choice, etc.), agency policies and procedures, billing, and post-payment audits
- Waiver providers are evaluated on a two or three year cycle
- State staff complete second line monitoring for a random sample of the provider evaluations completed by DMS contracted QIO agency
- The citation and sanctions process is outlined in regulation

HCB Participant and Provider Surveys

- Participant interviews are carried out during on-site monitoring

HCB Areas Requiring Revision

- The tools, including checklists used during on-site monitoring, do not include all of the new HCBS rules
- State staff and monitoring QIO agency do not base their evaluations on all of the new HCBS rules
- Monitoring process manuals do not include all of the new HCBS rules
- Participant surveys need to be developed focusing on compliance with the HCBS final rules with mechanisms in place to eliminate provider influence

Current PDS Oversight Process

- Every agency is evaluated annually
- The monitoring process includes reviewing participant records, incident reports, and complaints
- Home visits or phone interviews with waiver participants are completed
- The citation and sanctions process is outlined in regulation

PDS Participant and Provider Surveys

- Participant satisfaction surveys are distributed by the provider prior to monitoring and are reviewed by state staff during the monitoring process

PDS Areas Requiring Revision

- The tools, including checklists used during on-site monitoring, do not include all of the new HCBS rules
- State staff do not base their monitoring on all of the new HCBS rules
- Consumer PDS training is not based on the new HCBS rules
- Participant surveys need to be developed focusing on compliance with the HCBS final rules with mechanisms in place to eliminate provider influence

IV. Provider Assessment

To determine the providers' compliance level, the workgroup used a combination of provider surveys and state staff knowledge. Providers "self-assessed" their compliance with the HCBS final rules through surveys, providing examples to demonstrate their compliance. The state staff reviewed the survey results, validated each provider's response, and assigned each provider a level of compliance. In order to validate setting locations, the workgroup mapped the addresses of waiver provider settings and non-HCB settings (ICF/IID, hospitals, institutions for mental disease, and nursing facilities). Locations with high density waiver provider settings and non-HCB settings were analyzed to help determine each provider's compliance level.

Below are the initial categorizations of provider compliance for non-residential providers. This is not intended to be the final analysis of provider compliance with the HCBS final rules, but rather is a starting point to identify areas that providers will need to change to come into compliance. Providers will have ample opportunity to review their compliance level and make modifications where possible to come into compliance. Providers will be notified of their initial compliance level when DMS distributes the compliance plan template, during the

first quarter of calendar year 2015.

A. Non-Residential Settings

In addition to a survey targeted for residential providers, the workgroup created a similar survey for non-residential providers that focused on the HCB setting requirements. The workgroup developed this survey using CMS' toolkits and distributed it to non-residential providers via email and provider letters. The non-residential survey is outlined in Appendix A. The target provider types for this survey were adult day health centers (ADHC), home health agencies, adult day training (ADT), and other non-residential waiver providers, such as case managers, who render services to the waiver population. Approximately 40% of the total non-residential waiver providers in the state completed the survey. The providers who responded to the survey render a variety of services, including ADT, ADHC, home health agencies, case management, behavior supports, and physical/occupational/speech therapy.

For non-residential providers who did not complete this survey, DMS will provide additional opportunities for providers to submit information, which will indicate their compliance level. However, DMS believes that the distribution of non-residential providers who completed the survey closely represents the non-residential provider population as a whole.

After receiving providers' responses, the workgroup analyzed the providers' self-reported compliance level. The QA staff reviewed and validated the survey responses and the workgroup then categorized each non-residential provider into one of four compliance levels, as defined by CMS:

- Fully align with the federal requirements
- Do not comply with the federal requirements and will require modifications
- Cannot meet the federal requirements and require removal from the program and/or the relocation of individuals
- Are presumptively non-HCB but for which the state may provide evidence to show that those settings do not have the characteristics of an institution and do have the qualities of HCB settings (to be evaluated by CMS through the heightened scrutiny process)

The providers in compliance level four were further analyzed and categorized into the following categories:

- Not isolating – These providers probably fall into compliance level two, but additional information is needed to ensure that these settings will not require heightened scrutiny.
- Potentially isolating – These providers will potentially fall into compliance level four, but additional information is needed to determine if these settings will or will not require heightened scrutiny.
- Isolating – The characteristics of these provider settings are not HCB, but rather institution-like, and these providers will require heightened scrutiny.

The results of the non-residential provider survey and validation by state staff are outlined below. Percentages are used instead of counts because there was not 100% participation among non-residential providers. These percentage estimates are based on the number of provider agencies, not the number of actual settings each provider has. If a provider renders both ADT and ADHC, the provider was only counted once.

Non-Residential Providers (ABI, ABI-LTC, SCL, MPW, HCB) Estimates

Category 1: Fully align with the federal requirements

Estimate Number of Providers: 0 (0%)

Main Areas of Non-Compliance:

Category 2: Do not comply with the federal requirements and will require modifications

Estimate Number of Providers: 62%

Main Areas of Non-Compliance:

- The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community
- Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices

Category 3: Cannot meet the federal requirements and require removal from the program and/or the relocation of individuals

Estimate Number of Providers: 0 (0%)

Main Areas of Non-Compliance:

Category 4: Are presumptively non-HCB but for which the state will provide evidence to show that those settings do not have the characteristics of an institution and do have the qualities of HCB settings (to be evaluated by CMS through the heightened scrutiny process)

Estimate Number of Providers - Not Isolating: 5%

Estimate Number of Providers – Potentially Isolating: 18%

Estimate Number of Providers – Isolating: 15%

Main Areas of Non-Compliance:

- Located in a building that is also a facility that provides in-patient institutional treatment
- On the grounds of, or immediately adjacent to an institution
- Setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS
- Operated in an area (e.g., a neighborhood, a street or a neighboring street, etc.) where there is more than one residence in the area that is occupied by individuals receiving HCBS
- Operated in multi-family properties with more than one unit occupied by individuals receiving Medicaid HCBS
- Operated in a remote location (rural, farmstead, etc.)

V. Remedial Strategies

DMS will implement several strategies over the next five years to transition policies and operations into compliance with the HCBS final

rules. The strategies identified in this section are the results of assessments completed by the workgroup over the past five months.

A. State Level Remedial Strategies

1. Policy

The workgroup completed a thorough review of waiver regulations and applications, as outlined in section III. The overarching goal is for each regulation and waiver application to be in compliance with the HCBS final rules. The following includes the identified changes to each regulation and application that are required to transition the HCB waiver policies into compliance with each HCBS rule related to settings.

DMS is implementing the HCBS final rules in two rounds to assure that providers have adequate time to become compliant with all rules. Additional reasons for the extended timeline are as follows.

1. The rules included in the second round may have a significant impact on KY HCBS providers and create an access issue depending on the number of providers who will lose the ability to render services because of the rules, if adequate time is not allowed for implementation.
2. DMS has allotted a full year to work with the high volume of providers who will need to undergo heightened scrutiny to assure that DMS can spend adequate time working with each provider.
3. DMS is giving time for providers to stabilize the first round of changes before moving into the second round.
4. DMS will be educating providers as soon as the rules are fully defined and operationalized. The education and compliance process for the second round changes will start before 2018 giving providers ample time to become compliant.

Potential HCB Waiver Regulation and Application Actions for Compliance

Rule: The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS

Timeline: 7/15/2017 – 1/1/2018 (Second Round)

Status: Not Started

Potential Actions to be Compliant:

- Clarify indicators of integration into the greater community and incorporate into the regulation
- Add stronger language that focuses on outcomes related to the individual's experience
- Identify potential opportunities to use technology to promote integration
- Include clarifying language that community integration is individualized, appropriate, and outlined in the plan of care (POC)

Rule: The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.

Timeline: 1/1/2015 – 4/30/2015 (First Round)

Status: Not Started

Potential Actions to be Compliant:

- Include assurance that individuals must be informed of every available setting option each time s/he is selecting a new setting, every time the individual moves or changes service provider
- Require case manager to document all available settings options considered and selected by the individual in the POC
- Include explanation of how informed choice should be provided
- Include assurance that the individual is included in both the selection of the provider and setting (location), and describe how the setting options were presented to the participant

Rule: Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint

Timeline: 1/1/2015 – 4/30/2015 (First Round)

Status: Not Started

Potential Actions to be Compliant:

- Add language ensuring the individual's privacy, dignity, and respect

Rule: Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

Timeline: 1/1/2015 – 4/30/2015 (First Round)

Status: Not Started

Potential Actions to be Compliant:

- Add general language to clearly define this rule
- Add language allowing the individual to select daily activities and with whom they interact

Rule: Facilitates individual choice regarding services and supports, and who provides them.

Timeline: 1/1/2015 – 4/30/2015 (First Round)

Status: Not Started

Potential Actions to be Compliant (HCB Application):

- Add clear and centrally located definition of freedom of choice

Potential Actions to be Compliant (HCB Regulation):

- Use HCBS rule language

Rule: Home and community-based settings do not include the following:

- (i) A nursing facility;
 - (ii) An institution for mental diseases;
 - (iii) An intermediate care facility for individuals with intellectual disabilities;
 - (iv) A hospital; or
 - (v) Any other locations that have qualities of an institutional setting, as determined by the Secretary. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution unless the Secretary determines through heightened scrutiny, based on information presented by the State or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings.
- Timeline: 7/15/2017 – 1/1/2018 (Second Round)

Status: Not Started

Potential Actions to be Compliant:

- Include restrictions for providers that have qualities of an institutional setting
- Include restrictions for providers that are located within, on the grounds of, or immediately adjacent to a public institution, or any other setting that has the effect of isolating individuals receiving HCBS
- Include HCBS rule language

DMS will submit revised ordinary regulations for setting-related rules in two rounds in order to allow stakeholders time to review and providers time to implement. The HCBS final rules will be implemented in two rounds based on the ease of implementation and complexity of the change. DMS will draft the regulation language for the first round from January 1, 2015 to February 28, 2015. The first round of revised ordinary regulations will be submitted in April 2015 and effective in November 2015. DMS will draft the regulation language for the second round from July 2017 to October 2017. The second round of revised ordinary regulations will be submitted in January 2018, with an effective date in July 2018, and an implementation date of January 2019. The implementation date of January 2019 is when all providers must be compliant with all HCBS settings final rules.

DMS will draft the waiver amendment language for the first round from January 1, 2015 to February 28, 2015. The revised waiver amendments are targeted for submission to CMS for approval on the below date. This date was selected to coincide with the waiver renewal date and is during the regulation adoption timelines to assure consistency.

- HCB – April 1, 2014

To confirm that the applications and regulations mirror the same requirements for the HCB waiver, DMS will draft the waiver amendment language for the second round from November 2017 to March 2018 and submit the revised waiver application to CMS for approval in April 2018. The goal is for the both the regulations and applications to be approved and effective in July 2018.

2. Operations

State staff and the workgroup will be preparing operational practices for compliance over the next three years. This includes developing a tool for providers that outlines the federal requirements and how they will be evaluated, and hosting a webinar for waiver providers. Once updated state policies take effect, state staff will transition from current operational practices to revised, compliant protocols to administer the HCBS waivers. The HCBS final rules affect several areas of DMS' waiver operations including, but not limited to, internal processes, monitoring, and service delivery. Below is a list of operational changes required for each waiver to bring their practices into compliance.

Potential Waiver Operational Actions for Compliance

Internal Processes

Prior Authorizations

Timeline: 1/1/2015 – Ongoing

Status: Not Started

Potential Actions to be Compliant:

- Update PA processes to incorporate new HCBS rules in regards to the participant setting selection process

State staff training

Timeline: 1/1/2015 – Ongoing

Status: Not Started

Potential Actions to be Compliant:

- Train PA staff, focusing on the POC and case management in relation to PAs
- Train state staff, including waiver and QA staff, on HCBS rules
- Train state staff, including waiver and QA staff, on the transition process, new monitoring processes and checklists, related to the HCBS rules

Capacity, resources and services

Timeline: 10/1/2015 – Ongoing

Status: Not Started

Potential Actions to be Compliant:

- Evaluate provider capacity throughout the state
- Determine appropriateness of resources for providers
- Evaluate if covered services are adequately meeting the needs of the participants, in view of any changes required by the HCBS final rules

Provider Processes:

Requirements (mission/values)

Timeline: 1/1/2015 – Ongoing

Status: Not Started

Potential Actions to be Compliant:

- Providers should update their mission/values and policies/procedures to align with the new DMS regulations

Trainings

Timeline: 1/1/2015 – Ongoing

Status: Not Started

Potential Action to be Compliant:

- Update relevant provider trainings and offer providers all relevant information and trainings

Transition Process

Timeline: 1/1/2015 – Ongoing

Status: Not Started

Potential Actions to be Compliant:

- Develop HCBS evaluation tool (monitoring tool) and HCBS compliance plan template to be used by providers, outlining their plan for complete compliance
- Host webinars for waiver providers
- Validate each provider's compliance level during annual evaluation
- Notify providers outlining their compliance level
- Complete on-site reviews for all groups based on provider and waiver staff provider evaluations
- Review, track, and approve/deny the providers' HCBS compliance plans
- Assist providers to ensure compliance and resolve any access issues found
- Use processes outlined in state regulations for provider corrective action or actions not to certify or to terminate non-compliant providers

Monitoring Processes:

Requirements

Timeline: 1/1/2015 – Ongoing

Status: Not Started

Potential Actions to be Compliant:

- Validate that the current monitoring processes are sufficient to monitor new and existing providers against the HCBS rules and modify as necessary

Tools (on-site items, checklists, etc.)

Timeline: 1/1/2015 – Ongoing

Status: Not Started

Potential Actions to be Compliant:

- Update provider checklists and survey tools for provider sites (residential, ADT, ADHC, etc.) based on the revised regulations that comply with the HCBS rules
- Implement provider requirements using the CMS toolkit to determine the materials/evidence providers need to submit as validation of HCB setting under heightened scrutiny

Surveying Process

Timeline: 1/1/2015 – Ongoing

Status: Not Started

Potential Actions to be Compliant:

- Update PDS provider on-site surveys
- Establish process for participant surveys

Grievance Process

Timeline: 1/1/2015 – Ongoing

Status: Not Started

Potential Actions to be Compliant:

- Review grievance process and implement updates as needed for participants to file complaints about non-compliant providers
- Determine method to confirm participants are aware of grievance process

Miscellaneous:

Communication plan for additional stakeholders (advocacy groups, provider associations, etc.)

Timeline: 1/1/2015 – Ongoing

Status: Not Started

Potential Actions to be Compliant:

- Develop stakeholder engagement process to obtain input on implementation of the final rules, focusing on defining and operationalizing rules before policies and tools are established
- o Host public forums and/or focus groups for providers and participants, representatives, family members, and advocates

- o Attend meetings of established public consumer, advocacy, and provider groups to review and provide feedback on key changes
 - o Accept public comments from stakeholders during public comment periods for waiver regulations, waiver amendments, and waiver renewals
 - Communication activities could include periodic email updates with rule summaries, educational materials, webinars, and presentations at conferences and advocacy group meetings upon request
- Relocation Process (due to HCBS rules)
 Timeline: 1/1/2015 – Ongoing
 Status: Not Started
 Potential Actions to be Compliant:
- Determine relocation process

3. Participants

The significance of the changes to DMS' HCBS waivers warrants continuous communication with waiver participants and advocacy groups that communicate with participants and their families. Communicating regularly with participants also provides opportunities for state staff to conduct further monitoring of providers. In addition to public notices, state staff will organize outreach to participants to inform them of the key changes to their programs, and confirm they understand their rights. In certain cases, participants may need to be relocated based upon the results of the provider assessments. If the provider falls under compliance level three (not compliant and never will be), state staff will follow the same protocols to relocate participants as currently are in place when providers are terminated.

Potential Participant Actions for Compliance

Rule: ALL HCBS rules

Timeline: 1/1/2015 – Ongoing

Status: Not Started

Potential Actions to be Compliant:

- Develop stakeholder engagement and education plan and implement process for informing participants of the HCBS rules
- Send information to waiver participants targeted to each participant's situation explaining waiver changes related to HCBS rules
- o Include information outlining the new participant rights, provider requirements, and links to all related information

4. Technology

Kentucky has operated the Kentucky Health Benefit Exchange (KHBE), also known as kynect, since October 2013. Included in the next release of KHBE in April 2015, is a Medicaid Waiver Management Application (MWMA), which converts the majority of waiver processes to a central online system. The system tracks the application, assessment, and POC process. Many of DMS' existing waiver forms will be switched from paper to electronic through MWMA, and the HCBS setting final rules impact the language that must be included in the MWMA screens. Below are the primary changes required for the MWMA to comply with the federal requirements.

Medicaid Waiver Management Application

Timeline: 1/1/2015 – 12/15/2015

Status: Not Started

Potential Technology Actions for Compliance

Forms: Plan of care/prior authorization form, long term care facilities and home and community based program certification form, Medicaid waiver assessment form, demographic and billing information form, and freedom of choice and case management conflict exemption form

- Modify forms/screen within MWMA to comply with HCBS rules

B. Provider Level Remedial Strategies

As described in section III, the workgroup categorized providers into four compliance levels on a preliminary basis: 1) fully aligned with federal requirements and require no changes, 2) do not comply with federal requirements and require modifications, 3) cannot meet the federal requirements and require removal from the program and relocation of individuals, and 4) presumed not to be HCB and requires heightened scrutiny. The preliminary compliance level of each provider was determined based on surveys and state staff knowledge, but it may change over time, as additional information is obtained and providers present evidence of their compliance.

The compliance plan template is a tool that the HCBS workgroup will be developing with input from stakeholders to assist providers in identifying potential areas of non-compliance. This tool is meant for collaboration and is not a corrective action plan. State staff will implement the following activities from January 2015 to July 2018 to assist providers in transitioning to compliance.

1. Develop an HCBS evaluation tool (monitoring tool) and HCBS compliance plan template for providers to be notified of their initial compliance and identify actions they will complete to address areas of non-compliance
 - a. Distribute HCBS compliance plan template to providers and inform them of their compliance level
 - b. First round: January 2015 to March 2015
 - c. Second round: July 2017 to September 2017
2. Develop and implement HCBS final rule communication plan for providers and stakeholders through webinars, presentations at conferences, and provider association meetings
 - a. The HCBS compliance plan template will follow similar protocols to the current waiver provider corrective action plan (907 KAR 7:005 – section 4)
 - b. First round: April 1, 2015 to April 30, 2015
 - c. Second round: October 2017 to January 2018

3. State staff will review and approve/deny providers' plans

a. First round: May 2015 to October 2015

b. Second round: January 2018 to June 2018

4. Conduct routine evaluations and on-site assessments with the updated HCBS evaluation tool to validate each provider's compliance plan and level of compliance

a. Both rounds: March 2015 to ongoing

For providers in compliance level one (fully align with federal requirements), there will be no changes required of the provider and they can continue providing services. State staff will continue to monitor these providers and participants with on-site visits to verify compliance based on the HCB waiver's updated monitoring process (as outlined in section III).

For providers in compliance level two (do not comply and require modifications), changes are required for the provider to become compliant with the HCBS setting rules. These changes may be short-term (0-3 months) or long-term (3-12 months), but all changes must be completed before the updated state policies are implemented in January 2019. The remedial activities included below are examples of activities that the providers may complete to come into compliance with the HCB setting rules. State staff will implement the following activities from January 2015 to July 2018:

1. Track provider compliance plans

a. First round: May 2015 to October 2015

b. Second round: January 2018 to June 2018

2. Conduct routine on-site monitoring to review providers' progress towards complete compliance

a. Both rounds: March 2015 to ongoing

3. For non-compliant providers, the HCB waiver will follow the termination process outlined in Kentucky regulations

For providers in compliance level three (not compliant and never will be), state staff will complete an additional on-site meeting with the provider to confirm that the setting does in fact fall under compliance level three. If after the on-site meeting, the setting is confirmed to be in compliance level three, state staff will offer the opportunity for the provider to relocate the setting before the updated state policies become effective. If the provider is able to successfully relocate to a setting that complies with the federal requirements and to assure that operations in that setting comply with the HCBS rules, the provider will not be terminated. Should a provider not comply or qualify with HCBS rules for a particular service, they could potentially provide other HCBS services, as long as they comply with the applicable HCBS requirements for those services. However, if the provider chooses not to relocate, is unable to find an appropriate setting, or is unable to come into compliance with the HCBS rules, the provider will be terminated. The provider's termination will be based on 907 KAR 7:005 (Certified waiver provider requirements) or 907 KAR 1:671 (Conditions of Medicaid provider participation; withholding overpayments, administrative appeal process, and sanctions) after revised waiver regulations are effective. DMS will identify the waiver participants who will be impacted by provider termination and the process will be outlined. All affected participants will be relocated within 90 days of their providers' termination, following the current relocation process. The relocation process will follow the person-centered planning process. The state staff will provide reasonable notice and due process to all parties. If state staff determines the provider should not be in compliance level three, then they will fall under compliance level four and will require heightened scrutiny.

1. Settings presumed not to be HCB

For settings in compliance level four (presumed not to be HCB), providers will be required to submit evidence to the state first, outlining how their settings do not have the qualities of an institution and do have the qualities of an HCB setting. State staff will conduct an additional on-site assessment and will coordinate closely with these providers to verify they are providing the necessary documentation to prove they have the qualities of HCB setting. DMS will corroborate provider evidence and determine whether to send the evidence to CMS for the heightened scrutiny process. DMS will further define the process of heightened scrutiny when further guidance is provided by CMS. To assist providers in establishing evidence that they have the qualities of an HCB setting, state staff will complete the following activities from January 2016 to July 2018.

1. Notify providers that they will need to undergo heightened scrutiny

2. Collaborate with providers on additional documentation that must be presented as evidence of being HCB

3. Add additional requirements to the HCBS compliance plan template

4. Conduct additional detailed on-site visits to obtain further evidence, as needed

5. Submit provider's evidence to CMS for determination

6. For non-compliant providers or providers determined not to be an HCB setting, the termination process outlined in regulation 907 KAR 7:005 (Certified waiver provider requirements) or 907 KAR 1:671 (Conditions of Medicaid provider participation; withholding overpayments, administrative appeal process, and sanctions) will be followed

Once these providers submit evidence of having the qualities of HCB settings in the HCBS compliance plan template, state staff will evaluate the provider's submission. As needed, state staff will reserve time for more assessments and will prioritize this group of providers when scheduling on-site evaluations. After state staff's analysis, the provider's evidence will be submitted to CMS for final determination. If the determination is that the provider does not have the qualities of a HCB setting, state staff will evaluate the provider as now falling under compliance level three, and the provider will need to relocate the setting and comply with all HCBS rules, or face termination.

Below includes some examples of suggested provider level remedial activities that providers may complete to come into compliance with the HCB setting rules. The activities are identified as short-term (0-3 months) or long-term (3-12 months) depending on their ease of

implementation.

Potential Provider Actions for Compliance

Provider Requirements

Rule: The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS;

Potential Actions to be Compliant:

- Short-term (based on the individual's person-centered plan)
 - o Assist/provide training to individuals on how to access public transportation
 - o Support individuals in their job search with activities such as supported employment
 - o Encourage individuals to participate in community activities of their choosing and explore community access opportunities
 - o Ensure individuals have access to personal resources
 - o Provide staff training
- Long-term
 - o Provide transportation to community activities if public transportation is not available
 - o Work with individuals to help them establish valuable relationships within the community
 - o Update mission/values to meet the rule

Rule: The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board

Potential Actions to be Compliant

- Short-term (based on the individual's person-centered plan)
 - o Provide individuals with all setting options available and ensure individual makes an informed choice for both setting and provider
 - o Case manager must offer each individual a private unit if available in the setting selected
 - o Document all setting and provider options presented and considered by the individuals in the POC
 - o Ensure setting options align with individual's needs and preferences
 - o Provide staff training

Rule: Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint

Potential Actions to be Compliant

- Short-term (based on the individual's person-centered plan)
 - o Ensure individual has privacy
 - o Encourage the individual to come and go as s/he wishes, consistent with the POC and provide necessary supports to facilitate
 - o Ensure provider staff speak to individuals with respect
 - o Provide staff training
- Long-term
 - o Update and implement mission/values to meet the rule

Rule: Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact

Potential Actions to be Compliant

- Short-term (based on the individual's person-centered plan)
 - o Encourage the individual to create his/her own schedule and provide necessary supports to facilitate
 - o Encourage the individual to make independent choices during POC planning and on a daily basis
 - o Establish policies and procedures which encourage individual choice of activities
 - o Provide staff training
- Long-term
 - o Update and implement mission/values to meet the rule

Rule: Facilitates individual choice regarding services and supports, and who provides them

Potential Actions to be Compliant

- Short term (based on the individual's person-centered plan)
 - o Provide necessary information (documents, site visits, etc.) that allows the individual to indicate his/her preferences for services and supports and who provides them
 - o Document all setting and provider options presented and considered by the individuals in the POC
 - o Provide staff training

Rule: Home and community-based settings do not include the following:

- (i) A nursing facility;
- (ii) An institution for mental diseases;
- (iii) An intermediate care facility for individuals with intellectual disabilities;
- (iv) A hospital; or
- (v) Any other locations that have qualities of an institutional setting, as determined by the Secretary. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds

of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution unless the Secretary determines through heightened scrutiny, based on information presented by the State or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings

Potential Actions to be Compliant:

- Short-term (based on the individual's person-centered plan)
 - o Depending on compliance level, develop compliance plan to become compliant with HCBS rules
 - o Consolidate evidence of community integration among recipients
 - o Provide evidence that setting does not have qualities of an institution
 - o Remove isolating barriers or institutional qualities
 - o Provide staff training
- Long-term
 - o Cooperate with state staff and CMS on-site assessments

VI. Public Comment Process

This Statewide Transition Plan was submitted to CMS and posted on December 19th, 2014. The following website can be used to view the plan: <http://www.chfs.ky.gov/dms>.

In order to allow stakeholders time to provide input in a convenient and accessible manner, DMS submitted this Statewide Transition Plan for public comment through an announcement on the DMS website, publication in newspapers, public forum, and informal channels. The public notice was published and posted on November 5, 2014 and provided stakeholders a 30-day public notice and comment period. CHFS distributed individual emails to waiver providers, provider associations, members of the HB144 Commission and the Commonwealth Council on Developmental Disabilities (CCDD), and DMS' advocacy distribution list to notify those stakeholders of the Statewide Transition Plan. The following website can be used to view the proposed Statewide Transition Plan: <http://www.chfs.ky.gov/dms>.

The public notice and comment period was published in six newspapers (Lexington Herald Leader, Cincinnati/Northern KY Enquirer, Louisville Courier Journal, Bowling Green Daily News, Owensboro Messenger, Kentucky/Cincinnati Enquirer) on November 5, 2014. DMS and the workgroup also promoted and made informal communication about the transition plan and comment period to the following groups: waiver providers, provider associations, HB144 Commission members, the Commonwealth Council on Developmental Disabilities, and other advocacy groups.

A. Public Comments

All public comments were submitted to DMS through mail, email, advocacy groups and the HB144 Commission meeting and were evaluated by the workgroup. The workgroup categorized similar comments together, summarized the comments, and responded and/or updated the transition plan accordingly. The summary and response of all comments is described below. If the state's determination differed from the public comment, then additional evidence and the rationale the state used to confirm its determination was included. If the state's determination agreed with the public comment, then the location of the supporting evidence in the transition plan was indicated. All public comments on the transition plan will be retained and available for CMS review during the duration of the transition period or approved waiver, whichever is longer.

Summary of modifications based on public comments:

- I. Background – more details added
- II. Introduction – references added
- II. Introduction
 - o A. Purpose – more details and public forums added
- III. Assessment Process Systemic Review
 - o A. Regulation and Waiver Application Assessment – more details and participant surveys added
- IV. Provider Assessment – more details added
- IV. Provider Assessment
 - o B. Non Residential Settings – more details added
- V. Remedial Strategies
 - o A. State Level Remedial Strategies
 - 1. Policy – more details added
 - State staff training – more details added
 - Capacity, resources, and services – section added
 - Surveying process – participant surveys added
 - Grievance process – section added
 - Communication plan for stakeholders – stakeholder engagement process added
 - o B. Provider Level Remedial Strategies – more details added
 - 1. Settings presumed not to be HCB – clarifications added
 - Clarifications added

At the time the Statewide Transition Plan is filed with CMS, the transition plan will also be posted to the state website. The URL for the filed transition plan is <http://www.chfs.ky.gov/dms>. The Statewide Transition Plan, with any modifications made as a result of public input, will be posted for public information no later than the date of submission to CMS.

VII. Appendix

A. Non-Residential Provider Survey

The below survey questions were administered to all non-residential waiver providers through a web-based survey tool. The providers were notified of the survey either by email or provider letter.

1. Name:
2. Agency:
3. Email Address:
4. Please provide the addresses of all of your settings, if applicable:
5. Please select the Medicaid HCB waiver for which your agency/organization provides services: ABI, ABI-LTC, HCB, MPW, MII or SCL
6. Please select which of the following provider types best describes your agency: ADHC, Home Health Agency, or Other
 - i. Other Non-residential Provider (specify here): ADT, Case Management, OT, PT, ST, CLS, etc.
7. Are participants' schedules for PT, OT, medications, restricted diet, etc., posted in a general open area for all to view?
 - i. Please explain how privacy is ensured/protected:
8. As part of your waiver services, do your participants participate in activities in the greater community?
 - i. Please provide examples of activities that participants engage in in the greater community:
9. Do participants have the freedom to make their own choices while receiving services at your program (if s/he is able to make independent choices)?
 - i. Consider the following in your response:
 1. Do participants have autonomy to choose daily activities?
 2. Do participants choose who they interact with?
 - ii. Please provide examples of how participants have freedom of choice:
10. Do you facilitate the participants' choice of services, supports, and who provides them?
 - i. Please explain:
11. Are participants given a choice of available options regarding where to receive services (not applicable to ADHCs)?
 - i. Please explain how the participants are given choice:
12. Is it made clear that participants are not required to adhere to a set schedule for activities, etc.?
 - i. Please explain your response to set schedules for participants:
13. Do participant schedules vary from others in the same setting?
 - i. Please explain your response to varying schedules among participants:
14. Do participants have access to things that interest them and can they schedule such activities at their convenience?
15. Are any of your programs within, on the grounds of, or adjacent to, an institution (nursing facility, institution for mental disease, intermediate care facility for participants with intellectual disabilities, or hospital)?
 - i. Please provide address/addresses of any programs within, on the grounds of, or adjacent to, an institution:
16. Do any of your programs operate in an area (e.g. a neighborhood, a street or a neighboring street, etc.) where there is more than one facility/program in the area providing services to individuals receiving Medicaid Home and Community-Based Services (HCBS)?
 - i. If you answered yes in the previous question, please provide examples of how your agency helps participants engage in the broader community:
 - ii. Please provide the address/addresses of your programs where there is more than one facility/program in the area providing services to individuals receiving Medicaid HCBS:
17. Is the non-residential site considered to be remote and outside of a city limits?
18. Do you ensure that participants have rights of privacy, dignity and respect, and freedom from coercion and restraint?
 - i. Please provide justification that you ensure participants have rights of privacy, dignity and respect and freedom from coercion and restraint:
19. Does staff converse with participants while providing assistance and during the regular course of daily activities?
20. Does staff address participants in the manner in which they would like to be addressed?
21. Is individual choice facilitated in a manner that leaves the participant feeling empowered to make decisions?
 - i. Please provide justification that individual choice is facilitated to make the participant feel empowered:
22. Does staff ask participants about their needs and preferences?
23. Does your program accommodate the participant's needs and preferences?
 - i. Please explain how your program does, or does not, accommodate the participant's needs and preferences:
24. Do participants know how to change or request a change to their program, service, or activity they receive?
25. Does the participant know how and to whom to make a request for a new provider?
 - i. Please explain the process for how participants request a new provider:
26. Do you ask your participants if they are satisfied with their services, outside of surveying?
 - i. If yes, please explain how you use that information:
 - ii. If no, please explain why you do not ask the participants if they are satisfied:

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:

Department for Aging and Independent Living

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

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: DMS will have a written contract with DAIL that is reviewed annually and updated as needed. DMS has delegated the following functions to DAIL:

- 1) Provide daily oversight and administration of the waiver,
- 2) Serve as the Independent Assessor Agency
- 3) Provide technical assistance for providers and participants,
- 4) Conduct Case management training and development,
- 5) Monitor nutrition providers, Centers for Independent Living, and Area Agencies on Aging and Independent Living.
- 6) Implement the DMS approved policy, procedures and information systems governing the program.
- 7) Submit monthly updates to DMS.

DMS will use the following methods to ensure DAIL performs its assigned waiver operational and administrative functions in accordance with waiver requirements.

- 1) Approval of all policy, standards and procedures, provider qualifications, certification and training requirements and methods.
- 2) Review monthly updates from DAIL,
- 3) Participation in the DAIL monthly implementation meetings during the two year implementation phase,

- 4) Review monitoring reports and recommendations as completed,
- 5) An annual review of the contract and deliverables to ensure DAAIL has met the standards listed in the contract.

Home Health and ADHCs will be monitored by the QIO. DMS will continue as the second line monitor.

Appendix A: Waiver Administration and Operation

- 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 a non-governmental agency to provide services as a Quality Improvement Organization (QIO). The QIO determines level of care, eligibility determinations, prior authorizes requests for services and approves the Plan of Care.
 - 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

- 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 and the Department for Aging and Independent Living (DAAIL).
DAAIL is responsible for assessing the performance of the Area Agencies on Aging and Independent Living, Area Development Districts, Public Health Agencies, Centers for Independent Living, and nutrition providers.
OIG is responsible for oversight of licensure and waiver requirements for adult day health care and home health.

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, quality reviews, post payment auditing processes, second line monitoring and periodic 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 type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input 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 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 checked="" type="checkbox"/>	<input type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input 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:

Number and percent of required reports the QIO provides to DMS within the required timeframes.
 N=The number of required reports the QIO provided to DMS within the required timeframes
 D=The number of required reports due to DMS within the required timeframes.

Data Source (Select one):

Reports to State Medicaid Agency on delegated

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 checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input 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: Fiscal Agent, QIO	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input 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 type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Fiscal Agent, QIO	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of required reports the operating agency provides to DMS within the required timeframes. N=The number of required reports the operating agency provided to DMS within the required timeframes. D=The number of required reports the operating agency was required to provide to DMS within the required timeframes.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

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 checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input 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 type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input 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 type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input 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. The DMS contracts with the fiscal agent who in turn contracts with the QIO for medical necessity review. DMS and the fiscal agent meet on a periodic basis to review and identify issues/problems related to the level of care, plan of care and prior authorization of services. Should problems be identified, then a collaborative plan is developed to resolve the issue/problem.

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. 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 monitors the Fiscal Agent to ensure that contract

objectives and goals for LOC are met as appropriate. Should the Fiscal Agent not meet the requirements then 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"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Fiscal Agent, QIO	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other 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 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 checked="" type="checkbox"/> Aged or Disabled, or Both - General					
	<input checked="" type="checkbox"/>	Aged	65		<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/>	Disabled (Physical)	0	64	
	<input checked="" type="checkbox"/>	Disabled (Other)	0	64	
<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 type="checkbox"/> Intellectual Disability or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism			<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
	<input type="checkbox"/>	Intellectual Disability			<input type="checkbox"/>
<input type="checkbox"/> Mental Illness					

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	<input type="checkbox"/>	Mental Illness	<input type="text"/>	<input type="text"/>	
	<input type="checkbox"/>	Serious Emotional Disturbance	<input type="text"/>	<input type="text"/>	

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

Individuals that meet the Nursing Facility Level of Care regulation as defined in the 907 KAR 1:022.

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:

Members who have physical and other disabilities will remain in the Home and Community Based waiver upon turning 65 years of age should they chose to do so. The actual transition plan will be for them to remain in the current waiver that they are in and to continue to receive the services that currently benefit them. For some members they may consider moving into a Nursing Facility or Assisted Living instead of continuing in the waiver. If the members opt to move out of the waiver then they will be assisted in finding a Nursing Facility or Assisted Living facility.

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	17050
Year 2	17050
Year 3	17050
Year 4	17050
Year 5	17050

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).**

Purpose(s) the State reserves capacity for:

Purposes	
Nursing Home Transition	

Appendix B: Participant Access and Eligibility

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

Purpose *(provide a title or short description to use for lookup):*

Nursing Home Transition

Purpose *(describe):*

Kentucky will reserve 150 slots per year to allow for the transition of individuals served under Kentucky Transitions Program (Money Follows the Person) and individuals transitioning from nursing homes.

Describe how the amount of reserved capacity was determined:

Capacity is reserved for Money Follows the Persons grant members who will admit into the HCB Waiver as transitioned from NF facilities. Capacity is reserved based on the projected number of transitions from the MFP program. Projections are based on current transition trends. After the initial transitions, it is projected that a reserved capacity of 150 will be needed each year for future year transitions. MFP transition projections are based on trends from the past three fiscal years and CMS approved benchmarks.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	150
Year 2	150
Year 3	150
Year 4	150
Year 5	150

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:

The waiver provides for the entrance of all eligible members until maximum capacity is reached.

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 (TWWIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
 Working individuals with disabilities who buy into Medicaid (TWWIA 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 criteria for eligibility groups that are covered under the State Medicaid Plan that the state proposes to include under this waiver renewal includes:

42 CFR 435:110 Parents and other caregiver 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

- 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:

- 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 \$20 General Exclusion

- Other

Specify:

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:

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:

- 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:

The Department for Aging and Independent Living will now serve as the Independent Assessment Agency with DAIL staff conducting assessments, reassessments and developing plans of care.

Assessors employed by DAIL shall have:

- 1) Master's degree in Health or Human Services from an accredited college or university, OR
- 2) RN currently licensed as defined in KRS 314.011(5), AND
- 3) Shall be supervised by an individual who meets all assessor qualifications and who shall have four years or more direct experience in the field of aging and disability.

The assessment and reassessment must be developed with current or potential providers using a person centered planning approach.

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.

A participant status decision shall be based on medical diagnosis, care needs, services and health personnel required to meet these needs and the feasibility of meeting the needs through alternative institutional or non-institutional services.

Kentucky will begin a phase-in utilization of a new validated functional assessment tool adapted from the Wisconsin Functional Assessment Tool. The Kentucky Home Assessment Tool (K-HAT) will assess the participant for functional needs based on deficits in activities of daily living, instrumental activities of daily living and needed nonresidential and nonmedical home and community supports to remain in the community.

The functional assessment will provide guidelines for developing a person-centered service plan that provides identified supports to address the identified needs of the client and the feasibility of meeting the needs through alternative institutional or non-institutional services.

Participants will be determined by the department to be eligible for the waiver if the participant:

- 1) Is medically stable; and
- 2) Meets NF level of care requirements as defined in 907 KAR 1:022 (4); and
- 3) Has service needs which can be met through alternative institutional or non-institutional services but not 24/7 care; and
- 4) Would, without waiver services, be admitted by a physician's order to an NF.

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 documents used to establish Level of Care for the HCB Waiver and for a Nursing Facility differ; however, both documents are designed to capture the information needed to fulfill the same regulatory criteria set forth in 907 KAR 1:022. The document used for the HCB Waiver is a validated tool adapted from Wisconsin. This document evaluates the member, the home situation and other supports that the member receives in addition to requested Waiver services. The document used for Nursing Facility Level of Care, the MAP 726A, evaluates only the member, for a 30 day period of time. Field Nurses are then dispatched to the facility to have face to face meeting and a full chart review.

- 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:

The initial evaluation may begin outside of the persons residence, but will be completed within the persons residence. All applicants must have an order stating that Nursing Facility Level of Care is needed and must be signed by a Physician, Nurse Practitioner, or Physician Assistant. Once the assessment is completed by the Independent Assessor it is reviewed by the QIO. If the assessment meets the LOC guidelines then the Independent Assessor is notified the assessment is approved.

Services may not begin nor will payment be rendered until such time as the applicant has met all eligibility requirements for the waiver. The applicant is determined to have met all eligibility requirements and be a waiver member when the following has occurred.

- 1) A final LOC determination has been approved by both the Independent Assessor and the QIO; and
- 2) A Service Plan has been developed by the Independent Assessor and approved by the QIO; and
- 3) Financial eligibility has been determined by the Department for Community Based Services and a valid MAP 552 is on file for a new applicant for Medicaid; or
- 4) The applicant is a current Medicaid recipient receiving services through a managed care organization at which time the services may begin on the first day of the first month following level of care determination. The managed care organization is responsible for ensuring the health, safety and welfare of the applicant during the period between LOC determination and the first day of the month.

- 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*):

Once a person meets the LOC criteria, those dates are entered into the MMIS with a 12 month span. The date begins with the date the MAP-351 is signed and must be updated in order for the person to continue to receive services and the provider to receive payment for those services that are provided.

- 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:

Documentation of the evaluations and reevaluations shall be maintained by the Case Manager and agencies providing services to the member. Electronic documentation shall be maintained by the QIO. All records shall be maintained a minimum of three (3) 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:

Number and percent of applicants who had a level of care assessment. N=The number of applicants who had a level of care assessment. D=The number of applicants.

Data Source (Select one):

Reports to State Medicaid Agency on delegated

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 checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input 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: Fiscal Agent, 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 (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 type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Fiscal Agent, QIO	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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:

Number and percent of waiver participants who received a redetermination of level of care within 12 months of their initial or last level of care determination. N= The number of waiver participants who received a redetermination of level of care D= The number of waiver participants who should have received a redetermination of level of care determination.

Data Source (Select one):

Reports to State Medicaid Agency on delegated

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 checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input 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: Fiscal Agent, QIO	<input 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"/> Other 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"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Fiscal Agent, QIO	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

- 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:

Number and percent of applicants who had level of care which met the criteria for the waiver.
 N=Number of applicants who had LOC which met criteria D=Number of applicants

Data Source (Select one):

Reports to State Medicaid Agency on delegated

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 checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

<input checked="" type="checkbox"/> Other Specify: Fiscal Agent, QIO	<input 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 type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Fiscal Agent, QIO	<input 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. Assessment services include a comprehensive initial assessment which shall be conducted by the Independent Assessor within seven (7) calendar days of receipt of the request for the assessment. The provider keeps a list of requests, date the requests are made, dates that the assessment was completed, and reasons why the assessment was not performed. Once a person meets the LOC criteria, those dates are entered into the MMIS with a 12 month span. The date begins with the date the assessment is signed and must be updated in order for the person to continue to receive services and the provider to receive payment for those services that are provided. The state contracts with a fiscal agent who in turn contracts with the QIO for implementation of the LOC process, to ensure that all forms are used appropriately and accordingly using the 907 KAR 1:022 Nursing Facility Level of Care regulation. The contracts are evaluated and monitored on a yearly basis to ensure the process is carried out according to DMS rules and regulations.

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 in order to identify problems and discuss resolution. If the problem is a provider issue, then DMS or DAIL will contact the provider and request a resolution to the situation. If a resolution is not provided then DMS reserves the right to place the provider on moratorium and/or recoup identified paid claims.

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):
---	--

Responsible Party <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 type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Fiscal Agent, QIO	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other 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.

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 applicants are informed by the independent assessor of their choice of institutional or waiver care, available services and available providers. This information is provided at the initial evaluation and at each reevaluation and documented on the "Long Term Care Facilities and Home and Community Based Program Certification Form." Written copies of this signed form is retained in the persons chart and maintained by the Independent Assessor and Case Manager. Electronic copies are maintained by the QIO.

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 Independent Assessor Agency and the copy is sent to the QIO.

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 members 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 members served by the provider, provision of interpreter services at no cost to the member, 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, ease 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. The Waiver has a mechanism to fund translation services through the goods and services process.

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	Conflict Free Case Management		
Statutory Service	Specialized Respite		
Supports for Participant Direction	Participant Directed Coordination		
Other Service	Attendant Care		
Other Service	Environmental and Minor Home Adaptation		
Other Service	Goods and Services		
Other Service	Home and Community Supports		
Other Service	Home Delivered Meals		
Other Service	Non-Specialized Respite		

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:

Sub-Category 1:

04 Day Services 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:

This service is limited to 50 hours per calendar week.

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 Centers

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:

Adult Day Health Care Centers

Provider Qualifications

License (specify):

Office of the Inspector General as regulated by 902 KAR 20:066

Certificate (specify):

Other Standard (specify):

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

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

Office of the 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:

Case Management

Alternate Service Title (if any):

Conflict Free Case Management

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):**DEFINITION:**

Case Management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet individual and family comprehensive needs through communication and available resources to promote quality cost effective outcomes.

FUNCTIONS:

Case management services shall assist individuals who receive waiver services in gaining access to needed waiver, state plan and other community services. Case managers shall be responsible for monitoring the services included in the individual's plan of care. Case managers will work closely with the individual to assure the participant has access to available supports, services, and resources and that ongoing need are met. Case managers will also work closely with the Independent Assessors at DAIL.

Case management involves face-to-face and related contacts to make arrangements for activities which assure the following:

- 1) The health, safety and welfare of the individual is met;
- 2) The on-going needs of the individual are determined and reflected in the plan of care;

- 3) The supports and services needed by the individual are identified and implemented;
- 4) Housing and employment (when applicable) issues are addressed;
- 5) Appointments and meetings are scheduled;
- 6) The quality of the supports and services as well as the health and safety of the individuals are monitored; and
- 7) Benefits are managed as needed.

Case management functions include:

- *Collaboration;
- *Implementation of the plan of care;
- *Knowledge of all programs and resources;
- *Education of participant on programs and resources available to them;
- *Knowledge of participant's strengths and weaknesses;
- *Referral to services;
- *Coordination of services;
- *Monitoring activities and services;
- *Reporting of incidents;
- *Facilitation of the service team;
- *Identification of barriers to participant's needs;
- *Input from all disciplines and team members involved in the participant's care;
- *Advocacy for the participant not the program or provider;
- *Monitoring of health, safety and welfare

CONFLICT FREE

Case Management shall be conflict free. Conflict free means a provider, including any subsidiary, partnership, not-for-profit, or for profit business entity that has a business interest in the provider who renders case management to an individual, must not also provide another waiver service to that same individual unless the provider is the only willing and qualified provider in the geographical area (within 30 miles from the participant's residence). Case managers will assure that participants have freedom of choice of providers in a conflict free climate. Agencies providing case management services to a person may not provide other waiver services to that same person. Case management shall not include direct services.

QUALIFICATIONS:

Case managers employed by a qualified provider shall have:

- 1)BA/BS in Health or Human Services from an accredited college or university , with one (1) year experience or the educational or experiential equivalent in the field of aging or disabilities; OR
- 2)RN currently licensed as defined in KRS 314.011(5), and who has two (2) years or more experience as a professional nurse in the field of aging or disabilities; OR
- 3) A Master’s degree in Health or Human services from an accredited college or university can substitute for experience; AND
- 5) Shall be supervised by a case management supervisor who shall have four (4) years or more experience as a case manager.

Case Managers must meet the minimum case management standards as defined by the Cabinet for Health and Family Services and included in training and the provider manual.

Case managers or their designees must be available for on call services.

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

This service is limited to one unit per member per month, (one unit of service is defined as one calendar month). The member contact shall be monthly. At a minimum, the case manager shall conduct one direct face to face contact every other month with telephonic contact on alternate months.

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 (AAAIL)
Agency	Public Health Departments

Provider Category	Provider Type Title
Agency	Home Health Agency
Agency	Centers for Independent Living
Agency	Adult Day Health Care Centers

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Conflict Free Case Management

Provider Category:

Agency

Provider Type:

Area Agencies on Aging and Independent Living (AAAIL)

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

AAAIL as defined in Section 1321.33 of the Older American's Act

Specified in 907 KAR 1:160 and program services manual

Verification of Provider Qualifications

Entity Responsible for Verification:

DAIL

Frequency of Verification:

Annually or more frequently if necessary

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Conflict Free Case Management

Provider Category:

Agency

Provider Type:

Public Health Departments

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Only as defined in KAR 902 Chapter 8 and certified by the Department for Public Health in the Cabinet for Health and Family Services.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DAIL

Frequency of Verification:

Annually or more frequently if necessary

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Statutory Service
Service Name: Conflict Free Case Management

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications**License (specify):**

Office of the Inspector General as regulated by 902 KAR 20:081

Certificate (specify):

Other Standard (specify):

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

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

Office of the 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: Statutory Service
Service Name: Conflict Free Case Management

Provider Category:

Agency

Provider Type:

Centers for Independent Living

Provider Qualifications**License (specify):**

Certificate (specify):

Other Standard (specify):

Center for Independent Living as defined in Section 702 the Rehabilitation Act

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

DAIL

Frequency of Verification:

Annually or more frequently if necessary

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Statutory Service
Service Name: Conflict Free Case Management

Provider Category:

Agency

Provider Type:

Adult Day Health Care Centers

Provider Qualifications**License (specify):**

Office of the Inspector General as regulated by 902 KAR 20:066

Certificate (specify):

Other Standard (specify):

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

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

Office of the 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:

Service:

Alternate Service Title (if any):

Specialized Respite

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):

Specialized Respite services are defined as short term care which is provided to a waiver member due to the need for relief of the primary caregiver or the sudden absence or illness of the primary caregiver who normally provides care for the individual.

Specialized Respite Service direct care staff must have 24 hour access to an RN for consultation and emergency situations.

Respite services cannot be utilized to provide respite to a paid caregiver.

Services must be provided at a level to appropriately and safely meet the support needs of the waiver member and that the respite provider has the appropriate training and qualifications. Specialized Respite care services shall be required to be of a skill level beyond normal babysitting.

Specialized Respite can be provided in conjunction with Participant Directed respite but not at the same time.

Respite services shall only be provided by licensed home health agencies or adult day health care agencies and can be provided in the following locations:

- (a) The home of the participant or
- (b) An adult day health care center licensed by the state of Kentucky
- (c) Combination of home and adult day health care center

Respite services shall be prior authorized.

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

Reimbursement for Specialized Respite services shall be limited to no more than \$4,000 per member per year. The case manager shall be responsible for assisting individuals to access other State Plan services, natural supports or services available through other funding streams if their needs exceed this limit. Specialized Respite services can be provided 24/7 but shall not exceed \$200 per day. Specialized Respite services alone or combined with Specialized Respite cannot exceed \$4,000 per year without DMS approval. Specialized Respite Service direct care staff must have 24 hour access to an RN for consultation and emergency situations.

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 Center
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Specialized Respite

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

Certificate (*specify*):

Other Standard (*specify*):

Meets all applicable standards for a waiver provider agency.

Must meet 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 Attendant Care Health Certification Training and maintained Annual Certification.

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

Traditional Respite Service direct care staff must have 24 hour access to an RN for consultation and emergency situations.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of the 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: Statutory Service

Service Name: Specialized Respite

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License (specify):

Office of the Inspector General as regulated by 902 KAR 20:081

Certificate (specify):

Other Standard (specify):

Meets all applicable standards for a waiver provider agency.

Must meet 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 Attendant Care Health Certification Training and maintained Annual Certification.

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

Traditional Respite Service direct care staff must have 24 hour access to an RN for consultation and emergency situations.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of the 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):**

Participant Directed Coordination

HCBS Taxonomy:**Category 1:**12 Services Supporting Self-Direction **Sub-Category 1:**12010 financial management services in support of self-directi **Category 2:**12 Services Supporting Self-Direction **Sub-Category 2:**12020 information and assistance in support of self-direction **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):

Participant Directed Coordination (PDC) includes the coordination of the participant's service plan, providing guidance to the participant in understanding the role and responsibility of an employer in PDS and management and distribution of funds in the members approved participant-directed budget. The provider shall ensure person centered planning principles are applied in the implementation of the service plan. The provider shall perform the employer responsibilities of payroll processing which shall include: issuance of paychecks; withholding federal, state and local tax and making tax payments to the appropriate tax authorities; and, issuance of W-2 forms. The provider shall be responsible for performing all fiscal accounting procedures including issuance of expenditure reports to the member, their representative, and the service advisor. The provider shall maintain a separate account for each member while continually tracking and reporting funds, disbursements and the balance of the member's budget. The provider shall process and pay invoices for participant directed goods and services approved in the member's service plan.

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

Providers of Participant Directed Coordination (PDC) cannot provide any other waiver service to the participant and must demonstrate the ability through experience as a financial management entity for state or federal participant directed programs.

Participant Directed Care Coordination is defined as two units per member per month. PDC services are limited to members opting to participant direct some or all of their non-medical 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	Adult Day Health Care
Individual	Home Health Agencies
Agency	Area Agencies on Aging and Independent Living

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Participant Directed Coordination

Provider Category:

Agency

Provider Type:

Adult Day Health Care

Provider Qualifications

License (specify):

Office of the Inspector General as regulated by 902 KAR 20:066

Certificate (specify):

Other Standard (specify):

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

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: Supports for Participant Direction
Service Name: Participant Directed Coordination

Provider Category:

Individual

Provider Type:

Home Health Agencies

Provider Qualifications

License (specify):

Office of the Inspector General as regulated by 902 KAR 20:081

Certificate (specify):

Other Standard (specify):

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

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: Supports for Participant Direction

Service Name: Participant Directed Coordination

Provider Category:

Agency

Provider Type:

Area Agencies on Aging and Independent Living

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

AAAIL as defined in Section 1321.33 of the Older American's Act
Specified in 907 KAR 1:160 and program services manual

Verification of Provider Qualifications

Entity Responsible for Verification:

DAIL

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:

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:

Attendant Care

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08030 personal care

Category 2:

08 Home-Based Services

Sub-Category 2:

08040 companion

Category 3:

08 Home-Based Services

Sub-Category 3:

08050 homemaker

Category 4:

15 Non-Medical Transportation

Sub-Category 4:

15010 non-medical transportation

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):

Attendant Care Services are provided through traditional providers and enable waiver participants to accomplish tasks that they normally would do for themselves if they did not have a disability.

Attendant Care may include hands-on assistance (actually performing a task for the person), reminding, observing, and/or guiding a waiver participant in ADLs (such as bathing, dressing, toileting, transferring and maintaining continence) and IADLs (more complex life activities such as personal hygiene, light housework, laundry, meal planning and preparation, transportation, grocery shopping, money management, and assistance with medication administration). This service may also include assisting the waiver participant in managing his/her medical care including making medical appointments and accompanying the participant during medical appointments but does not include the provision of direct medical services. The provision of home health medical services through the state plan does not prohibit the provision of attendant care waiver services.

Attendant care services may only be used to meet the needs as defined on the POC.

Attendant Care cannot duplicate state plan services or other waiver services.

Attendant Care shall not replace the natural support system. Natural Supports are defined as a non-paid person, persons, or community resource, which can provide, or has historically provided assistance to the consumer or due to the familial relationship, would be expected to provide assistance.

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

Determined by the independent assessment and identified on the plan of care. Maximum daily allowance for Attendant Care alone or in combination with Adult Day is \$200 per day based on a seven day week. The amount of Attendant Care services is based on the assessment and included on the plan of care.

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	Centers for Independent Living
Agency	Adult Day Health Care
Agency	Area Agencies on Aging and Independent Living
Agency	Home Health Agency

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:

Centers for Independent Living

Provider Qualifications

License (specify):

Certificate (specify):

Centers for Independent Living must be individually certified by DAIL as defined in 910 KAR 1:220.

Other Standard (specify):

Center for Independent Living as defined in Section 702 the Rehabilitation Act

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 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.

Verification of Provider Qualifications

Entity Responsible for Verification:

DAIL

Frequency of Verification:

At least yearly and 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

Provider Qualifications

License (specify):

Office of the Inspector General as regulated by 902 KAR 20:066

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 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.

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: Provider Specifications for Service

Service Type: Other Service

Service Name: Attendant Care

Provider Category:Agency **Provider Type:**

Area Agencies on Aging and Independent Living

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

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

DAIL

Frequency of Verification:

Annually or more frequently as 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 the Inspector General as regulated by 902 KAR 20:081

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 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.

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of the 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:

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 Adaptation

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14020 home and/or vehicle accessibility adaptations

Category 2:

14 Equipment, Technology, and Modifications

Sub-Category 2:

14010 personal emergency response system (PERS)

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 adaptations to the home, required by the member's plan of care, which are necessary to ensure the health, welfare and safety of the individual or which enable the member to function with greater independence in the home, and without which, the member would require institutionalization. Such adaptations may include 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 individual. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the member, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this service. All services shall be provided in accordance with applicable State or local building codes. All environmental and minor home adaptations shall be prior authorized. All providers for environmental and minor home adaptations shall be licensed and insured as verified by the case manager.

Environmental and minor home adaptation shall also include the installation and monthly support of personal emergency response systems.

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

Reimbursement for environmental and minor home adaptations shall be limited to \$2,500 per member per year. The case manager shall be responsible for assisting the participant to access other State Plan services, natural supports or services available through other funding streams if their needs exceed this limit.

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 Center
Agency	Other approved waiver providers
Agency	Home Health Agency
Agency	Area Agencies on Aging and Independent Living
Agency	Centers for Independent Living

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Environmental and Minor Home Adaptation****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

Certificate *(specify):*

Other Standard *(specify):*

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

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

Office of the 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: Other Service****Service Name: Environmental and Minor Home Adaptation****Provider Category:**

Agency

Provider Type:

Other approved waiver providers

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

	▲ ▼
Certificate (specify):	
	▲ ▼

Other Standard (specify):

As approved by the Department for Medicaid Services at the request of a provider agency or participant when no other provider agency is available or willing to provide the service.

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

DMS

Frequency of Verification:

At time of request

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Environmental and Minor Home Adaptation

Provider Category:

Agency ▼

Provider Type:

Home Health Agency

Provider Qualifications**License (specify):**

Office of the Inspector General as regulated by 902 KAR 20:081

Certificate (specify):

	▲ ▼
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Other Standard (specify):

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

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

Office of the 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: Other Service

Service Name: Environmental and Minor Home Adaptation

Provider Category:

Agency ▼

Provider Type:

Area Agencies on Aging and Independent Living

Provider Qualifications**License (specify):**

	▲ ▼
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Certificate (specify):

Area Agencies on Aging and Independent Living are defined in 910 KAR 1:220 and in Section 1321.33 of the Older American's Act.

Other Standard (specify):

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

DAIL

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: Environmental and Minor Home Adaptation

Provider Category:

Agency

Provider Type:

Centers for Independent Living

Provider Qualifications

License (specify):

Certificate (specify):

Centers for Independent Living must be individually certified by DAIL as defined in 910 KAR 1:220.

Other Standard (specify):

Center for Independent Living as defined in Section 702 the Rehabilitation Act

Verification of Provider Qualifications

Entity Responsible for Verification:

DAIL

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:

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:

Goods and Services

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17010 goods and services

Category 2:

17 Other Services

Sub-Category 2:

17020 interpreter

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):

The purchase of goods and services must be individualized and may be utilized to reduce the need for personal care or enhance the independence within the home or community of the program participant. All items purchased must be prior authorized and included on the Plan of Care. Goods and Services must be clinically necessary and be supported by clinical documentation. As a Medicaid funded service, this definition will not cover experimental goods and services inclusive of items which may be defined as restrictive under G.S. 122C-60. Examples of services and supports provided under Goods and Services may include nutritional and incontinent supplies and interpreter support.

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. Good and services shall be prior authorized and can not exceed \$3,500.00 per year without DMS approval.

In addition the following services shall have a hard limit of \$3,500.00 per member per year for incontinent supplies and \$2,750.00 per member per year for nutritional supplies.

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	Adult Day Health Care Centers
Agency	Home Health Agency
Agency	Area Agency on Aging and Independent Living

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Goods and Services

Provider Category:

Individual ▼

Provider Type:

Agency/Store

Provider Qualifications

License (specify):

▼
▼

Certificate (specify):

▼
▼

Other Standard (specify):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Case Manager

Frequency of Verification:

Based on participant purchase

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Goods and Services

Provider Category:

Agency

Provider Type:

Adult Day Health Care Centers

Provider Qualifications

License (specify):

Office of the Inspector General as regulated by 902 KAR 20:066

Certificate (specify):

Other Standard (specify):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of the 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: Other Service

Service Name: Goods and Services

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License (specify):

Office of the Inspector General as regulated by 902 KAR 20:081

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of the 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: Other Service

Service Name: Goods and Services

Provider Category:

Agency

Provider Type:

Area Agency on Aging and Independent Living

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

AAAIL as defined in Section 1321.33 of the Older American's Act

Specified in 907 KAR 1:160 and program services manual

Verification of Provider Qualifications

Entity Responsible for Verification:

DAIL

Frequency of Verification:

Annually or more frequently 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:

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:

Home and Community 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):

Home and Community Direct Support Services enable waiver participants who elect to utilize participant directed services to accomplish tasks that they normally would do for themselves if they did not have a disability, and would not typically be provided by natural supports. Home and Community Supports may include hands-on assistance (actually performing a task for the person), reminding, observing, and/or guiding a waiver participant in ADLs (such as bathing, dressing, toileting, transferring and maintaining continence) and IADLs (more complex life activities such as personal hygiene, light housework, laundry, meal planning and preparation, transportation, grocery shopping, money management, and assistance with medication administration). This service may also include assisting the waiver participant in managing his/her medical care including making medical appointments and accompanying the participant during medical appointments. Home and Community Support Services may only be used to meet the needs as defined on the POC. Home and Community Support Services cannot duplicate state plan services or other waiver services and shall not replace the natural support system. Natural Supports are defined as a non-paid person, persons, or community resource, which can provide or has historically provided assistance to the consumer or due to the familial relationship, would be expected to provide assistance.

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

Determined by the independent assessment and identified on the plan of care. Maximum daily allowance for Home and Community Support Services alone or in combination with Adult Day or Attendant Care cannot exceed \$200. Home and Community Support Services can be provided if the participant is also receiving Adult Day Services or Attendant Care if the service is identified as a need via the independent assessment, the service is listed on the plan of care and the service is not provided at the same time as another service. Home and Community Support Services cannot exceed 45 hours per week. Travel to and from the waiver member's home is excluded.

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 participant approved provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home and Community Supports

Provider Category:

Individual

Provider Type:

Qualified participant approved provider

Provider Qualifications

License (specify):

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 Attendant Care Health Certification Training and maintained Annual Certification.

Case managers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

PDS Care Coordinator

DAIL will perform second line verification during monitoring.

Frequency of Verification:

Initial, 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:

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:

Home Delivered Meals

HCBS Taxonomy:

Category 1:

06 Home Delivered Meals

Sub-Category 1:

06010 home delivered meals

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):

Home Delivered Meal Service is defined as the provision of meals to a waiver participant who has a need for a home delivered meal based on a deficit in an ADL or an IADL identified during the assessment process. The service includes the preparation, packaging and delivery of safe and nutritious meals to a consumer at his or her home. A consumer may be authorized to receive one home delivered meal per day. Also, for the purposes of this service, reheating a prepared home delivered meal is not the same as preparing a meal.

Home delivered meals:

- 1) Shall be provided to persons who are unable to prepare their own meals and for whom there are no other persons available to do so.
- 2) Shall be furnished in accordance with menus that are approved in writing by a licensed dietitian.

- 3) Shall take into consideration the consumer's medical restrictions, religious, cultural and ethnic background and dietary preferences,
- 4) Shall be individually packaged if they are heated meals.
- 5) May be individually packaged if they are unheated, shelf-stable meals, or may have components separately packaged so long as the components are clearly marked as components of a single meal. Also, for the purposes of this service, reheating a prepared home delivered meal is not the same as preparing a meal.

Home delivered meals shall not:

- 1) Supplement or replace meal preparation activities that occur during the provision of attendant care services or any other similar service.
- 2) Supplement or replace the purchase of food or groceries
- 3) Include bulk ingredients, liquids and other food used to prepare meals independently or with assistance. Bulk ingredients and liquids include but are not limited to: food that must be portioned out and prepared, or any food that must be cooked or prepared.
- 4) Be provided while the consumer is hospitalized or residing in an institutional setting, or receiving adult day health services, including crisis services.
- 5) Duplicate service provided through other programs funded or operated by the Department for Aging and Independent Living, community feeding program or any other governmental agency.

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

Limited to one unit of service per day. One unit of service equals one meal.

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	Approved agency meal providers

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Approved agency meal providers

Provider Qualifications

License (*specify*):

Certificate (*specify*):

All home delivered providers shall meet the definition of a food establishment in Kentucky according to the Food Establishment Act and State Retail Food Code -902 KAR 45:005 and KRS 217.015. All providers must follow regulations and procedures outlined in the above statute also known as the Kentucky Food Code.

According to KRS 217.015 a food establishment is defined as any fixed or mobile commercial establishment that engages in the preparation and serving of ready to eat foods in portions to the consumer. It does not include vending machines, establishments serving beverages only or retail stores which only cut slice and prepare cold-cut sandwiches for individual consumption.

Providers must be able to deliver meals on the day which it is to be consumed. Exception to this same day consumption is limited to situations in anticipation of inclement weather or for week-end or holiday service or in areas where no other meal service is an option.

Providers must:

- 1) Have all permits and conform to applicable laws and regulations under the Kentucky Food Code;
- 2) Deliver meals daily in accordance with the contractual requirements, in a sanitary manner, and at the correct temperature for the specific type of food;
- 3) Provide meals which contain at least 1/3 of the recommended daily allowance per meal and meet the requirements of the Dietary Guidelines for Americans. Menus must be certified in writing by a Licensed Dietician as meeting those criteria;
- 4) Allow federal, state and local agency staff to monitor for compliance.

Other Standard (*specify*):

Must be an approved provider as designated by the State Dietician within the Department for Aging and Independent Living.

Verification of Provider Qualifications

Entity Responsible for Verification:

DAIL

Frequency of Verification:

Annually or more frequently 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:

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:

Non-Specialized Respite

HCBS Taxonomy:

Category 1:

09 Caregiver Support

Sub-Category 1:

09012 respite, in-home

Category 2:

09 Caregiver Support

Sub-Category 2:

09011 respite, out-of-home

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*):

Non-Specialized Respite services are defined as short term care which is provided to a waiver member due to the need for relief of the primary caregiver who normally provides care for the individual.

Non-Specialized Respite services cannot be utilized to provide respite to a paid caregiver.

Services must be provided at a level to appropriately and safely meet the support needs of the waiver member and that the respite provider has the appropriate training and qualifications. Respite care services shall be required to be of a skill level beyond normal babysitting.

Non-Specialized services cannot replace the natural support system. Natural Supports are defined as a non-paid person, persons, or community resource, who can provide, or has historically provided assistance to the consumer or due to the familial relationship, would be expected to provide assistance.

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

Non-Specialized Respite cannot exceed 45 hours per week. Non-Specialized Respite alone or combined with Specialized Respite cannot exceed \$4,000 per year unless approved by DMS.

Respite services shall be prior authorized.

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 participant approved provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Non-Specialized Respite

Provider Category:

Individual

Provider Type:

Qualified participant approved provider

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Meets all applicable standards for a qualified waiver provider.

Must meet 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 Attendant Care Health Certification Training and maintained Annual Certification.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

PDS Care Coordinator must ensure initial verification.

DAIL upon monitoring

Frequency of Verification:

Initial, annually or more often if necessary.

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:

Case managers employed by a qualified provider shall have:

- 1) BA/BS in Health or Human Services from an accredited college or university, with one (1) year experience or the educational or experiential equivalent in the field of aging or disabilities; OR
- 2) RN currently licensed as defined in KRS 314.011(5), and who has two (2) years or more experience as a professional nurse in the field of aging or disabilities; OR
- 3) A Master's degree in Health or Human services from an accredited college or university can substitute for experience; AND
- 5) Shall be supervised by a case management supervisor who shall have four (4) years or more experience as a case manager.

Case Managers must meet the minimum case management standards as defined by the Cabinet for Health and Family Services and included in training and the provider manual.

Case managers or their designees must be available for on call services.

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 representatives and employees of members participating in the Participant Directed Services Option are required to submit to a state criminal background check. DAIL will conduct annual certifications of non-licensed waiver providers. During the annual 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 and employee records are reviewed to ensure compliance. State laws and regulations governing are KRS 209 and 620, 902 KAR 20:080 and 907 KAR 1:160 and the incorporated program manual.

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 the Participant Directed Services Option non-medical waiver services are required to submit to screening through a State-maintained abuse registry. DMS or DAIL conduct annual recertification of non-licensed waiver providers. During the recertification, employee records are reviewed for this check. Licensed providers are inspected annually by the Office of Inspector General and employee records are reviewed to ensure compliance. State laws and regulations governing are KRS 209 and 620, 902 KAR 20:080 and 907 KAR 1:160 and the incorporated program manual.

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 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.

If the participant chooses a legally responsible individual to provide this service. The member choice is documented in the client file and retained by the PDC Agency. Documentation of services provided shall be submitted to the PDC Agency. The participant/representative shall sign the employees timesheet verifying the accuracy of the time reported. The Participant Directed Coordinator 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.*

Under no circumstances may a legal guardian or an immediate family member provide traditional waiver services. Immediate family member is defined according to KRS 205.8451 as: a parent, grandparent, spouse, child, stepchild, father-in-law, mother-in-law, son-in-law, daughter-in-law, sibling, brother-in-law, sister-in-law, or grandchild.

For participant directed services, the PDC provider only pays for services specified in the Service Plan, and monitors the provision of these services. These services may be participant directed and provided by a friend, family member or other person hired by the participant. A family member living in the home of the waiver recipient may be hired by the participant to provide supports only in specific circumstances including:

- Lack of a qualified provider in remote areas of the state; or
- Lack of a qualified provider who can furnish services at necessary times and places; or
- The family member or guardian has unique abilities necessary to meet the needs of the person; and
- Service must be one that the family member doesn't ordinarily provide.

In addition, in order for a legally responsible individual to provide paid services the following must also apply. 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.

- 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.

If one or more of the above specific circumstances is met for a family member to provide services, the following conditions and situations must also be met:

- Family member must have the skills, abilities, and meet provider qualifications to provide the service;
- Service delivery must be cost effective;
- The use of the family member must be age and developmentally appropriate;
- The use of the family member as a paid provider must enable the person to learn and adapt to different people and form new relationships;
- The participant must be learning skills for increased independence; and
- Having a family member as staff:
 - i. Truly reflects the persons wishes and desires,
 - ii. Increases the persons quality of life in measurable ways,
 - iii. Increases the persons level of independence,
 - iv. Increases the persons choices, and
 - v. Increases access to the amount of service hours for needed supports.

- 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.

- 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 individual or entity that meets provider qualifications. A potential provider may make application by contacting provider enrollment through a toll free number, completing the application process and obtaining an agency license or certification. These provider enrollment forms are also accessible through Internet web access.

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:

Number and percent of providers who meet certification requirements prior to the furnishing of waiver services. N= Number of providers who meet certification requirements prior to furnishing services D= Number of providers

Data Source (Select one):

On-site observations, interviews, 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 type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input 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: QIO, 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 style="width: 100%; height: 20px;" type="text"/>	
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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: QIO	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

Performance Measure:

Number and percent providers with a corrective action plan completed within the required time frame. N=Number of providers required to complete a corrective action plan D=Number of providers

Data Source (Select one):

Reports to State Medicaid Agency on delegated

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 type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input 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%; height: 20px;" type="text"/>
<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%; height: 20px;" type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>
	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" 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: QIO	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of providers with approved corrective action plans have been implemented successfully. N=Number of providers whose approved plan has been implemented D=Number of providers required to have a corrective action plan

Data Source (Select one):

Reports to State Medicaid Agency on delegated

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 type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input 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: QIO	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input 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):

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 type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: QIO	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of providers with no repeat citations at recertification review.

N=Number of providers with with no repeat citations D=Number of providers with citations

Data Source (Select one):

Reports to State Medicaid Agency on delegated

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 checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input 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 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 type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

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

Performance Measure:

Number and percent of OIG licensed waiver providers that meet OIG licensing requirement at review. N=Number of OIG licensed providers meeting requirements D=Number of OIG licensed providers

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 type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input 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 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 type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other	<input checked="" type="checkbox"/> Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Specify: OIG	
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

b. Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

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:

Number and percent of PDS employees complying with personnel requirements. N=Number of PDS employees complying with personnel requirements. D=Number of PDS employees

Data Source (Select one):

Operating agency 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 type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input 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 type="checkbox"/> Other Specify: <input type="text"/>	<input 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 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 type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of meal providers meeting certification requirements. N=Number of meal provider applicants meeting certification requirements D=Number of meal providers applicants

Data Source (Select one):

On-site observations, interviews, 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 type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input 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 type="checkbox"/> Other Specify: <input type="text"/>	<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 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"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. **Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.**

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:

Number and percent of providers with mandatory training completed by staff. N=Number of providers iwth mandatory training completed by staff D=Number of providers

Data Source (Select one):

Training verification records

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 type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input 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: QIO, OIG	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify:	

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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 type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: QIO	<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:

Number and percent of direct service workers employed through participant directed services who received background investigations prior to rendering services.

Data Source (Select one):

On-site observations, interviews, 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 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 checked="" type="checkbox"/> Representative Sample Confidence Interval = According to Raosoft software located at http://www.raosoft.com/samplesize.html A sample size of 370 will provide a 95% confidence level of current waiver population of 9200.
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> Other 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 type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: QIO	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of providers that obtained background investigations on all new employees prior to rendering services.

Data Source (Select one):

On-site observations, interviews, 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 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 checked="" type="checkbox"/> Representative Sample Confidence Interval = According to Raosoft software located at http://www.raosoft.com/samplesize.html A sample size of 370 will provide a 95% confidence level of current waiver population of 9200.
<input checked="" type="checkbox"/> Other Specify: QIO, OIG	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify:	

	<input style="width: 90%; height: 20px;" type="text"/>	
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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 type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: QIO	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

Performance Measure:

Number and percent of reviewed agencies that provide case management services in which case managers have successfully completed all required case management training.

Data Source (Select one):

On-site observations, interviews, 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 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 checked="" type="checkbox"/> Representative Sample Confidence Interval = According to Raosoft software located at http://www.raosoft.com/samplesize.html A sample size of 370 will provide a 95% confidence level of current waiver population of 9200.
<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%; height: 20px;" type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>
	<input type="checkbox"/> Other Specify:	

	<input type="text"/>	
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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 type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: QIO	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of provider agencies who completed all required trainings prior to enrollment.

Data Source (Select one):

On-site observations, interviews, 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 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 checked="" type="checkbox"/> Representative Sample Confidence Interval = According to Raosoft software located at http://www.raosoft.com/samplesize.html A sample size of 370 will provide a 95% confidence level of current waiver population of 9200.
<input checked="" type="checkbox"/> Other Specify: QIO	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify:	

	<input style="width: 90%; height: 20px;" 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 type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: QIO	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

Performance Measure:

Number and percent of provider agency staff who completed all required trainings prior to rendering services.

Data Source (Select one):

On-site observations, interviews, 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 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 checked="" type="checkbox"/> Representative Sample Confidence Interval = According to Raosoft software located at http://www.raosoft.com/samplesize.html A sample size of 370 will provide a 95% confidence level of current waiver population of 9200.
<input checked="" type="checkbox"/> Other Specify: QIO, OIG	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%; height: 20px;" type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>
	<input type="checkbox"/> Other Specify:	

	<input style="width: 100%; height: 20px;" 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 type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: QIO	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" 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. The State currently verifies that 100% of all HCB waiver providers are qualified and licensed prior to rendering services. Providers who have completed the OIG process to receive a license are eligible to become a Medicaid provider. The States OIG monitors and re-licenses them on a yearly basis. If a providers license is revoked, DMS is notified by the OIG. The Department for Aging and Independent Living certifies the non-licensed providers. The State does not contract with non-licensed or non-certified providers. The State implements its policies and procedures and provides for training as needed related to policy changes through letters, DMS website or by attending the various associations of each of the provider entities.

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.

If the Provider Agency has not provided or ensured training of their employees, then the provider is informed that unless training is completed, their paid claims will be recouped and any new admissions will not be allowed until training is completed and a corrective action plan is accepted and implemented to prevent the occurrence from happening in the future. Should OIG revoke a Provider Agency's license, then new placement is found for the participants in order to prevent any loss of services.

DAIL performs trainings upon request of providers and provides technical assistance daily and on an on-going basis. Should an enrolled certified provider not meet requirements to provide services, DAIL would recommend termination of the provider to DMS.

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"/> 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: QIO, Fiscal Agent	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	<input type="checkbox"/> Other Specify: <input data-bbox="863 275 1323 331" 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 Qualified Providers that are currently non-operational.

- No**
 Yes

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

Appendix C: Participant Services**C-3: Waiver Services Specifications**

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services**C-4: Additional Limits on Amount of Waiver Services**

- a. Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- Not applicable-** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
 Applicable - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

- Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

- Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

- Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCBS Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

This waiver does not include residential settings. All services with the exception of adult day health are provided in the participants or family's own home, either privately owned or leased, including senior retirement communities.

Minor changes are needed to ensure adult day health care facilities meet compliance with the new CFR. Currently, not all Kentucky providers comply with the federal HCBS setting requirements. Kentucky developed an extensive plan to assure that providers will comply with these requirements in the near future, which is included in the transition plan and can be found in Attachment Two of the Main Application.

Kentucky currently monitors all providers consistently throughout the year. Once the state regulations become effective, the evaluation tools will be updated to include the federal HCBS setting requirements. Providers will be held to these standards moving forward.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Service Plan

- a. Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

- Registered nurse, licensed to practice in the State**
- Licensed practical or vocational nurse, acting within the scope of practice under State law**
- Licensed physician (M.D. or D.O)**
- Case Manager** (qualifications specified in Appendix C-1/C-3)
- Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

- Social Worker**

Specify qualifications:

A Master's Degree from an accredited college or university

- Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

- b. Service Plan Development Safeguards.***Select one:*

- Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

- **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

- c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Kentucky will require a person centered approach to services. A description and the expectations for person centered planning process will be provided to each participant and/or their family or guardian during the initial assessment period. In preparation for the service plan development the assessor will share waiver service and certified provider information. The assessor will also describe the option of participant directed services including the importance of the employer responsibilities if PDS is chosen as an option.

The assessor will work with the participant to identify family or other individuals or entities that can assist in keeping the participant at home. Those identified will be invited to the service plan meeting at a time convenient for the participant and other team members.

The members service plan is developed utilizing the Kentucky Home Assessment Tool (K-HAT). The service plan shall include all identified needs from the assessment as well as identify goals, objectives/interventions and outcomes. The service plan is developed utilizing a person centered approach with the participation of the member and/or guardian as well as their identified circle of support, including current or potential providers. All individuals participating in the development of the service plan must sign the document to indicate their involvement.

It is the responsibility of the assessor and the case manager to provide detailed information to the member regarding available waiver services and providers to meet the identified needs. The independent assessor shall utilize a person centered planning process in the development of the plan. The member is free to choose from the listing of available waiver providers for identified services.

All service plans are reviewed and requested services prior authorized through the QIO. When service plan are submitted to the QIO a copy of the completed assessment is included in the packet. The QIO is responsible for review of the assessment ensuring all identified needs are included and adequately addressed in the service plan. If through the prior authorization process, it is determined that identified needs are not addressed in the service plan, the QIO will issue written notification to the independent assessor requiring additional information as to how these needs will be addressed.

The state regulations include the members or guardians freedom of choice of service providers as well, as participation in the development of the service plan. The member or guardian shall sign the service plan indicating their participation in the development. The provider is required to ensure the member has been informed of their rights to choose provider agencies and the individual employees of that agency. This documentation is maintained in the clients file by the case manager.

The service plan shall be updated at least every twelve (12) months and as often as necessary to address changes in the member's needs.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

- d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Kentucky will begin a phase-in of the Kentucky Home Assessment Tool K-HAT. The K-HAT includes information about the member's support needs in the areas of daily living at home and in the community, health and safety, caregiver support, behavioral,

and medical needs. DAIL staff will be trained to conduct the K-HAT tool which is a validated tool adapted from Wisconsin. The K-HAT screens for overall health risk related to disability and aging, and provides the assessor and person centered planning team guidance in determining the persons plan of care. The K-HAT will be conducted statewide on the plan renewal date.

The service plan shall include all identified needs from the assessment and will be developed with the participation of the member and/or guardian as well as their identified circle of support. All individuals participating in the development of the service plan must sign the document to indicate their involvement. It is the responsibility of the independent assessor to provide detailed information to the member regarding available waiver services and providers to meet the identified needs. The member is free to choose from the listing of available waiver providers as well as identified services.

All service plans are reviewed and requested services prior authorized through the QIO entity contracted by Medicaid through the fiscal agent. When POCs are submitted, the completed assessment is included in the packet. The QIO is responsible for review of the assessment ensuring all identified needs are included and adequately addressed in the service plan. If through the prior authorization process, it is determined that identified needs are not addressed in the service plan, the QIO will issue written notification to the assessor requiring additional information as to how these needs will be addressed.

The member's case manager is responsible for the coordination and monitoring all of the member's services including non-waiver services. The case manager shall conduct contacts at least monthly to make arrangements for activities which ensure the supports and services desired and needed by the member are identified and implemented; appointments and meetings are scheduled; a person-centered approach to planning is provided; informal and community supports are utilized; the quality of the supports and services as well as the health and safety of the individual are monitored; income/benefits are coordinated; activities are documented; and plans of supports/services are reviewed at least annually and at such intervals as are indicated during planning.

The service plan shall be updated at least every twelve (12) months and as often as necessary to address changes in the member's needs. Any changes in the members needs shall be identified by the case manager during the monthly contact. All modifications to a service plan must be conducted by the DAIL independent assessor.

All service plan requirements shall be contained in the state regulation and manual governing the waiver program.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

- e. Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Potential risks to the member are identified during the assessment/reassessment process. All health, safety and welfare risks are required to be identified and addressed on the service plan. Providers are required to have agency emergency plans and person specific crisis and safety plans based on individual needs. The QIO reviews the submitted assessment and service plan ensuring all identified risks are appropriately addressed. If the QIO determines an identified risk has not been addressed in the service plan, the QIO will issue written notification to the independent assessor requiring additional information as to how these risks will be addressed. Assessor and Case management training will provide education about this expectation.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

- f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Both the Independent Assessor and the members case manager are responsible for notification of available waiver service providers. Documentation of this notification is required to be maintained within the members chart and shall contain the member or guardians signed acknowledgement.

The assessor and case manager are responsible for assisting the member in choosing his or her providers of services specified in the service plan. This assistance may include telephonic or on-site visits with members and their families, assisting them in accessing the provider listing, answering questions about providers, and informing them of web-based provider profiles.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The assessor submits a service packet to the QIO for a medical necessity review. Services are authorized or denied based on the presentation of the information in the packet. The packet consists of the assessment tool, LTC Facilities and HCB Program Certification Form, Freedom of Choice Form, Signed Physician Order, and the Service Plan/Prior Authorization for Waiver Services. The QIO reviews all information prior to issuing a determination and prior authorizations.

QIO will perform first line monitoring of ADHCs and HHs only and DMS will perform second line for ADHCs and HH's. DAIL will perform first line monitoring for certified providers. Monitoring the service plans include ensuring all needs of the members are met by appropriate interventions or services. This includes monitoring and coordinating non-waiver services reflected in the service plan.

The QIO submits a packet to DMS which entails which members chart was reviewed and if the submission of the forms and the services requested were appropriate by using a detailed monitoring report. If services are not appropriate, the QIO may reflect in the report that a Corrective Action Plan (CAP) is needed. DMS issues the report to the enrolled provider and requests a CAP, if needed. The enrolled provider submits a CAP to DMS with supporting evidence of the implementation of the corrective action.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

- h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- Every three months or more frequently when necessary
- Every six months or more frequently when necessary
- Every twelve months or more frequently when necessary
- Other schedule

Specify the other schedule:

- i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

- Medicaid agency
- Operating agency
- Case manager
- Other

Specify:

Quality Improvement Organization (QIO) and Independent Assessor Agency

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

- a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The Independent Assessors are responsible for the initial service plan development during the assessment/reassessment process. The Independent Assessor shall be:

1) RN currently licensed as defined in KRS 314.011(5), and who has two (2) years or more experience as a professional nurse in the field of aging or disabilities; OR

2) A Master's degree in Health or Human services from an accredited college or university; AND

3) Shall be supervised by an individual who meets all assessor qualifications and who shall have four years or more working with individuals who are elderly or disabled.

Case managers shall have on-going responsibility for monitoring and requesting modifications to the service plan as needed. Case managers shall have intensive knowledge of the member, family and the community and may request the assessor to modify the plan of care as needed and as approved by the QIO. Case Managers are not allowed to provide other direct services to the participant. The service plan is developed utilizing person centered principles via a meeting with the participant and others who the

participant wishes to participate.

Service planning results in the development of a plan of care that reflects the needs of the member; list interventions and services as related to the members identified needs; be in place prior to the provision of services; specify the services needed by the member; determine the amount, frequency, and duration of services; contain provisions for reassessment at least every twelve (12) months; have input from other persons which may include other professionals and home health aides. During this process the member's freedom of choice in selecting providers is ensured.

During the initial assessment period and again in the service plan process the member or their representative such as their family, guardian, or primary caregiver, is given a list of the providers in their area from which they can choose to provide their services. The service plan lists all of the providers, their provider number, address, and phone number of the provider which the member has chosen to provide their services. The Home and Community Based Waiver Services, Selection of Provider Form is designed to be an instrument that is utilized:

1. To allow the HCB Waiver member the freedom to select whom will provide reassessment and/or case management services;
2. To document which provider is chosen to provide conflict-free case management services;
3. To allow, at any time, the HCB Waiver member the freedom to make changes to whom will provide the reassessment and/or case management services; and
4. By the PRO (QIO) to maintain a record of selected (current) providers.

The Independent Assessor performs the assessment or reassessment and then submits the information to the QIO for the final level of care determination. If the participant is determined to meet the level of care, the Independent Assessor will develop the service plan using the information obtained in the assessment and the information gathered from those who the participant requests to attend the service plan meeting. The information is then faxed to the QIO for completion of the process and prior authorizes the services requested. Once approved the member will choose a case management entity. Should a member experience a hospitalization, rehabilitation in a nursing facility, changes in their current life such as death of caregiver, etc., then a modification to the current plan of care will be requested to the Independent Assessor by the case manager. A modification will be requested should a member need an increase or decrease in services, or a change in the primary caregiver and is submitted to the QIO for medical review and prior authorization of services.

The case manager is responsible for education, referral, and coordinating community resources to meet the needs of members by:

1. Ensuring all activities documented meet the service definitions of the approved waiver;
2. Ensuring the services are provided in accordance with approved POC; and
3. Ensuring participants are involved in the care planning process.

Monitoring of the service plan is completed by either the QIO or DAIL for all enrolled providers by using a sample of the members served in this waiver. The reviews are conducted to determine the appropriateness and adequacy of the services and to ensure that the services furnished are consistent with the nature and severity of the individuals disability. The minimum schedule under which these reviews occur is every twelve months.

Prompt follow-up, remediation of problems, methods for systematic collection/compilation of monitoring results and how issues are reported to the State are as follows:

Require providers to adhere to state-mandated reporting laws. Waiver providers are mandatory reporters under State Statute.

Require providers to train all staff in the prevention, identification, and reporting of abuse, neglect and exploitation.

Require providers to develop an incident report form and a process for investigation, communication, and prevention of incidents.

Monitor the procedure providers have implemented to ensure the reporting of all incidents. QIO Monitoring Staff review all incident reports that have occurred during the time period that is being monitored.

Require providers to have a complaint process in place and to educate waiver members, family members and legal representatives regarding this process.

Monitor the complaint process by examining complaint logs and the results of client satisfaction surveys.

Require providers to develop a contingency plan for emergencies and to accommodate a back-up when usual care is unavailable.

Renewing and monitoring providers contingency plans by on-site monitoring and results of client satisfaction surveys.

Reviewing results of on-site monitoring data and corrective action plans. This is done by an internal Quality Assurance Team comprised of State Medicaid Agency clinical and program staff.

Ensure that waiver participants have access to case management staff and know their case managers name and how to contact their case manager.

Require providers to make the toll-free Fraud and Abuse Hotline telephone number of the Office of Inspector General available to the waiver provider agency staff, waiver participants, and other interested parties. The purpose of this telephone Hotline is to enable complaints or other concerns to be reported to the Office of Inspector General.

Require providers to deliver at least one case management contact per month to assess waiver members and service delivery. At least one-half of the contacts must be face-to-face.

Monitor the case management contacts when reviewing documentation in the waiver members medical record and making sure changes are reflected in the members service plan.

b. Monitoring Safeguards. *Select one:*

- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

- a. Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.**

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:

Number and percent of reviewed service plans in which services and supports align with assessed needs of what is important for the person. N=Number of reviewed service plans that align with assessed needs. D=Number of reviewed service plans

Data Source (Select one):

Record reviews, on-site

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 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 checked="" type="checkbox"/> Representative Sample Confidence Interval = According to Raosoft software located at http://www.raosoft.com/samplesize.html A sample size of 370 will provide a 95% confidence level of current waiver population of 9200.
<input type="checkbox"/> Other Specify: <input type="text"/>	<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 type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: QIO	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of reviewed service plans that reflect personal goals and preferences of what is important to the person. N=Number of reviewed service plans that reflect personal goals D=Number of reviewed service plans

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 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 checked="" type="checkbox"/> Representative Sample Confidence Interval = According to Raosoft software located at http://www.raosoft.com/samplesize.html A sample size of 370 will provide a 95% confidence level of current waiver population of 9200.
<input checked="" type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input 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 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: QIO	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

b. *Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.*

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:

Number and percent of service plan development activities that are completed as described in the waiver application for reviewed service plans. N=Number of reviewed service plans completed as described in the waiver application. D=Number of reviewed service plans

Data Source (Select one):

Record reviews, on-site

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 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 checked="" type="checkbox"/> Representative Sample Confidence Interval = According to Raosoft software located at http://www.raosoft.com/samplesize.html A sample size of 370 will provide a 95% confidence level of current waiver population of 9200.
<input checked="" type="checkbox"/> Other Specify: 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 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: QIO	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- c. **Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.**

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:

Number and percent of reviewed service plans indicating appropriate change in service related to documented change in need. N=Number of reviewed service plans indicating change in service due to change in need D=Number of reviewed service plans

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 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 checked="" type="checkbox"/> Representative Sample Confidence Interval = According to Raosoft software located at http://www.raosoft.com/samplesize.html A sample size of 370 will provide a 95% confidence level of current waiver population of 9200.
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input 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 <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<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: QIO, Fiscal Agent	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of service plans revised at least annually. N=Number of service plans revised annually D=Number of participants in waiver for a one year review period.

Data Source (Select one):

Record reviews, on-site

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 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 checked="" type="checkbox"/> Representative Sample Confidence Interval = According to Raosoft software located at http://www.raosoft.com/samplesize.html A sample size of 370 will provide a 95% confidence level of current waiver population of 9200.
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input 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>

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input 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: QIO	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- d. *Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.*

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:

Number and percent of providers demonstrating services are delivered in accordance with the reviewed service plans including the type, scope, amount, duration and frequency. N= Number of providers delivering services in accordance with the reviewed service plan D= Number of providers delivering services for reviewed service plans

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 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 checked="" type="checkbox"/> Representative Sample Confidence Interval = According to Raosoft software located at http://www.raosoft.com/samplesize.html A sample size of 370 will provide a 95% confidence level of current waiver population of 9200.
<input checked="" type="checkbox"/> Other Specify: OIG, QIO	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

		<input type="text"/>
	<input 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 type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- e. **Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.**

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:

Number and percent of waiver participant records reviewed with an appropriately completed and signed freedom of choice form that specifies choice was offered between/among waiver services and providers. N=Number of waiver records reviewed containing signed freedom of choice forms. D= Number of records reviewed

Data Source (Select one):

Record reviews, off-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 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 checked="" type="checkbox"/> Representative Sample Confidence Interval = According to Raosoft software located at http://www.raosoft.com/samplesize.html A sample size of 370 will provide a 95% confidence level of current waiver population of 9200.
<input checked="" type="checkbox"/> Other Specify: QIO, Fiscal Agent	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input 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 type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: QIO, Fiscal Agent	<input checked="" type="checkbox"/> Annually
	<input 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. If the QIO determines an identified risk noted on the assessment has not been addressed on the service plan, the QIO will issue written notification to the provider requiring additional information as to how these risks will be addressed.

QIO will perform first line monitoring and DMS performs second line monitoring of licensed agencies. QIO will monitor a random sample of 50% of HCBW home health agencies and 30% of adult day health care agencies. DMS will monitor 10% of all licensed agencies that QIO monitored.

DAIL performs first line monitoring of the HCB certified providers and DMS performs second line monitoring of the certified HCB providers which consist of 10% of enrolled certified active providers on a yearly basis.

Monitoring the service plan includes ensuring all needs are met by appropriate interventions with specific goals, and outcomes.

If services are not appropriate, DMS will request in the report that a Corrective Action Plan (CAP) is required. The enrolled provider submits a CAP with supporting evidence of the implementation of the corrective action.

A follow-up survey/review may be performed after DMS's acceptance of the providers CAP to determine whether the corrective action plan submitted to DMS has been implemented.

Identified individual problems are researched and addressed by the Division Director and Medicaid staff. This may involve Medicaid staff to conduct an on-site agency review, and/or a home visit with the waiver member and caregiver(s). Issues may require a policy clarification.

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.

The State receives a Utilization Management report showing the number of service plans received, the number returned for lack of information, the number of service plans corrected and returned in timely manner, the number not returned in a timely manner. DMS is able to request corrective action plans from the QIO if a service plan is approved, but does not meet requirements and is found during the 2nd line monitoring provided by DMS.

- ii. **Remediation Data Aggregation**

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

Responsible Party <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 checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Fiscal Agent, QIO, DAIL	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other 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 Service Plans that are currently non-operational.

- No
- Yes

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request):*

- Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested (*select one*):

- Yes. The State requests that this waiver be considered for Independence Plus designation.
- No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

- a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Participant directed supports facilitate independence while decreasing the need for human assistance for individuals residing in their own home or the home of their family member. The supports include assistance, support (including reminding, observing, and/or guiding) and/or training in activities such as meal preparation; laundry; routine household care and maintenance; activities of daily living as such as bathing, eating, dressing, personal hygiene, reminding, observing, medication management (not to include administration of medication); non-medical care (not requiring a nurse or physician intervention); respite; socialization, and participation in generic community activities. These supports are based upon therapeutic goals.

As a participant in PDS Option, members or their representative must have the ability to fulfill the employer (paperwork, timesheets, supervision of employees, oversight, training) responsibilities of the program. The participant must be capable and willing to assume the Rights, Risks and Responsibilities of serving as an employer. Employees and Representatives must pass all applicable background checks. Employees must meet the same requirements as traditional providers.

Home and Community Support, goods and services, environmental and minor home adaptations and respite services may be participant directed and provided by a friend, neighbor or individual person hired by the participant.

Neither participant directed services or traditional services can replace the natural support system. Natural Supports are defined as a non-paid person, persons, or community resource, which can provide, or has historically provided assistance to the consumer or due to the familial relationship, would be expected to provide assistance. In addition, providers for these services must be listed on the service plan.

Immediate family members may serve as employees if it does not replace the natural support system as defined above and the family member meets requirements as defined under provider specifications in Appendix C. Immediate family member is defined in KRS 205.8451 (3).

Participant Directed Coordination (PDC) is one service that covers all fiscal and service support components of PDS. The member choice is documented in the client file and retained by the PDC agency.

Documentation of services provided shall be submitted by the employer to the PDC agency. Participants in the PDS Option must have the ability to meet the requirements and responsibilities of the program as an employer. As such, timesheets are the responsibility of the employer/participant. The participant, representative, or relative/guardian acting as the employer must submit an accurate time sheet to the PDC agency. The PDC agency submits claims to the MMIS for payment of services and reimburses the employee. The member/representative shall sign the employee's timesheet verifying the accuracy of the time reported. Incorrect timesheets submitted by the employer will not be paid until such time as a correct timesheet is submitted and a new payroll run is conducted by the fiscal agent within the PDC Agency. Both the employer and PDC advisor are responsible for monitoring service provision.

Goods and services shall include purchases of goods which must be individualized and may be utilized to reduce the need for personal care or enhance the independence within the home or community of the member. As a Medicaid funded service, this definition will not cover experimental goods and services inclusive of items which may be defined as restrictive under G.S. 122C-60. Individuals shall not receive these services through both traditional and participant directed supports.

A member may receive a combination of participant directed and traditional waiver services providing duplication of services does not occur. Services shall be deemed necessary if the service is indicated based on the independent assessment, is listed on the plan of care and prior authorized. Payment for these services shall not exceed the unit rate as set by Medicaid.

Both the PDC Advisor and Independent Assessor are responsible for educating members regarding participant directed opportunities. Assessors during the initial assessment and reassessment and PDC will meet with members to: detail the participant directed service options; determine ability of the participant or representative to assume the responsibilities as an employer, provide guidance regarding employee recruitment and hiring procedures; develop the new service plan to include participant directed services; establish the members budget allowance; and, assist the member with any other question they may have regarding participant direction.

A monthly contact is required between the PDC advisor and the member and members representative (if applicable) to ensure the members needs are being met in appropriate manner and to monitor health, safety and welfare.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one:*

- Participant: Employer Authority.** As specified in *Appendix E-2, Item a*, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- Participant: Budget Authority.** As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- Both Authorities.** The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

- Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy (*select one*):

- Waiver is designed to support only individuals who want to direct their services.**
- The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

As a participant in the PDS Option, participants must have the ability to meet the requirements and responsibilities of the program as an employer. Employer responsibilities include oversight of the plan of care, training, and supervision, hiring and firing of employees, the ability to communicate with the case manager and participant, and the ability to complete all paperwork, including timesheets, accurately and in a timely manner and meeting all requirements of the program. The participant or representative must be capable of understanding documents and forms and have the ability to have a general understanding of federal and state employer responsibilities such as the purpose of a federal employer identification number (FEIN).

If monitoring activities reflect the member's needs are not being met in accordance with the approved service plan and/or the participant or representative cannot accurately meet the requirements of serving as an employer, the PDC service advisor will work with the consumer or the designated representative to resolve the issues and develop a corrective action plan. The PDC service advisor will monitor the progress of the corrective action plan and resulting outcomes. If the member is unable to resolve the issue, or unable to develop and implement a corrective action plan within sixty (60) days of identification of the issue, the PDC service advisor will proceed with withdrawal of the PDS Option. The participant will be provided with written information regarding the traditional program and available providers and will be given thirty (30) days to obtain a traditional provider. The PDC service advisor shall document the reason for the PDS option withdrawal, actions taken to assist the

member to develop a prevention plan and the outcomes. If the participant cannot obtain a willing traditional provider within the thirty (30) day timeframe, the participant will be terminated from the waiver and provided with the right to a hearing.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

- e. Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

The Independent Assessors and Conflict Free Case Managers are required to provide information about participant directed opportunities to the waiver members at the time of initial assessment, each reassessment and at any point of member or guardian inquiry. Waiver participants will be provided a brochure outlining the benefits of the PDS Option at the time of entry into the waiver and at each reassessment. Potential PDS Option participants will also be fully informed of the Rights, Risks and Responsibilities of serving as an employer in the PDS Option. Participants or their representatives will be required to document their understanding of the responsibilities by signing the Rights, Risks and Responsibilities Form. PDC service advisor will assist the participant in determining if they have the time and capability to serve as an employer and make a determination if the participant meets the criteria to receive services in the PDS Option.

If the participant chooses the PDS Option, the assessor or current case manager will forward the current assessment and service plan to the PDC service advisor which serves as notification for the PDS Option agency to contact the member (if the member has not made initial contact). At that time the PDS Option agency will schedule a face-to-face visit with the member and/or guardian to provide detailed information regarding the participant direction opportunities available through the waiver program.

The Department for Aging and Independent Living (DAIL) and the Department for Medicaid Services (DMS) monitor the PDS Option agencies to ensure timely contacts are conducted.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

- f. Participant Direction by a Representative.** Specify the State's policy concerning the direction of waiver services by a representative (*select one*):

- The State does not provide for the direction of waiver services by a representative.**
 The State provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: (*check each that applies*):

- Waiver services may be directed by a legal representative of the participant.**
 Waiver services may be directed by a non-legal representative freely chosen by an adult participant.

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

A non-legal or legal representative may be freely chosen by an adult waiver member to direct waiver services. However, the representative may not be hired as an employee to provide any of the directed waiver services. The representative must undergo the same background check as identified for employees. The representative may not be an immediate family member of any employee. The PDC agency is responsible for monitoring the member's service plan and ensuring needed services are being appropriately provided to the member.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

- g. Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Home and Community Supports	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Goods and Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Environmental and Minor Home Adaptation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Non-Specialized Respite		

Waiver Service	Employer Authority	Budget Authority
	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

- Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

Governmental entities

Private entities

- No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

- FMS are covered as the waiver service specified in Appendix C-1/C-3**

**The waiver service entitled:
Participant Directed Coordination**

- FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

FMS as a component of Participant Directed Coordination (PDC) service can be provided by PDS Care Coordination Agencies that have been certified by DAIL. Certification can be provided to licensed home health agencies, public health departments, Area Agencies on Aging, Centers for Independent Living and licensed adult day centers. PDC includes service advice, information, education and referral, fiscal management and oversight of PDS services.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The Department for Medicaid Services (DMS) compensates PDS Care Coordination providers based on a specified rate of \$325 per eligible member per month for a unit of service which includes monthly face to face contact, case management, fiscal management, education and information, monitoring and oversight.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies):*

Supports furnished when the participant is the employer of direct support workers:

- Assist participant in verifying support worker citizenship status**
 Collect and process timesheets of support workers
 Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
 Other

Specify:

Supports furnished when the participant exercises budget authority:

- Maintain a separate account for each participant's participant-directed budget**

- Track and report participant funds, disbursements and the balance of participant funds**
- Process and pay invoices for goods and services approved in the service plan**
- Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- Other services and supports**

Specify:

Additional functions/activities:

- Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

All financial management services (FMS) are included in PDC agencies and are subject to an annual on-site review by the Department for Aging and Independent Living. This review shall include audits of submitted timesheets and supporting documentation against any payments issued to employees by the FMS. The audit shall identify any deficiencies and require a corrective action plan from the FMS. Member satisfaction surveys shall be conducted annually (at a minimum) and those survey results will be utilized to address and resolve FMS issues.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

- Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Case managers for traditional services will be trained in answering questions regarding PDS for participants who are receiving blended services or who may wish to start PDS services.

On-going information and assistance is provided by the PDC service advisor through PDS Care Coordination and is an on-going component.

A monthly contact is required between the PDC service advisor and the member and members representative (if applicable) to ensure the members needs are being met in appropriate manner and to monitor health, safety and welfare.

- Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service Information and Assistance Provided through this Waiver Service Coverage	
Adult Day Health	<input type="checkbox"/>
Specialized Respite	

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
	<input type="checkbox"/>
Home Delivered Meals	<input type="checkbox"/>
Participant Directed Coordination	<input checked="" type="checkbox"/>
Home and Community Supports	<input type="checkbox"/>
Goods and Services	<input type="checkbox"/>
Attendant Care	<input type="checkbox"/>
Environmental and Minor Home Adaptation	<input type="checkbox"/>
Conflict Free Case Management	<input checked="" type="checkbox"/>
Non-Specialized Respite	<input type="checkbox"/>

Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

The assessors hired through the Department for Aging and Independent Living as the operating entity are responsible for the initial education of members regarding participant directed opportunities and the responsibilities of the participant and/or representative as an employer. The assessor will meet with the members and the person centered team to detail the participant directed service options; modify the Plan of Care to include participant directed services; establish the member’s roles and responsibilities; and, assist the member with any other question they may have regarding participant direction. This information is provided as a component of the assessment process.

DAIL is compensated under an administrative contract with DMS. DMS is responsible for oversight of DAIL through random sampling of cases. Participants will sign documentation stating they have been made aware of the PDS option. The document must be kept in the participant's case file.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

- No. Arrangements have not been made for independent advocacy.**
- Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

A member may voluntarily dis-enroll from the participant direction opportunities at any time. The PDC service advisor shall begin to assist the member and/or guardian within one (1) business day of the requested termination in order to assist the member in locating traditional waiver service providers of their choice. The PDS Option case manager will continue working with the member and/or guardian and current employees until a traditional provider is located and services are started to ensure there is no gap in service provision.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

- m. Involuntary Termination of Participant Direction.** Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

The PDC service advisor for the PDS Option monitors all services provided for the participant and ensures that the health and welfare of participant is guarded.

If the PDC service advisor feels that the participant is in immediate danger or the health, safety and welfare of the participant is at risk, the PDC service advisor will immediately assist the participant in transferring the participant to a qualified traditional waiver provider, and notify DAIL of the transfer. In addition, the PDC service advisor shall immediately notify appropriate agencies and authorities regarding any suspected abuse, safety or neglect allegations.

If the PDS Option participant, employee or representative has exhibited abusive, intimidating or threatening behavior, the PDC service advisor will work with the consumer or the designated representative to discuss the issue and develop a corrective action plan. The PDC service advisor will monitor the progress of the corrective action plan. If the member is unable or unwilling to resolve the issue, the PDC service advisor will request DAIL to proceed with involuntary termination of the PDS option. If DAIL approved, the participant will be provided by the PDC service advisor with written information regarding the traditional program and available traditional providers and will be given thirty (30) days to obtain a traditional provider. The PDC service advisor shall document the reason for the termination, actions taken to assist the member to develop a corrective action plan and the outcomes. If the participant cannot obtain a willing traditional provider within the thirty (30) day timeframe, the participant will be terminated from the waiver and provided with the right to a hearing. If the participant has been terminated from a traditional service provider due to any of the above listed behaviors, the participant shall not be approved to be served under the participant directed services option.

If monitoring activities reflect the participant's needs are not being met in accordance with the approved service plan and/or the funds in the individualized budget are not being utilized according to program criteria and/or the participant or representative fail to fulfill the duties of their requirements as an employer, the PDC service advisor will work with the consumer or the designated representative to resolve the issues and develop a corrective action plan. The PDC service advisor will monitor the progress of the corrective action plan and resulting outcomes. If the member is unable to resolve the issue, or unable to develop and implement a corrective action plan within sixty (60) days of identification of the issue, the PDC service advisor will request approval from DAIL to proceed with involuntary termination of the PDS option. If approved, the participant will be provided by the PDC service advisor with written information regarding the traditional program and available providers and will be given thirty (30) days to obtain a traditional provider. The PDC service advisor shall document the reason for the PDS option withdrawal, actions taken to assist the member to develop a corrective action plan and the outcomes. If the participant cannot obtain a willing traditional provider within the thirty (30) day timeframe, the participant will be terminated from the waiver.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

- n. Goals for Participant Direction.** In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

Waiver Year	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
	Number of Participants	Number of Participants
Year 1		3006
Year 2		3264
Year 3		3523
Year 4		3781
Year 5		4039

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

- a. Participant - Employer Authority** Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both:*

- Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

- Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

- Recruit staff**
 Refer staff to agency for hiring (co-employer)
 Select staff from worker registry
 Hire staff common law employer
 Verify staff qualifications
 Obtain criminal history and/or background investigation of staff

Specify how the costs of such investigations are compensated:

The participant, as the employer, is responsible for the cost of obtaining criminal background checks, drug testing and all cost associated with training.

- Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
 Determine staff duties consistent with the service specifications in Appendix C-1/C-3.
 Determine staff wages and benefits subject to State limits
 Schedule staff
 Orient and instruct staff in duties
 Supervise staff
 Evaluate staff performance
 Verify time worked by staff and approve time sheets
 Discharge staff (common law employer)
 Discharge staff from providing services (co-employer)
 Other

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

- Reallocate funds among services included in the budget**
 Determine the amount paid for services within the State's established limits
 Substitute service providers
 Schedule the provision of services

- Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3
- Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3
- Identify service providers and refer for provider enrollment
- Authorize payment for waiver goods and services
- Review and approve provider invoices for services rendered
- Other

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

- ii. **Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

DMS shall establish an individualized budget based on needs as identified in the K-HAT and the QIO shall prior authorize services in the Person-Centered plan of care. The budget can be adjusted as needs change. The participant may negotiate wage rates with employees however the hourly rate shall not exceed the maximum rate listed in the waiver for the service.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

- iii. **Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The independent assessor will inform the participant and the team of the authorized services and total budget amount. At any time, if a participant's needs change, the PDC service advisor shall submit a request to modify the plan of care for approval by the independent assessor and the QIO.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

- iv. **Participant Exercise of Budget Flexibility.** *Select one:*

- Modifications to the participant directed budget must be preceded by a change in the service plan.
- The participant has the authority to modify the services included in the participant directed budget without prior approval.

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

- v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The PDC agency monitors service usage and the budget for each participant. DAIL conducts monitoring reviews of all participants who direct their services and are in contact with the PDC agency as issues arise.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) 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. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

An applicant, recipient or guardian shall be informed of his right to a cabinet level administrative hearing in writing if an adverse action is taken affecting covered services. An applicant, recipient or guardian shall be informed of the method by which he may obtain a hearing and that he may be represented by:

- (a) Legal counsel;
 - (b) A relative;
 - (c) A friend;
 - (d) Other spokesperson;
 - (e) Authorized representative; or
 - (f) Himself.
- (3) The notice shall contain a statement of:
- (a) The Medicaid adverse action;
 - (b) The reason for the action;
 - (c) The specific federal or state law or administrative regulation that supports the action;
 - (d) An explanation of the circumstances under which payment for services shall be continued if a hearing is requested timely.

Reasons for appeals would include denials for level of care, denial for services, eligibility for Medicaid services and reduction in services. Disenrollment from Participant Directed Services Option due to failure to comply with a corrective action plan is not subject to appeal when services and providers under the traditional model are available and willing to serve the recipient.

If the request for a cabinet level administrative hearing is postmarked or received within ten (10) days of the advance notice date of denial specified on the notice for denial of level of care, a Medicaid vendor payment shall continue until the date the final cabinet level hearing decision order is rendered. The denial for services is also sent to the servicing provider to inform them of the denial. The participant may elect to have their Case Manager or even the servicing provider assist them with the appeal process. The cabinet level administrative hearing shall be conducted in-state where the recipient or authorized representative may attend without undue inconvenience. A statement that the local Department for Community Based Services staff regarding the availability of free representation by legal aid or welfare rights organization within the community.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

- a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- No. This Appendix does not apply
- Yes. The State operates an additional dispute resolution process

- b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

DMS provides for a reconsideration process that is operated currently by the QIO. The provider, recipient or guardian acting on behalf of the recipient may file a reconsideration request upon receipt of written notice of a denial of services or level of care. A

written request for reconsideration must be postmarked or submitted to the QIO via facsimile within ten (10) calendar days from the date of the written notice of denial. If the request is postmarked or dated and time stamped by the facsimile service more than ten (10) calendar days from the date of the denial, the request is invalid. A denial may be overturned, upheld, or modified as a result of reconsideration. If the denial is not overturned or if the request for reconsideration is past the ten (10) day time frame, then the recipient can appeal the denial through the Medicaid appeal process and request an Administrative Hearing. The process is as follows:

1. The provider, recipient, or guardian acting on behalf of the recipient may file a reconsideration request up on receipt of written notice of a denial of services or level of care.
2. A written request for reconsideration must be postmarked or submitted to the QIO via facsimile within ten (10) calendar days from the date of the written notice of denial. If the request is postmarked or dated and time-stamped by the facsimile service more than ten (10) calendar days from the date of the denial, the request is invalid. As a result, an out of time frame letter will be generated that indicates that the request for reconsideration was untimely and not valid.
3. The QIO will conduct the reconsideration and render a determination within three (3) calendar days of the request.
4. Within two (2) business days of the reconsideration determination, a letter communicating the decision will be mailed to the recipient (or his/her guardian), attending physician, and provider.

A denial may be overturned, upheld, or modified as a result of a reconsideration.

If the reconsideration determination upholds the original decision to deny service(s) or level of care, the recipient, his/her legal guardian, or his/her representative (authorized in writing) may request an administrative hearing. Administrative hearings are handled by the Hearing and Appeals Branch of the Cabinet for Health and Family Services. For individuals who have a certified level of care and who are receiving services, DMS will pay for continuation of those services through the date a final decision is made, provided that the hearing request is submitted within the specified time frame.

If the reconsideration determination overturns the original decision, a prior authorization will be issued.

If the reconsideration determination modifies a portion of the original decision, the portion of the decision that remains denied may be further disputed by the recipient, his/her legal guardian, or his/her representative (authorized in writing) through an administrative hearing. For the portion of the decision that overturns the original decision, a prior authorization will be issued.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System.*Select one:*

- No. This Appendix does not apply**
- Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

The grievance/complaint system shall be operated by the Department for Aging and Independent Living for certified providers and the Office of the Inspector General (OIG) for Home Health Agencies and Adult Day Health Care Centers that provide services for the HCBS waiver

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Waiver members may register any grievance/complaint regarding a waiver service provision or service providers. The member may contact DMS, DAIL or the OIG who will enter the complaint into a tracking database. The agency will immediately assess the gravity of the grievance/complaint. If a member's health, safety and welfare are in jeopardy, the agency will immediately respond. Other complaints/grievances shall be addressed within five (5) business days. All complaints/grievances are tracked and trended to identify if additional provider trainings should be developed and conducted.

In addition to the agencies grievance/complaint system, each waiver provider shall implement procedures to address member complaints and grievances. The providers are required to educate all members regarding this procedure and provide adequate resolution in a timely manner. The provider grievance and appeals are monitored through on-site surveys, investigations and technical assistance visits.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

- a. Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. *Select one:*

- Yes. The State operates a Critical Event or Incident Reporting and Management Process** (complete Items b through e)
- No. This Appendix does not apply** (do not complete Items b through e)

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

- b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Waiver providers must have procedures in place to ensure that the following is reported in accordance with KRS Chapters 209 or 620:

- 1) Abuse, neglect, or exploitation of an HCB recipient;
- 2) A slip or fall;
- 3) A transportation incident;
- 4) Improper administration of medication;
- 5) A medical complication; or
- 6) An incident caused by the recipient, including:
- 7) Verbal or physical abuse of staff or other recipients;
- 8) Destruction or damage of property; or
- 9) Recipient self-abuse;

A copy of each incident reported is maintained in a central file subject to review by the department during the monitoring process. Providers must implement a process for communicating the incident, the outcome, and the prevention plan to:

- 1) An HCB recipient, family member, or his responsible party; and
- 2) The attending physician, PA, or ARNP.

The provider is to maintain documentation of any communication and ensure documentation is recorded in the HCB recipient case record and signed and dated by the staff member making the entry.

- c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The waiver provider shall have written policies and procedures detailing the processes regarding member rights to be free of abuse, neglect and exploitation. These policies and procedures shall include the process for filing complaints with the provider agencies or the contact information for the Department for Community Based Services (DCBS), Division of Permanency and Protection to initiate an investigation of the complaint. All policies and procedures are to be explained to each member and/or guardian and a copy of the DCBS contact information shall be provided.

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The provider agency shall initiate investigations into incidents and shall report these incidents to DAIL, members guardian and case manager. The provider agency shall include a complete written report of the incident investigation and follow-up in its notification to the agency.

The Department for Community Based Services, Division of Permanency and Protection shall be notified if the incident is involving suspected abuse, neglect, or exploitation in accordance with KRS Chapter 209.

DAIL shall assign Quality Initiative staff to review incident reports within twenty-four hours of receipt. Any issues needing immediate action are investigated and addressed through technical assistance with the provider agency.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Department for Medicaid Services and its contractors conduct monitoring of the providers to ensure waiver policies and procedures are being appropriately implemented. The state incident management system requires waiver providers to complete and submit the required incident report form and have a process in place for investigation, communication and prevention of incidents. Incident reports that are not required to be submitted to the agency or OIG are required to be maintained in the record at the provider site. These are reviewed by DAIL during surveys, monitoring visits and investigations to ensure reporting requirements are all being met. Surveys and monitoring visits are conducted annually.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. Use of Restraints.** (Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)

The State does not permit or prohibits the use of restraints

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

Kentucky recognizes that person-centered thinking and planning is the key to prevention of risk of harm for all recipients. It is the responsibility of all service providers to utilize person centered thinking as a means of crisis prevention.

Kentucky is dedicated to fostering a restraint-free environment in all waiver programs. The use of mechanical restraints, seclusion, manual restraints including any manner of Prone (breast-bone down) or Supine (spine down) restraint is expressly prohibited.

The use of chemical restraint is expressly prohibited. A chemical restraint is the use of a medication either over the counter or prescribed, to temporarily control behavior, restrict movement or the function of an individual and is not a standard treatment for the individuals medical or psychiatric diagnosis.

A psychotropic PRN is a pharmacological intervention defined as the administration of medication for an acute episodic symptom of a person's mental illness or psychiatric condition. It shall be documented by a physician's order which shall include drug, dosage, directions and reason for use. Psychotropic medication is that which is capable of affecting the mind, emotions, and behavior; commonly denoting drugs used in the treatment of mental illnesses. The protocol for use of a psychotropic PRN shall be incorporated into a crisis prevention plan.

The state operating agency-DAIL, is responsible for oversight of the person centered planning process which includes monitoring of case management reports, incident reports, and complaints. The continuous quality improvement process will reveal trends, patterns and remediation necessary to ensure proper implementation of plan of care and participant safety.

State laws, regulations, and policies will be made available to CMS upon request through the Medicaid agency or the operating agency.

The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions.(Select one):

- The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

- The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

- i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

Any interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior must be reviewed and approved on an annual basis by DAIL. State laws, regulations, and policies related to use of restrictive interventions will be made available to CMS upon request through the Medicaid agency or the operating agency.

When an individual's circle of support believes that a right restriction is necessary to maintain health, safety and welfare, the rights restriction must be reviewed and approved by DAIL. DAIL must review sound documentation that less restrictive attempts to teach and support the individual to make an informed choice are not effective. The rights restriction must include a plan to restore the individual's rights and should be reviewed on at least an annual basis.

Utilization of restrictive interventions is monitored as part of individual critical incident review conducted by Regional Nurses in addition to monitoring of incident data trends on each of the following levels: participant, provider, regionally and statewide.

DAIL staff also monitor individual's plan of care implementation and supports as a routine part of their visits to providers. Through this process, DAIL can determine that technical assistance may be needed. This assistance may be provided in a variety of ways, as best suited to the identified issue, to include sharing of information, formal training event or consultation by DAIL staff.

Restrictive measures prohibited include withholding of food or hydration as a means to control or impose calm; access to a legal advocate or ombudsman; access to toilet, bath or shower; deprivation of medical attention or prescribed medications; deprivation of sleep; access to personal belongings; and access to natural supports.

A psychotropic PRN is a pharmacological intervention defined as the administration of medication for an acute episodic symptom of a person's mental illness or psychiatric condition. It shall be documented by a physician's order which shall include drug, dosage, directions and reason for use. Psychotropic medication is that which is capable of affecting the mind, emotions, and behavior; commonly denoting drugs used in the treatment of mental illnesses. The protocol for use of a psychotropic PRN shall be incorporated into a crisis prevention plan.

A chemical restraint is the use of a medication either over the counter or prescribed, to control behavior, restrict movement, or the function of an individual and is not a standard treatment for the individual's medical or psychiatric diagnosis. The use of chemical restraint is never acceptable.

Utilization of restrictive interventions is monitored as part of individual critical incident review conducted by Regional Nurses in addition to monitoring of incident data trends on each of the following levels: participant, provider, regionally and statewide.

- ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The operating agency, DAIL, is responsible for monitoring and overseeing the use of restrictive interventions. At a minimum, rights restrictions are reviewed by DAIL staff members during the provider's monitoring process. In addition, human rights restrictions are reviewed by the program integrity branch through the incident and complaint process. Issues found with rights restrictions through this screening process are referred the waiver branch staff to provide intervention.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

- c. **Use of Seclusion.** (Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)

- The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

Kentucky recognizes that person-centered thinking and planning is the key to prevention of risk of harm for all recipients. It is the responsibility of all service providers to utilize person centered thinking as a means of planning and crisis prevention.

Kentucky is dedicated to fostering a safe and healthy environment in all waiver programs. The use of seclusion including any form of time out is expressly prohibited.

The state operating agency-DAIL, is responsible for oversight of the person centered planning process which includes monitoring of case management reports, incident reports, and complaints; and conducting investigations as necessary. The continuous quality improvement process will reveal trends, patterns and remediation necessary to ensure proper implementation of plan of care and participant health, safety and welfare.

State laws, regulations, and policies will be made available to CMS upon request through the Medicaid agency or the operating agency.

- The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

- i. **Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

- a. **Applicability.** Select one:

- No. This Appendix is not applicable** (do not complete the remaining items)
 Yes. This Appendix applies (complete the remaining items)

- b. **Medication Management and Follow-Up**

- i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

- ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

i. Provider Administration of Medications. *Select one:*

- Not applicable.** *(do not complete the remaining items)*
- Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

- ii. **State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. *Select one of the following:*

- Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record*:

(c) Specify the types of medication errors that providers must *report* to the State:

- Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

- iv. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.
 (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. Sub-Assurances:

- a. **Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.** (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)

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:

Number and percent of critical incident reports of potential abuse, neglect, and exploitation submitted within required timeframe. N= Number of critical incident reports of potential abuse, neglect and exploitation submitted in timeframe D= Number of critical incident reports of potential abuse, neglect and exploitation

Data Source (Select one):

Critical events and incident reports

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 type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input 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 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 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	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of deaths reviewed by a clinical committee to determine if deaths were expected, medically explained or preventable. N=Number of deaths reviewed by a clinical committee D=Number of deaths

Data Source (Select one):

Critical events and incident reports

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 checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input 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 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 type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

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

b. *Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

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:

Number and percent of incidents in which staff training needs were identified. N= Number of incidents where staff training needs were identified D= Percent of incidents

Data Source (Select one):

Critical events and incident reports

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 type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input 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 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 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	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of class 3 incidents in which needed changes were identified. N=Number of class 3 incidents identifying needed changes D=Number of class 3 incidents

Data Source (Select one):

Critical events and incident reports

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 checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input 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 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 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	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. **Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.**

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:

Number and percent of waiver participants with no restrictive interventions including restraints and seclusions reported. N=Number waiver participants with no restrictive interventions reported D=Number of waiver participants

Data Source (Select one):

Critical events and incident reports

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 checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input 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 type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify:	

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

- d. *Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated 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:

Number and percent of reviewed participants who had a physical examination in the last year.
N= Number of participants who had a physical examination in the last year. D= Number of reviewed participants

Data Source (Select one):

Participant/family observation/opinion

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 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 checked="" type="checkbox"/> Representative Sample Confidence Interval = According to Raosoft software located at http://www.raosoft.com/samplesize.html A sample size of 370 will provide a

		95% confidence level of current waiver population of 9200.
<input checked="" type="checkbox"/> Other Specify: QIO	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input 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 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: QIO	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of reviewed participants who had a dental visit last year. N=Number of reviewed participants who had a dental visit within the last year. D=Number of reviewed participants

Data Source (Select one):

Participant/family observation/opinion

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 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 checked="" type="checkbox"/> Representative Sample Confidence Interval = According to Raosoft software located at http://www.raosoft.com/samplesize.html A sample size of 370 will provide a

		95% confidence level of current waiver population of 9200.
<input checked="" type="checkbox"/> Other Specify: QIO	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input 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 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: QIO	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of reviewed charts indicating the participant has had a health risk screening in the past year. N=Number of reviewed charts in which the participant had a health risk screening in the past year D=Number of reviewed charts

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 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 checked="" type="checkbox"/> Representative Sample Confidence Interval = According to Raosoft software located at http://www.raosoft.com/samplesize.html A sample size of 370 will provide a

		95% confidence level of current waiver population of 9200.
<input checked="" type="checkbox"/> Other Specify: QIO	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input 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 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: QIO	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of charts reviewed indicating participants who had a health screening that indicated a need for follow-up had follow-up. N=Number of charts reviewed indicating participants who had a health screening indicating follow-up needs received follow-up
 D=Number of charts reviewed indicating participants who had a health screening indicating follow-up was needed

Data Source (Select one):

Participant/family observation/opinion

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 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 checked="" type="checkbox"/> Representative Sample Confidence Interval = According to Raosoft software located at

		http://www.raosoft.com/samplesize.html A sample size of 370 will provide a 95% confidence level of current waiver population of 9200.
<input checked="" type="checkbox"/> Other Specify: OIG	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input 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 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: QIO	<input checked="" type="checkbox"/> Annually
	<input 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. Licensed provider agencies are reviewed yearly by the OIG which includes the monitoring of the employees records for criminal checks and abuse registry checks. Certified agencies are reviewed by DAIL.

QIO or DAIL performs 1st line monitoring and identifies deficiencies of the HCB waiver provider and DMS or DAIL requires a Corrective Action Plan to address the deficiencies identified. During the surveys, procedures that the providers have implemented to train employees and ensure the health, safety and welfare of participants and all of the incident reports for the time period are reviewed.

The QIO or DAIL monitors the complaint process by examining complaint logs and the results of client satisfaction surveys.

Providers must ensure that waiver participants have access to agency staff and know their case managers name and contact information.

Require providers to make the toll-free Fraud and Abuse Hotline telephone number of the Office of Inspector General available to agency staff, waiver participants and their caregivers or legal representatives, and other interested parties; The purpose of this telephone Hotline is to enable complaints or other concerns to be reported to the Office of Inspector General.

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.

OIG performs annual licensing and routine surveys of the enrolled providers and DAIL performs monitoring and certification of the certified providers. Should an enrolled provider not meet requirements to provide services, OIG would terminate the provider license and DMS would terminate the provider Medicaid enrollment. QIO or DAIL performs 1st line monitoring and audit reviews. Should the documentation for services not be present or forms found as regulated in the 907 KAR 1:160, then paid claims will be recouped and a corrective action plan may be requested.

All documentation concerning the monitoring process for providers is kept for a period of six years.

ii. **Remediation Data Aggregation**

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

Responsible Party <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: QIO,	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other 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 Health and Welfare that are currently non-operational.

- No**
- Yes**

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

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver’s critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state’s waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver’s relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

DMS contracts with the fiscal agent who in turn, contracts with the QIO. DMS currently receives a Utilization Management Review report that is generated by the fiscal agent on a monthly basis which includes Information such as the number of LOC's, service plans approved and denied, services approved and denied. The UM report lists the accomplishments, current activities, and a section for activities in the future called "Looking Ahead". DMS is currently working with the fiscal agent to upgrade the utilization report to include the provider number and member number for members that have changes in the LOC date which effect s the waiver segment in the MMIS due to the Assessments or Recertifications that are late or missed. When the waiver segment date is interrupted, or dates found to not be consecutive, then the provider will not be paid for the dates they are out of compliance with the regulation. Should providers contact DMS inquiring as to why a claim denied, DMS will be able to determine which providers are repeat offenders. Providers can subsequently be contacted as to request Plan of Corrections or possibly terminate providers who continue to be repeat offenders. DMS is also currently working on data bases to include information gathered during the monitoring process of the HCB waiver provider by the QIO. Data analysis will include indicators gathered from the satisfaction survey and participant charts. Analysis of sample data (such as flu vaccines, pneumonia vaccines, etc.) can indicate trends related to quality health care initiatives for the elderly and disabled population.

- ii. **System Improvement Activities**

Responsible Party(<i>check each that applies</i>):	Frequency of Monitoring and Analysis(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Quality Improvement Committee	<input checked="" type="checkbox"/> Annually
<input checked="" type="checkbox"/> Other Specify: QIO, DAIL, Fiscal Agent	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
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b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

Waiver providers are required to conduct satisfaction surveys and revise their Quality Improvement Plan based on the results of the surveys. These are monitored during on site monitoring surveys and during investigations of complaints regarding dissatisfaction or issues with service provision. Providers are required to address any issues identified through Corrective Active Plans (CAP) which are then monitored to ensure implementation of corrective actions.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Through analysis of data obtained from the satisfaction surveys, recommendations for corrective action plans, etc., DMS will modify existing systems and trainings to ensure continuing quality and satisfaction. The DAIL will continuously review all reports to identify changing trends so that proactive modifications may be implemented to ensure continuing quality care. DMS provides policy clarifications to the waiver providers to ensure appropriate implementation of program policy and any revisions as they occur.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DMS, directly or through its contractors, will conduct post payment billing reviews of all waiver providers on the following annual schedule: Home Health - 50% of providers reviewed each year, ADHC-30% of providers reviewed each year, Certified providers-100% of providers reviewed each year. These audits shall include a post-payment review of Medicaid reimbursement to the provider agency for services rendered to a waiver member. The reviewing entity shall utilize reports generated from the Medicaid Management Information System (MMIS) reflecting each service billed by the waiver provider. Comparison of payments to member records, documentation and approved service plan shall be conducted. If any payments were issued without the appropriate documentation or not in accordance with approved service plan, the reviewing entity shall notify the Department for Medicaid Services (DMS). DMS will initiate recoupment of the monies by sending a letter to the provider requiring repayment of adjudicated claims along with a copy of the ad hoc used for the billing review showing all claims being recouped. Once the provider receives this letter they will have 30 days to request a dispute resolution (DR) or document consideration (DC). If they request a DR or DC then the amount of the recoupment is placed in a hold status until the DR or DC is completed. Once the DR or DC is completed, the provider is notified of the findings through a letter. The provider again has 30 days to appeal the findings and request an Administrative Hearing (AH). If an AH is requested, the recoupment remains on hold until the AH is held and a judgment rendered. If a DR, DC or AH is not requested, then the provider can pay the recoupment or Medicaid will deduct the recoupment amount 60 days after the date of the recoupment letter.

The Department for Aging and Independent Living (DAIL) shall conduct annual audits of 100% of all AAAILs, CILs and PDC entities. These audits shall include a post-payment review of Medicaid reimbursement to the case management agency for payment to the member's employees through participant directed opportunities. DAIL shall be responsible for auditing 10% of the total case management records randomly selected from the case management entities per year. DAIL shall utilize reports generated from MMIS reflecting each service billed for each member by a PDC agency. Comparison of payments to member records, documentation and approved service plans shall be conducted. If any payments were issued without the appropriate documentation or not in accordance with the approved service plan, DAIL shall notify DMS to initiate recoupment of the monies. Additional billing reviews shall be conducted based on issues identified during these post payment audits.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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: Financial Accountability

State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

- a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. (Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)**

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:

Number and percent of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. N=Number of claims coded and paid in accordance with methodology D=Number of claims coded and paid

Data Source (Select one):

Financial records (including expenditures)

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 type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input 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: MMIS	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input 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

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

Performance Measure:

Number and percent of system defects identified and corrected in the waiver program.

N=Number of system defects identified and corrected D=Number of system defects identified

Data Source (Select one):

Financial records (including expenditures)

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 checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input 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: MMIS	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input 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 type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

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"/> Other Specify: MMIS	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

b. **Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.**

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:

Number and percent of rates that remain consistent with the approved rate methodology throughout the five year waiver cycle. N=Number of rates that remain consistent with rate emthodology throughout waiver period D=Number of rates

Data Source (Select one):

Financial records (including expenditures)

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 checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input 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: MMIS	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input 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 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: MMIS	<input checked="" type="checkbox"/> Annually
	<input 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. DMS through a contract with its fiscal agent is able to provide ongoing training and technical assistance to waiver providers for billing procedures and the ability for oversight of claims paid, suspended and denied.

DMS is able to run Ad Hoc reports of paid claims to compile monthly reports for monitoring overall program expenditures.

DMS reviews and adds Edits/Audits to the Medicaid Management Information System (MMIS) periodically for program compliance and as policy is revised to ensure claims are not paid erroneously.

DMS reviews the CMS-372 report for accuracy prior to submission.

DMS modifies procedure codes in compliance with federal requirements. The State of Kentucky currently does not trend this information and relies on the MMIS organization to provide providers with training for issues regarding billing. The state does not allow for billing of claims that are over 12 months old per Federal regulations. Anytime a claim is noted to deny for timely filing, the provider must show proof of timely filing before the claim is overridden and paid. The State will begin the process of how this information can be captured and how to trend the information for possible future reporting needs.

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.

Should a provider call DMS to question why a claim did not pay, DMS is able to enter a Internal Control Number that is on the provider's Remittance Advice to look at the claim and see why the claim did not pay. Using this method DMS is able to identify if there is defect in the system, or if the problem is provider error. Also, when the QIO performs auditing of a provider, an ad hoc is of all paid claims is downloaded from the system for that provider. Using this ad hoc, DMS is able to tell if edits and audits are correctly working and the provider is cannot bill for more than what the prior authorization allows. When edits and audits are entered into the system, testing occurs to ensure that they will work correctly.

The State currently is using a Power Work Book which is available on line for State employees. The work book has all of the change orders, audits, edits and error messages that used for the MMIS. Anytime a problem with the system occurs, we are able to look at the change orders to make sure that they were written correctly and the testing was completed and the change was put into place.

- 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"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other	<input type="checkbox"/> Annually

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
Specify: QIO	
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other 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 Financial Accountability that are currently non-operational.

No

Yes

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

- a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Provider rates are established utilizing a fee-for-service system. Paid claim data was reviewed for waiver participants for rates of service, fiscal years 2011-2014, which included total units paid per service, total unduplicated users, total cost, average units of service and average cost. Data was trended forward, using historical information, factoring in rate of growth. Some rates were adjusted up or down to address underutilization, or to bring them into closer alignment with rates to similar services in other Kentucky 1915 (c) waiver programs. For new services, rates were established based on rates paid for similar services in other Kentucky Cabinet for Health and Family Services programs.

Rates are established by the Kentucky Department for Medicaid Services and incorporated into Kentucky Administrative Regulations. All new and amended administrative regulations are subject to a public comment process during promulgation.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Billings for waiver services shall flow directly from the waiver providers to the Commonwealth's MMIS.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

- c. Certifying Public Expenditures**(*select one*):

No. State or local government agencies do not certify expenditures for waiver services.

Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the

certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-a.)*

Certified Public Expenditures (CPE) of Local Government Agencies.

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

- d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

All waiver providers shall be enrolled with the Department for Medicaid Services (DMS), provider enrollment, and have a signed contract on file. The Medicaid Management Information System (MMIS) has edits and audits established to prevent non-enrolled provider claims from processing. The DMS or its contractors shall conduct audits of all waiver providers. These audits shall include a post-payment review of Medicaid reimbursement to the provider agency for services rendered to a waiver member. The DMS or its contractors shall utilize reports generated from the Medicaid Management Information System (MMIS) reflecting each service billed by the waiver provider. Comparison of payments to member records, documentation and approved Plan of Care (POC) shall be conducted.

Services may not begin nor will payment be rendered until such time as the applicant has met all eligibility requirements for the waiver. The applicant is determined to have met all eligibility requirements and be a waiver member when the following has occurred.

- 1) A final LOC determination has been approved by the QIO; and
- 2) A Plan of Care has been developed by the ICCA and approved by the QIO; and
- 3) Financial eligibility has been determined by the Department for Community Based Services and a valid MAP 552 is on file for a new applicant for Medicaid; or
- 4) The applicant is a current Medicaid recipient receiving services through a managed care organization at which time the services may begin on the first day of the first month following level of care determination. The managed care organization is responsible for ensuring the health, safety and welfare of the applicant during the period between LOC determination and the first day of the month.

- e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

- a. Method of payments -- MMIS (select one):**

- Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system (s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

- b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

- c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one*:

- No. The State does not make supplemental or enhanced payments for waiver services.**
- Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Local Health Departments can provide case management.

Local Area Agencies on Aging and Independent Living can provide PDC if the AAAIL chooses not to perform any other services other than case management. Otherwise, the AAAIL may provide attendant care, respite and nutrition services.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

- The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**

- Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System.*Select one:*

- No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.*Select one:*

- The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- The State contracts with a Managed Care Organization(s) (MCO) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

- a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

- Appropriation of State Tax Revenues to the State Medicaid agency**
- Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

In addition to the State Medicaid Agency, a portion of the non-federal share of waiver costs is from state tax revenues appropriated to the Department for Aging and Independent Living and the Department for Public Health. An Intergovernmental Transfer (IGT) from each of these state agencies to the Department for Medicaid Services is used to transfer funds.

Other State Level Source(s) of Funds.

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability**I-4: Non-Federal Matching Funds (2 of 3)**

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One:*

Not Applicable. There are no local government level sources of funds utilized as the non-federal share.

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability**I-4: Non-Federal Matching Funds (3 of 3)**

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one:*

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability**I-5: Exclusion of Medicaid Payment for Room and Board**

a. Services Furnished in Residential Settings. *Select one:*

- No services under this waiver are furnished in residential settings other than the private residence of the individual.
 - As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.
- b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:
Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.
- Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

- a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- No. The State does not impose a co-payment or similar charge upon participants for waiver services.
- Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.

i. **Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

- Nominal deductible
- Coinsurance
- Co-Payment
- Other charge

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

- No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
- Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	5501.39	9682.07	15183.46	36272.85	1631.28	37904.13	22720.67
2	5751.34	10098.43	15849.77	37168.25	1559.47	38727.72	22877.95
3	6017.38	10619.29	16636.67	38085.76	1490.83	39576.59	22939.92
4	6281.19	11231.49	17512.68	39025.91	1425.20	40451.11	22938.43
5	6719.57	11946.86	18666.43	39989.28	1362.47	41351.75	22685.32

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

- a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Nursing Facility	
Year 1	17050		17050
Year 2	17050		17050
Year 3	17050		17050
Year 4	17050		17050
Year 5	17050		17050

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

- b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Five years of CMS-372 report data utilized. Total days and unduplicated waiver participants have been declining at 1.5% and 3% respectively. Due to the Michele P. waiver reaching capacity there is reason to believe the persistent reduction in the HCB waiver has stopped, yet not solid enough data to forecast increases in days or participants. For that reason days and participants were maintained at the levels on the CMS 372 report with a run date of 3/13/2015.

Preserving the two factors listed above also preserved the average length of stay.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

- c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Waiver Services data from SFY 2010 through 2014 were identified using the CMS-372 reports.

Each service in the waiver was estimated individually. PDS and traditional users were forecast based upon 5 year average growth rates in usage of those services.

Users of each other service were based upon percentage of persons, by sub-category, using that service in SFY 2014 (For example: Home and Community Directed Support Service Users were estimated based on the share of PDS members receiving that service in SFY 2014). Total costs for unit based services, such as adult day health services, were based on estimated users and unit per user growth over the past 5 years. Total costs for non unit based services, such as Home adaptation were based on estimated users and cost per user growth over the previous 5 years.

- ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

5 years of CMS 372 report data utilized. Average growth rate of Factor D' applied to 2014 data and trended forward. Adjustment included for removal of OT/PT/ST to state plan.

- iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

5 years of CMS 372 report data utilized. Average growth rate of Factor G applied to 2014 data and trended forward.

- iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

5 years of CMS 372 report data utilized. Average growth rate of Factor G' applied to 2014 data and trended forward.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “*manage components*” to add these components.

Waiver Services	
Adult Day Health	
Conflict Free Case Management	
Specialized Respite	
Participant Directed Coordination	
Attendant Care	
Environmental and Minor Home Adaptation	
Goods and Services	
Home and Community Supports	
Home Delivered Meals	
Non-Specialized Respite	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						30561707.70
Adult Day Health	15 minute	3243	3330.00	2.83	30561707.70	
Conflict Free Case Management Total:						5257600.00
Conflict Free Case Management	pmpm	6572	8.00	100.00	5257600.00	
Specialized Respite Total:						2104557.00
Specialized Respite	15 minute	1183	593.00	3.00	2104557.00	
Participant Directed Coordination Total:						10441600.00
Participant Directed Coordination	pmpm	4016	8.00	325.00	10441600.00	
Attendant Care Total:						12386880.00
Attendant Care	1 HR	5610	92.00	24.00	12386880.00	
Environmental and Minor Home Adaptation Total:						2173752.00
Environmental and Minor Home Adaptation	Annual	4540	180.00	2.66	2173752.00	
GRAND TOTAL:						93798741.20
Total Estimated Unduplicated Participants:						17050
Factor D (Divide total by number of participants):						5501.39
Average Length of Stay on the Waiver:						315

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Goods and Services Total:						2996106.00
Goods and Services	Per Capita	3886	771.00	1.00	2996106.00	
Home and Community Supports Total:						21385963.50
Home and Community Supports	1 HR	3597	517.00	11.50	21385963.50	
Home Delivered Meals Total:						5335680.00
Home Delivered Meals	Per Meal	3176	224.00	7.50	5335680.00	
Non-Specialized Respite Total:						1154895.00
Non-Specialized Respite	15 min	647	714.00	2.50	1154895.00	
GRAND TOTAL:						93798741.20
Total Estimated Unduplicated Participants:						17050
Factor D (Divide total by number of participants):						5501.39
Average Length of Stay on the Waiver:						315

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. **Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						30156010.22
Adult Day Health	15 minute	3178	3353.00	2.83	30156010.22	
Conflict Free Case Management Total:						4936800.00
Conflict Free Case Management	pmpm	6171	8.00	100.00	4936800.00	
Specialized Respite Total:						1976469.00
Specialized Respite	15 min	1111	593.00	3.00	1976469.00	
Participant Directed Coordination Total:						12922650.00
Participant Directed Coordination	pmpm	4418	9.00	325.00	12922650.00	
Attendant Care Total:						11766432.00
Attendant Care	1 HR	5329	92.00	24.00	11766432.00	
Environmental and Minor Home Adaptation Total:						1911534.40
GRAND TOTAL:						98060424.12
Total Estimated Unduplicated Participants:						17050
Factor D (Divide total by number of participants):						5751.34
Average Length of Stay on the Waiver:						315

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental and Minor Home Adaptation	Annual	4534	170.00	2.48	1911534.40	
Goods and Services Total:						2902842.00
Goods and Services	Per Capita	3886	747.00	1.00	2902842.00	
Home and Community Supports Total:						24709486.50
Home and Community Supports	1 hr	3957	543.00	11.50	24709486.50	
Home Delivered Meals Total:						5443200.00
Home Delivered Meals	Per Meal	3240	224.00	7.50	5443200.00	
Non-Specialized Respite Total:						1335000.00
Non-Specialized Respite	15 Min	712	750.00	2.50	1335000.00	
GRAND TOTAL:					98060424.12	
Total Estimated Unduplicated Participants:					17050	
Factor D (Divide total by number of participants):					5751.34	
Average Length of Stay on the Waiver:						315

Appendix J: Cost Neutrality Demonstration
J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						29760217.74
Adult Day Health	15 minute	3114	3377.00	2.83	29760217.74	
Conflict Free Case Management Total:						5156100.00
Conflict Free Case Management	monthly	5729	9.00	100.00	5156100.00	
Specialized Respite Total:						1831056.00
Specialized Respite	Hourly	1031	592.00	3.00	1831056.00	
Participant Directed Coordination Total:						14212575.00
Participant Directed Coordination	monthly	4859	9.00	325.00	14212575.00	
Attendant Care Total:						11300616.00
Attendant Care					11300616.00	
GRAND TOTAL:					102596390.04	
Total Estimated Unduplicated Participants:					17050	
Factor D (Divide total by number of participants):					6017.38	
Average Length of Stay on the Waiver:						315

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	1 HR	5063	93.00	24.00		
Environmental and Minor Home Adaptation Total:						1907614.80
Environmental and Minor Home Adaptation	Annual	4529	162.00	2.60	1907614.80	
Goods and Services Total:						2809578.00
Goods and Services	Per Capita	3886	723.00	1.00	2809578.00	
Home and Community Supports Total:						28527360.00
Home and Community Supports	1 HR	4352	570.00	11.50	28527360.00	
Home Delivered Meals Total:						5550720.00
Home Delivered Meals	Per Meal	3304	224.00	7.50	5550720.00	
Non-Specialized Respite Total:						1540552.50
Non-Specialized Respite	15 Min	783	787.00	2.50	1540552.50	
GRAND TOTAL:						102596390.04
Total Estimated Unduplicated Participants:						17050
Factor D (Divide total by number of participants):						6017.38
Average Length of Stay on the Waiver:						315

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						29374981.16
Adult Day Health	15 minute	3052	3401.00	2.83	29374981.16	
Conflict Free Case Management Total:						4717800.00
Conflict Free Case Management	monthly	5242	9.00	100.00	4717800.00	
Specialized Respite Total:						1673712.00
Specialized Respite	Hourly	944	591.00	3.00	1673712.00	
Participant Directed Coordination Total:						15561000.00
Participant Directed Coordination	monthly	4788	10.00	325.00	15561000.00	
GRAND TOTAL:						107094324.80
Total Estimated Unduplicated Participants:						17050
Factor D (Divide total by number of participants):						6281.19
Average Length of Stay on the Waiver:						315

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Attendant Care Total:						10735920.00
Attendant Care	1 HR	4810	93.00	24.00	10735920.00	
Environmental and Minor Home Adaptation Total:						1884788.64
Environmental and Minor Home Adaptation	Annual	4529	153.00	2.72	1884788.64	
Goods and Services Total:						2720200.00
Goods and Services	Per Capita	3886	700.00	1.00	2720200.00	
Home and Community Supports Total:						32982138.00
Home and Community Supports	1 HR	4788	599.00	11.50	32982138.00	
Home Delivered Meals Total:						5661600.00
Home Delivered Meals	Per Meal	3370	224.00	7.50	5661600.00	
Non-Specialized Respite Total:						1782185.00
Non-Specialized Respite	15 Min	862	827.00	2.50	1782185.00	
GRAND TOTAL:						107094324.80
Total Estimated Unduplicated Participants:						17050
Factor D (Divide total by number of participants):						6281.19
Average Length of Stay on the Waiver:						315

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						28991015.25
Adult Day Health	15 minute	2991	3425.00	2.83	28991015.25	
Conflict Free Case Management Total:						4237200.00
Conflict Free Case Management	Per Month	4708	9.00	100.00	4237200.00	
Specialized Respite Total:						1499190.00
Specialized Respite	15 Min	847	590.00	3.00	1499190.00	
Participant Directed Coordination Total:						19110000.00
GRAND TOTAL:						114568591.13
Total Estimated Unduplicated Participants:						17050
Factor D (Divide total by number of participants):						6719.57
Average Length of Stay on the Waiver:						315

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Participant Directed Coordination	pmpm	5880	10.00	325.00	19110000.00	
Attendant Care Total:						10305408.00
Attendant Care	1 HR	4568	94.00	24.00	10305408.00	
Environmental and Minor Home Adaptation Total:						1866458.88
Environmental and Minor Home Adaptation	Annual	4532	144.00	2.86	1866458.88	
Goods and Services Total:						2634708.00
Goods and Services	Per Capita	3886	678.00	1.00	2634708.00	
Home and Community Supports Total:						38091611.00
Home and Community Supports	1 HR	5266	629.00	11.50	38091611.00	
Home Delivered Meals Total:						5775840.00
Home Delivered Meals	Per Meal	3438	224.00	7.50	5775840.00	
Non-Specialized Respite Total:						2057160.00
Non-Specialized Respite	15 Min	948	868.00	2.50	2057160.00	
GRAND TOTAL:					114568591.13	
Total Estimated Unduplicated Participants:					17050	
Factor D (Divide total by number of participants):					6719.57	
Average Length of Stay on the Waiver:						315