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:

Language was added to comply with CMS final rules for person centered planning, service plan development and settings requirements.

Requirements for conflict free case management were revised to comply with CMS final rules.

Quality Improvement Strategies updated to reflect current practices and include the Medicaid waiver management application system.

Assurances revised according to new CMS guidance and requirements and to reflect participant directed service planning and informed choice.

Some of the service provider types were updated and combined to reflect current providers of services.

Qualifications for impact services-community access and supported employment were broadened to allow for increased provider participation and increased use of the services to promote community integration.

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):

Supports for Community Living 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.0314
Draft ID: KY.002.04.00

D. Type of Waiver (select only one):

Regular Waiver

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

09/01/15

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

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

OBJECTIVES
The SCL Program objectives are to: 1) to identify individual needs by implementing a comprehensive evaluation utilizing the Supports Intensity Scale (SIS) and a screening tool to measure health risks, in order to assist in the person-centered planning process leading to development of the plan of care. 2) Ensure home and community based services are comprehensive alternatives to institutional services by providing positive assistive supports as needed to identify and eliminate barriers that create crisis situations. 3) Improve information, access and utilization of employment related supports for participants. 4) Enhance provider competency and continuity of care by offering training and continuing education through the College of Direct Support and through increased collaboration with schools, colleges, and public health entities, seeking human service internship experiences, through the SCL program.

ORGANIZATIONAL STRUCTURE
The Division of Developmental and Intellectual Disabilities (DDID) within the Department of Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) serves as the operating agency of the waiver through a contract with the Department for Medicaid Services (DMS). DMS exercises administrative discretion in the operation of the waiver and issues policies, rules and regulations related to the waiver.

SERVICE DELIVERY METHODS
The SCL waiver offers statewide availability of traditional services. Participants can choose to self-direct non-medical services also on a statewide basis. They can also choose either all traditional, all self-directed, or a combination (blend) of traditional and self-directed services. If a participant chooses to self-direct any services, they are informed of the Community Guide service.

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

If yes, specify the waiver of statewideness that is requested (check each that applies):
- Geographic Limitation. A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.
- Limited Implementation of Participant-Direction. A waiver of statewideness is requested in order to make participant-direction of services as specified in Appendix E available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.

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 preventative, 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 final draft of this waiver application will be posted, in full, for public comment on April 29 to DMS’ webpage. Additionally, the URL for this posting will be published in the newspapers, also on April 29. The public comment period will last for 30 days. If anyone in the public would like a printed copy of this waiver application, that will also be available by calling or emailing the Department.

SCL waiver staff will outreach various advocacy and provider groups across the state to make them aware that the renewal waiver application has been posted for public comment.

DMS will consider all comments and revise the waiver application, as needed, prior to final submission to CMS on June 1.

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:

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>Hoffmann</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name:</td>
<td>Leslie</td>
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<tr>
<td>Title:</td>
<td>Director</td>
</tr>
<tr>
<td>Agency:</td>
<td>The Department for Medicaid Services</td>
</tr>
<tr>
<td>Address:</td>
<td>275 East Main Street</td>
</tr>
<tr>
<td>Address 2:</td>
<td>Mail Stop 6W-B</td>
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<tr>
<td>City:</td>
<td>Frankfort</td>
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<tr>
<td>State:</td>
<td>Kentucky</td>
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<tr>
<td>Zip:</td>
<td>40621</td>
</tr>
<tr>
<td>Phone:</td>
<td>(502) 564-7540 Ext: 2122 TTY</td>
</tr>
<tr>
<td>Fax:</td>
<td>(502) 564-0249</td>
</tr>
</tbody>
</table>

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

Last Name: Johnson
First Name: Claudia
Title: Assistant Director
Agency: Department for Behavioral Health, Developmental and Intellectual Disabilities
Address: 275 East Main Street
Address 2: Mail Stop 4CF
City: Frankfort
State: Kentucky
Zip: 40621
Phone: (502) 782-6219
Fax: (502) 564-8917
E-mail: Claudia.Johnson@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: Hoffmann
First Name: Leslie
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:

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) Supports for Community Living (SCL) 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(t) 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.

II. Introduction
The Commonwealth of Kentucky (KY) Department for Medicaid Services (DMS) operates the Supports for Community Living (SCL) waiver under the 1915(c) benefit. This waiver is residential, and includes the option for Participant Directed Services (PDS). SCL participants are individuals who have an intellectual or developmental disability and meet the requirements for residence in an intermediate care facility for people with intellectual disabilities. SCL allows individuals to remain in their homes with services or to live in residential settings (907 KAR 12:010).

A. Purpose
The purpose of this SCL transition plan is to outline the assessments that DMS has completed, and planned remedial actions to bring the SCL waiver into compliance with the HCBS setting final rules.

B. Overview
This SCL Transition Plan contains the process that DMS is using to evaluate and revise this Kentucky 1915(c) waiver. The first section describes the assessments that were conducted to determine the compliance of the waiver with HCBS final rules at the state level. The second section is the remediation 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.

III. Assessment Process – Systemic Review
A. Regulation and Waiver Application Assessment
To evaluate the compliance of the SCL waiver with the HCBS final rules, DMS established a 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 each waiver regulation, including manuals incorporated by reference, each 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 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 analysis for the SCL waiver as it relates to the HCBS final rules. The tables below contain only the applicable HCBS final rules and therefore, DMS needs to add additional requirements to policies.

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

- 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.
- 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.
- 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.
- Facilitates individual choice regarding services and supports, and who provides them.
- Each individual has privacy in their sleeping or living unit.
- Individuals are able to have visitors of their choosing at any time.

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

- 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*.
- The setting is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity*.
- Units have entrance doors lockable by the individuals, with only appropriate staff having keys.
- Individuals sharing units have a choice of roommates in that setting.
- Individuals have freedom to furnish and decorate their sleeping and living areas within the lease or other agreement.
- Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.
- The setting is physically accessible to the individual.
- Modifications to provider-owned settings:
The requirements must be documented in the person-centered service plan in order to modify any of the criteria. The person-centered service plan be reviewed, and revised upon reassessment of function need, at least every 12 months, when the individual’s circumstances or needs change significantly, or at the request of the individual.

Identify a specific and individualized assessed need.

Document the positive interventions and supports used prior to any modifications to the person centered service plan.

Document less intrusive methods of meeting the need that have been tried but did not work.

Include a clear description of the condition that is directly proportionate to the specific assessed need.

Include a regular collection and review of data to measure the ongoing effectiveness of the modification.

Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

Include informed consent of the individual.

Include an assurance that interventions and supports will cause no harm to the individual.

A. Monitoring Process Assessment

DMS has set monitoring requirements for the SCL 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 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. After providers have fully implemented the HCBS final rules, monitoring processes will continue with compliant tools and standards. Table 3.5 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 in Table 3.5 since PDS for all waivers is centrally monitored by state staff.

Current Waiver Monitoring Processes

Current SCL Oversight Process

• Every agency must be certified by state staff prior to the initiation of a service

• Every agency is recertified at least once during their certification period (bi-annually, annually, or biennially)

• The citation and sanctions process is outlined in regulation

Participant and Provider Surveys

• Providers are required by regulation to participate in all department survey initiatives, including surveying participants

Areas Requiring Revision

• The tools, including checklists used during on-site monitoring, 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

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

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 both residential and 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. Residential Settings

As part of evaluating provider compliance with the HCBS final rules, the workgroup conducted a web-based survey in June 2014 for residential providers to measure each provider’s compliance level with the rules. The workgroup drafted questions using language provided by CMS, and included text boxes for providers to offer additional information for each requirement of the rule. The survey had 100% participation from all SCL residential waiver providers in KY and is included in Appendix A. Achieving 100% participation required individual outreach to each provider by members of the workgroup. The workgroup then summarized the provider data to establish initial estimates of compliant/non-compliant providers.
After analyzing the providers’ self-reported compliance level, state Quality Assurance (QA) staff from each residential waiver thoroughly reviewed provider responses. The purpose of this review was to validate that the survey responses submitted align with what has been observed by QA staff during regular on-site provider evaluations. The workgroup selected the QA staff to complete this validation because of their deep knowledge and experience with the residential providers. After completing survey validation, the workgroup categorized each 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**
- **Operate in a non-HCB setting and will require heightened scrutiny**

The results of the residential provider survey and validation by QA staff are outlined below. The estimated number of providers used represent the number of provider agencies, not the number of individual settings each provider operates.

**SCL Residential Provider Compliance Estimates**

**Category 1: Fully align with the federal requirements**

- **Estimate Number of Providers**: 0 (0%)
- **Main Areas of Non-Compliance**: None

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

- **Estimate Number of Providers**: 45 (38%)
- **Main Areas of Non-Compliance**:
  - The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community
  - Individuals/tenants have lease agreements
  - Individuals have the freedom and support to control their own schedules and activities

**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**: None

**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**

- **Estimate Number of Providers - Not Isolating**: 22 (18%)
- **Estimate Number of Providers - Potentially Isolating**: 13 (11%)
- **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

**Main Areas of Non-Compliance**

- **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 multiple-family properties with more than one unit occupied by individuals receiving Medicaid HCBS**
- **Operated in a remote location (rural, farmstead, etc.)**

**B. Non-Residential Settings**

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 B. 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**
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 serves participants across waivers, and/or 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:
- Setting that has the effect of isolating individuals receiving Medicaid HCBS from the greater 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.)

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

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 table includes the identified changes to each regulation and application that are required to transition KY’s 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 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)

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

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)

Potential Actions to be Compliant (SCL):
- 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), taking into account individual resources and provider restrictions

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)

Potential Actions to be Compliant (SCL):
- 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)

Potential Actions to be Compliant (SCL Application):
- Facilitates individual choice regarding services and supports, and who provides them.

Potential Actions to be Compliant (SCL 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)

Potential Actions to be Compliant (SCL):
- 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

Rule: Individual has the right to privacy in their living unit

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

Potential Actions to be Compliant (SCL):
- Add specific language: “Individual has the right to privacy in their living unit”

Rule: Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors

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

Potential Actions to be Compliant (SCL):
- Add requirement requiring the individual to have keys/locks for both their bedroom door and main house door
- Require that only appropriate staff have bedroom door keys

Rule: Individuals sharing units have a choice of roommates in that setting

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

Potential Actions to be Compliant (SCL):
- Add clarifying language allowing the individual to choose to live alone or with a roommate
• Add clarifying language allowing the individual to choose roommates and housemates where applicable and based on available resources for room and board
• Include requirement that providers show evidence of how they presented roommate options to the participant
Rule: Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement
Timeline: 1/1/2015 – 4/30/2015 (First Round)
Status: Not Started
Potential Actions to be Compliant (SCL):
• Add requirement allowing individuals the freedom to decorate/furnish their living unit as outlined in their lease
Rule: Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time
Timeline: 7/15/2017 – 1/1/2018 (Second Round)
Potential Actions to be Compliant (SCL):
• Add language allowing individuals to have visitors of their choosing at any time
• Include language regarding responsibility of the individual and respect for others living in the residential setting
Rule: The setting is physically accessible to the individual
Timeline: 1/1/2015 – 4/30/2015 (First Round)
Potential Actions to be Compliant (SCL):
• Define physical accessibility
• Add language requiring the individual to be able to physically access their building and other appropriate buildings at all times
Rule: Any modification of the additional residential conditions except for the setting being physically accessible requirement, must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:
• Identify a specific and individualized assessed need.
• Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
• Document less intrusive methods of meeting the need that have been tried but did not work.
• Include a clear description of the condition that is directly proportionate to the specific assessed need.
• Include regular collection and review of data to measure the ongoing effectiveness of the modification.
• Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
• Include the informed consent of the individual.
• Include an assurance that interventions and supports will cause no harm to the individual
Timeline: 1/1/2015 – 4/30/2015 (First Round)
Potential Actions to be Compliant (SCL):
• Add language that treats POC residential modifications like a “rights restriction”

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, 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 amendment is targeted for submission to CMS for approval on June 1, 2015. This date was selected to coincide with waiver renewal dates and are during or immediately after regulation adoption timelines to assure consistency.

To confirm that the applications and regulations mirror the same requirements for each waiver, DMS will draft the waiver amendment language for the second round from November 2017 to March 2018 and submit revised waiver applications for all waivers 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. Once updated state policies take effect, state staff will transition from current operational practices to revised, compliant protocols to administer the HCBS waivers. Below is a list of operational changes required for the SCL waiver to bring its practices into compliance.

Potential Waiver Operational Actions for Compliance

Internal Processes
Prior Authorizations
Timeline: 1/1/2015 – Ongoing
Potential Actions to be Compliant (SCL):
• Update PA processes to incorporate new HCBS rules in regards to the participant setting selection process

State staff training
Timeline: 1/1/2015 – Ongoing
Potential Actions to be Compliant (SCL):
• 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

Potential Actions to be Compliant (SCL):
• 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

Potential Actions to be Compliant (SCL):
• Providers should update their mission/values and policies/procedures to align with the new DMS regulations

Trainings
Timeline: 1/1/2015 – Ongoing

Potential Action to be Compliant (SCL):
• Update relevant provider trainings and offer providers all relevant information and trainings

Transition Process
Timeline: 1/1/2015 – Ongoing

Potential Actions to be Compliant (SCL):
• 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 waiver and provider 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

Potential Actions to be Compliant (SCL):
• 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

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

Potential Actions to be Compliant (SCL):
• Update PDS provider on-site surveys
• Establish process for participant surveys

Grievance Process
Timeline: 1/1/2015 – Ongoing

Potential Actions to be Compliant (SCL):
• 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

Potential Actions to be Compliant (SCL):
• 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 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
Potential Actions to be Compliant (SCL):
• Determine relocation process
• Determine how the lease agreement requirement will affect the availability of services and the relocation process
• Require the POC team/case manager to be involved in every move of the individual, ensuring the individual has a choice in every move or change in service provider

3. Participants
The significance of the changes to DMS’ SCL waiver 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
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
Rule: Residential rules
Timeline: 1/1/2015 – Ongoing
Potential Actions to be Compliant (SCL):
• Develop and implement communication process for informing residential waiver participants of waiver changes related to HCBS rules
  o Include information outlining the list of new participant rights, provider requirements, and links to related information
  o Include lease information and sample leases

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. 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
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, SCL demographic and billing information form, and SCL 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 each 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 in Table 5.5 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, each waiver will follow the termination process outlined in Kentucky regulations
   a. First round: May 2015 to October 2015
   b. Second round: January 2018 to June 2018

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 an HCB setting 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 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 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

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

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;

• 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

• 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.
• 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

• 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

• 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

• 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

• Long-term
  o Establish policies and procedures which encourage individual choice of activities

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.

• 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

• Long-term
  o Cooperate with state staff and CMS on-site assessments

Potential Residential Provider Actions for Compliance

Provider Owned/Controlled Settings Requirements

Rule: The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant and that the document provides protections that address eviction processes and appeals comparable to the jurisdiction’s landlord/tenant law.

• Short-term (based on the individual’s person-centered plan)
  o Draft lease or legally enforceable document that provides individuals the same responsibilities and protections from eviction that tenants have under KY law
  o Include furnish/decoration rules within each lease

• Long-term
  o Review lease document with each individual and his/her case manager to reach agreement on the rights and responsibilities included in the lease
  o Finalize and agree to lease with each individual residing in the home

Rule: Each individual has privacy in their sleeping or living unit

• Short-term (based on the individual’s person-centered plan)
  o Allow the individual to have a private bedroom if available or explore other options with the POC team
  o Define and implement what privacy means to each individual

• Long-term
  o Re-structure sleeping/living units to allow for optimal privacy for each individual based on the person-centered plan

Rule: Units have entrance doors lockable by the individuals, with only appropriate staff having keys

• Short-term (based on the individual’s person-centered plan)
  o Ensure that each individual has a key to his/her sleeping unit as well as a key to the entrance of the home based on factors in the person-centered plan
  o Provide keys to participant rooms only to appropriate provider staff
• Long-term
  o Require each sleeping unit to have a lockable entrance door and ensure that the individual has a key based on factors in the person-centered plan
  o Provide keys to participant rooms only to appropriate provider staff
Rule: Individuals sharing units have a choice of roommates in that setting
• Short-term (based on the individual’s person-centered plan)
  o Ensure that each individual has chosen his/her roommate and/or housemate
  o Re-locate individuals to a different room or home if a change is desired
• Long-term:
  o Establish process that allows each individual to have choice of roommate or housemate
  o Include roommate and housemate discussions
Rule: Individuals have freedom to furnish and decorate their sleeping and living areas within the lease or other agreement
• Short-term (based on the individual’s person-centered plan)
  o Allow individuals to furnish and decorate sleeping and living areas
  o Provide staff training
• Long-term:
  o Include furnish/decoration rules within each lease
Rule: Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time
• Short-term (based on the individual’s person-centered plan)
  o Encourage individuals to control their own schedule as indicated in POC and provide support to facilitate
  o Give individuals an option to help plan, shop, and cook meals
  o Allow access to appropriate areas of kitchen and food at any time as indicated in POC
• Long-term
  o Provide supports to enable individuals to do unscheduled social/community activities
Rule: Individuals are able to have visitors of their choosing at any time
• Short-term (based on the individual’s person-centered plan)
  o Revise operating procedures or policies, if necessary, to specify that individuals may have visitors at any time based on factors in the person-centered plan
  o Discuss roommate preferences to set appropriate limits to visitor hours, if the individual has a roommate
Rule: The setting is physically accessible to the individual.
• Short-term (based on the individual’s person-centered plan)
  o Determine how all participants residing in the home will be given independent access to all entrance doors, such as keys or keypads
VI. Public Comment Process
The 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.
DMS submitted the 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 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.

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.

(The complete item A-2-a).

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

Specify the division/unit name:
The Department for Behavioral Health, Developmental and Intellectual Disabilities

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

Appendix A: Waiver Administration and Operation

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 has a written contract with DBHDID that is reviewed annually and is updated as needed. DMS has delegated to DBHDID the following functions through a written contract:
1. Utilization management;
2. Maintenance of waiting list and allocations;
3. Provider development, training, and certification; and
5. Quality assurance and quality improvement activities.

DMS and DBHDID are jointly responsible for the following functions:
1. Establishment of a statewide rate methodology; and
2. Developing rules, policies, procedures and information development governing the waiver program

DMS uses the following methods to ensure DBHDID performs its assigned waiver operational and administrative functions in accordance with waiver requirements:
• Policy and clarification is reviewed and approved by DMS;
• DBHDID submits correspondence and reports to DMS;
• DMS and DBHDID hold regular meetings;
• DMS conducts an annual review of the contract to ensure DBHDID meets all requirements.

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 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.: Department for Medicaid Services contracts with a non-governmental agency for the Level of Care and Prior Authorization of Services functions. Fiscal agent services are contracted with a non-governmental agency for traditional waiver services and with quasi-governmental agencies for Participant Directed Services. The fiscal agent provides processing and payment of provider claims. DMS contracts with the operating agency, DDID, to review and recommend certification of non-licensed waiver providers and monitor quality assurance of these providers. DDID contracts with the Department for Aging and
Independent Living (DAIL) to perform functions of Participant Directed Services (PDS).

DMS contracts with Department for Community Based Services (DCBS) to determine medicaid eligibility.

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

Appendix A: Waiver Administration and Operation

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 functions, the fiscal agent, and the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID).

Appendix A: Waiver Administration and Operation

6. Assessment Methods and Frequency. Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

DMS assesses the performance of the contracted agencies continually through policy clarification, post payment auditing processes, second line monitoring, monthly, quarterly, and yearly reporting.

Appendix A: Waiver Administration and Operation

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (check each that applies):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. Note: More than one box may be checked per item.

Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.

<table>
<thead>
<tr>
<th>Function</th>
<th>Medicaid Agency</th>
<th>Other State Operating Agency</th>
<th>Contracted Entity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant waiver enrollment</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
</tbody>
</table>

https://wms-mmdl.cdsydc.com/WMS/faces/protected/35/print/PrintSelector.jsp
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:
Percentage 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 Administrative functions
If ‘Other’ is selected, specify:

<table>
<thead>
<tr>
<th>Responsible Party for data collection/generation (check each that applies):</th>
<th>Frequency of data collection/generation (check each that applies):</th>
<th>Sampling Approach (check each that applies):</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔ State Medicaid Agency</td>
<td>✔ Weekly</td>
<td>✔ 100% Review</td>
</tr>
<tr>
<td>✔ Operating Agency</td>
<td>✔ Monthly</td>
<td>✔ Less than 100% Review</td>
</tr>
<tr>
<td>✔ Sub-State Entity</td>
<td>✔ Quarterly</td>
<td>✔ Representative Sample</td>
</tr>
</tbody>
</table>

Confidence Interval =
Other
Specify:
Fiscal Agent, QIO

Anually

Stratified
Describe Group:

Continuously and Ongoing

Other
Specify:

Data Aggregation and Analysis:

<table>
<thead>
<tr>
<th>Responsible Party for data aggregation and analysis (check each that applies):</th>
<th>Frequency of data aggregation and analysis (check each that applies):</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Medicaid Agency</td>
<td>Weekly</td>
</tr>
<tr>
<td>Operating Agency</td>
<td>Monthly</td>
</tr>
<tr>
<td>Sub-State Entity</td>
<td>Quarterly</td>
</tr>
</tbody>
</table>
| Other
Specify:
Fiscal Agent, QIO | Annually |
| | Continuously and Ongoing |
| Other
Specify: | |

Performance Measure:
Percentage of required reports the operating agency provides to DMS within the required timeframes. N=the number of 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):
Record reviews, on-site
If 'Other' is selected, specify:

<table>
<thead>
<tr>
<th>Responsible Party for data collection/generation (check each that applies):</th>
<th>Frequency of data collection/generation (check each that applies):</th>
<th>Sampling Approach (check each that applies):</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Medicaid Agency</td>
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<td>100% Review</td>
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<tr>
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<td>Monthly</td>
<td>Less than 100% Review</td>
</tr>
<tr>
<td>Sub-State Entity</td>
<td>Quarterly</td>
<td>Representative Sample</td>
</tr>
</tbody>
</table>
| Other
Specify: | Annually | Stratified |
| | | Describe Group: |
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 contracts with the fiscal agent who in turn contracts with the QIO for medical necessity review. Fiscal agent submits utilization management reports to DMS and the operating agency monthly. DMS and the fiscal agent meet on a regular basis to review and identify issues/problems related to the level of care, service plan and prior authorization of services. Should problems be identified, then a collaborative plan is developed to resolve the issue/problem. DMS requires in contract quarterly reports from the operating agency.

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 DMS, the Operating agency and the Fiscal Agent through the use of monthly utilization management reports and other required reports. DMS monitors the Fiscal Agent and the Operating agency to ensure that contract objectives and goals are met as appropriate. Should the Fiscal Agent or Operating agency not meet the requirements then a corrective action plan is required and/or a recoupment of fund could occur.

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

<table>
<thead>
<tr>
<th>Responsible Party (check each that applies):</th>
<th>Frequency of data aggregation and analysis (check each that applies):</th>
</tr>
</thead>
<tbody>
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<td>State Medicaid Agency</td>
<td>Weekly</td>
</tr>
<tr>
<td>Operating Agency</td>
<td>Monthly</td>
</tr>
<tr>
<td>Sub-State Entity</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Other Specify:</td>
<td>Anually</td>
</tr>
</tbody>
</table>

| Other Specify:                               | Continuously and Ongoing                                    |
|------------------------------------------------|
| Other Specify:                               |                                                             |
|------------------------------------------------|
| Other Specify:                               |                                                             |

Data Aggregation and Analysis:

<table>
<thead>
<tr>
<th>Responsible Party for data aggregation and analysis (check each that applies):</th>
<th>Frequency of data aggregation and analysis (check each that applies):</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Medicaid Agency</td>
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</tr>
<tr>
<td>Sub-State Entity</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Other Specify:</td>
<td>Annually</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Specify:</th>
<th>Continuously and Ongoing</th>
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<tbody>
<tr>
<td>Other Specify:</td>
<td></td>
</tr>
<tr>
<td>Other Specify:</td>
<td></td>
</tr>
</tbody>
</table>
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)

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

Developmental disability is defined as: a disability that: (a) Is manifested prior to the age of twenty-two (22); (b) Constitutes a substantial disability to the affected individual; and (c) Is attributable to an Intellectual Disability or related condition that: Results in impairment of general intellectual functioning and adaptive behavior similar to that of a person with an intellectual disability; and are a direct result of, or are influenced by, the person’s cognitive deficits.

Adaptive behavior means the person has overall adaptive behavior which is significantly limited in three or more skill areas (self...
care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, economic self-

sufficiency) as measured by an instrument which is standardized, appropriate to the person’s living environment, and administered
and clinically determined by a qualified professional.

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

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

 Specify:

Appendix B: Participant Access and Eligibility

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

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

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

The limit specified by the State is (select one)

- A level higher than 100% of the institutional average.
  Specify the percentage:

- Other
  Specify:

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

Cost Limit Lower Than Institutional Costs. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

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

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

- The following dollar amount:
  Specify dollar amount:

- The dollar amount (select one)
  Is adjusted each year that the waiver is in effect by applying the following formula:
Specify the formula:

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

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

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility
B-2: Individual Cost Limit (2 of 2)

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

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

\[ \text{Specify the procedures for authorizing additional services, including the amount that may be authorized:} \]

\[ \text{Other safeguard(s)} \]

\[ \text{Specify:} \]

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>
<thead>
<tr>
<th>Waiver Year</th>
<th>Unduplicated Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>4941</td>
</tr>
<tr>
<td>Year 2</td>
<td>4941</td>
</tr>
<tr>
<td>Year 3</td>
<td>4941</td>
</tr>
</tbody>
</table>
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>
<thead>
<tr>
<th>Waiver Year</th>
<th>Maximum Number of Participants Served At Any Point During the Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td></td>
</tr>
<tr>
<td>Year 2</td>
<td></td>
</tr>
<tr>
<td>Year 3</td>
<td></td>
</tr>
<tr>
<td>Year 4</td>
<td></td>
</tr>
<tr>
<td>Year 5</td>
<td></td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Need</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Capacity Reserved</th>
</tr>
</thead>
<tbody>
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<tr>
<td>Year 2</td>
<td></td>
</tr>
</tbody>
</table>
Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

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

As long as capacity exists, eligible applicants will be selected for waiver entrance based on the date of their waiver application. If waiver capacity is not adequate for all eligible applicants, individuals will be selected for waiver entrance based on the date of their waiver application and their category of need, with individuals in crisis meeting criteria for emergency need receiving preference.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

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

2. Miller Trust State.

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

- No
- Yes

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

- Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)
Low income families with children as provided in §1931 of the Act
SSI recipients
Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
Optional State supplement recipients
Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

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

Specify percentage:

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

Specify:

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

- 42 CFR 435.110, Parents and other caretaker relatives,
- 42 CFR 435.116, Pregnant women, and

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 SSI 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: None. 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: None. 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:

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

- Health insurance premiums, deductibles and co-insurance charges
- 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:

- Health insurance premiums, deductibles and co-insurance charges
- 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)
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.


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.


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.


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 2.

   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:

The Quality Improvement Organization (QIO), CareWise Health is contracted by DMS’s MMIS contractor to perform the Level of Care (LOC) and Recertification process.

- Other

Specify:

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

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

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

The applicant’s initial Level of Care (LOC) is determined using a complete psychological evaluation that includes an IQ test and a current adaptive behavior assessment.

Annual Reassessment of Level of Care is determined using information from the Supports Intensity Scale (SIS) assessment along with a current adaptive living skills questionnaire completed by the case manager and person centered team.

Level of care criteria used to evaluate and reevaluate waiver eligibility per 907 KAR 1:022:

An individual shall meet ICF-IID patient status if the individual requires physical or environmental management or rehabilitation for moderate to severe intellectual disability and meets the following criteria:

(a) The individual has significant developmental disabilities or significantly subaverage intellectual functioning and requires a planned program of active treatment to attain or maintain the individual's optimal level of functioning, but does not necessarily require nursing facility or nursing facility with waiver services;

(b) The individual requires a protected environment due to developmental disabilities and sub average intellectual functioning while:

1. Learning fundamental living skills;
2. Learning to live happily and safely within his own limitations;
3. Obtaining educational experiences that will be useful in self-supporting activities; or
4. Increasing his awareness of his environment; or

(c) The individual has a psychiatric primary diagnosis or needs if:

1. The individual also has care needs as shown in paragraph (a) or (b) of this subsection;
2. The psychiatric care needs are adequately met in a supportive environment (i.e., the intermediate care facility for individuals with intellectual disability or a developmental disability); and
3. The individual does not require psychiatric inpatient treatment.
An individual who does not require a planned program of active treatment to attain or maintain the individual's optimal level of functioning shall not meet ICF-IID patient status.

An individual shall not be denied ICF-IID services based solely on advanced age, or length of stay in an institution, or history of previous institutionalization, if the individual qualifies for ICF-IID services on the basis of all other factors.

Excluding an individual with an intellectual disability, for an individual with a developmental disability to qualify for ICF-MR-DD services, the disability shall have manifested itself prior to the individual's 22nd birthday.

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

e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (select one):
   - The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
   - A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.

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

   Level of Care for the waiver uses the same criteria specified in 907 KAR 1:022, the determination is made through a review of clinical documentation including a psychological evaluation, a life history, a medical assessment and results of a supports intensity scale assessment to identify support needs.

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 reevaluation process utilizes the SIS assessment tool with additional documentation from the case manager on current functioning and an updated life story. An additional psychological evaluation or other supporting documentation is not required. The SIS includes information about the member’s support needs in the areas of home living, community living, learning, employment, health and safety, advocacy, behavioral, and medical needs. DDID staff that are trained and qualified by the American Association on Intellectual and Developmental Disabilities (AAIDD) conduct the SIS assessments with participation from the case manager and other respondents.

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

h. **Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations (select one):
   - The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
   - The qualifications are different.

   *Specify the qualifications:*

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

   The state of Kentucky requires that re-evaluations be performed at least every 12 months. The Case Manager is responsible for tracking renewal dates and submitting required documentation prior to the LOC expiration date. If the person meets the LOC then a waiver segment with a date range of one year is entered into the Medicaid Management Information System (MMIS). The provider’s responsibility is to ensure that the recertification is received in a timely manner by the QIO. If the recertification packet is not received by the QIO before the end date of the current LOC dates, then the Case Manager, nor any other provider will be able to bill and be paid for services rendered during the time that a LOC date was not active.

j. **Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:
Written documentation of the evaluations and reevaluations shall be maintained by the Case Manager and agencies providing services to the member. All records shall be maintained a minimum of six (6) years.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Percent of waiver applicants who had a level of care N= Total number of applicants who had a level of care evaluation D= Total number of waiver applicants for whom there is reasonable indication that services may be needed.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If ‘Other’ is selected, specify:

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<th>Responsible Party for data collection/generation (check each that applies)</th>
<th>Frequency of data collection/generation (check each that applies)</th>
<th>Sampling Approach (check each that applies)</th>
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<td>✔ Monthly</td>
<td>✔ Less than 100% Review</td>
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<td></td>
<td>✔ Continuously and Ongoing</td>
<td>✔ Other</td>
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<tr>
<td></td>
<td>✔ Other</td>
<td>✔ Specify: Fiscal agent, QIO</td>
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Confidence Interval =

Describe Group:
Data Aggregation and Analysis:

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<td></td>
<td>✔ Other Specify:</td>
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</table>

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.

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:**
Percentage of waiver participants reviewed by QIO whose initial and subsequent level of care eligibility was appropriately determined

N=number of applicants who had level of care which met criteria for the waiver
D=number of applicants

**Data Source** (Select one):

**Reports to State Medicaid Agency on delegated Administrative functions**

If 'other' is selected, specify:

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<th>Frequency of data collection/generation (check each that applies):</th>
<th>Sampling Approach (check each that applies):</th>
</tr>
</thead>
</table>
ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

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

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

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

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)
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<td>Continuously and Ongoing</td>
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</table>

**Appendix B: Participant Access and Eligibility**

**B-7: Freedom of Choice**

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

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

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

All waiver members are informed of their choice of institutional care or waiver programs and available services, including all available waiver providers by participating Case Management waiver providers. This information is provided at the initial evaluation and at each reevaluation and documented on the MAP-350, “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 Case Management provider. The freedom of choice form is completed annually or when a participant changes case management providers.

Waiver participants are also assured freedom of choice as defined by the experience of independence, individual initiative, or autonomy in making life choices, both in small everyday matters (what to eat or what to wear), and in large, life-defining matters (where and with whom to live and work);

The service, provider and setting are selected by the individual from among setting options including non-disability specific settings;

The individual must be provided with the choice of where to live with as much independence as possible, and in the most community-integrated environment;

The setting options are identified and documented in the person-centered service plan and are based on the individual's needs and preferences, and, for residential settings, resources available for room and board.

**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 waiver Providers.
Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficient 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, case manager and the service provider to determine the type of assistance needed and may require additional activities on the part of the provider to ensure the appropriate translation services are available to the individual.

Appendix C: Participant Services

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

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

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statutory Service</td>
<td>Conflict Free Case Management</td>
</tr>
<tr>
<td>Statutory Service</td>
<td>Consultative Clinical and Therapeutic Services</td>
</tr>
<tr>
<td>Statutory Service</td>
<td>Day Training</td>
</tr>
<tr>
<td>Statutory Service</td>
<td>Personal Assistance</td>
</tr>
<tr>
<td>Statutory Service</td>
<td>Residential Support Level I</td>
</tr>
<tr>
<td>Statutory Service</td>
<td>Respite</td>
</tr>
<tr>
<td>Statutory Service</td>
<td>Shared Living</td>
</tr>
<tr>
<td>Statutory Service</td>
<td>Supported Employment</td>
</tr>
<tr>
<td>Supports for Participant Direction</td>
<td>Community Guide</td>
</tr>
<tr>
<td>Supports for Participant Direction</td>
<td>Financial Management Services</td>
</tr>
<tr>
<td>Supports for Participant Direction</td>
<td>Natural Supports Training</td>
</tr>
<tr>
<td>Other Service</td>
<td>Community Access</td>
</tr>
<tr>
<td>Other Service</td>
<td>Community Transition</td>
</tr>
<tr>
<td>Other Service</td>
<td>Environmental Accessibility Adaptation Services</td>
</tr>
<tr>
<td>Other Service</td>
<td>Goods and Services</td>
</tr>
<tr>
<td>Other Service</td>
<td>Person Centered Coach</td>
</tr>
<tr>
<td>Other Service</td>
<td>Positive Behavior Supports</td>
</tr>
<tr>
<td>Other Service</td>
<td>Residential Support Level II</td>
</tr>
<tr>
<td>Other Service</td>
<td>Specialized Medical Equipment and Supplies</td>
</tr>
</tbody>
</table>
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:**

<table>
<thead>
<tr>
<th>Category 1:</th>
<th>Sub-Category 1:</th>
</tr>
</thead>
<tbody>
<tr>
<td>01 Case Management</td>
<td>01010 case management</td>
</tr>
</tbody>
</table>

**Service Definition (Scope):**

Case management involves working with the individual and others that are identified by the individual such as family members in developing a Person Centered Service Plan (PCSP) Case management is responsible for participating in the assessment, reassessment, arranging for appropriate evaluations, intake, referral, and eligibility processes. Using person centered planning process, case management assists in identifying and implementing support strategies. These strategies will incorporate the principles of empowerment, community inclusion, health and safety assurances, and the use of formal, informal and community supports. Case managers will work closely with the individual to assure his or her ongoing expectations and satisfaction with their lives in the community, the processes and outcomes of supports, services, and available resources. Case managers will assure that participants have freedom of choice of providers in a conflict free climate.

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

- The health, safety and welfare of the individual are met.
- The desires and needs of the individual are determined.
- The supports and services desired and needed by the individual are identified and implemented.
- Housing and employment issues are addressed.
- Social networks are developed.
- Appointments and meetings are scheduled.

A person-centered approach to planning is provided while utilizing waiver and other community supports. The quality of the supports and services as well as the health and safety of the individuals are monitored. Case manager will assist participant in managing benefits as needed.

Activities are documented, and plans for supports and services are reviewed at least annually and more often as needed utilizing person centered planning processes. The CM or designee must be able to respond to a call regarding a crisis event.
within 15 minutes and be able to respond or send a designee within 45 minutes if necessary.

Case management shall not include direct services. Conflict-free case management requires that 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 (30 miles from the participant’s residence).

Case managers employed by a qualified provider shall have:

- Bachelor's Degree- or higher degree- in human service field, from an accredited college or university; OR
- Bachelor's degree in any other field, from an accredited college or university, with 1 year experience in the field of intellectual disability; OR
- Registered Nurse currently licensed as defined in KRS 314.011(5), and who has one (1) year or more experience as a professional nurse in the field of intellectual disability; AND
- Shall be supervised by a case management supervisor who shall have 2 years experience as a case manager.

Case Management Standards: all case management entities shall adopt the following case management standards:

- a. Communication - Both intra/inter agency communication must be utilized to ensure the best interest of the client. Case managers must be able to identify and meet the needs of the client.
- b. Cultural Competency - Case managers must be competent not only in the client’s language, either through personal knowledge or interpretation, but also demonstrate a heightened awareness of the unique way in which clients interact with the world around them.
- c. Education - Case managers must ensure education for the client encompassing the client’s need for knowledge of the case management process, their personal rights, risks and responsibilities as well as awareness of available services. It is also the responsibility of all agencies to keep each other aware of changes in their scope of work as they evolve.
- d. Ethics - Each profession providing case management must have a Code of Ethics to guide their practice. The commonalities may include variations on beneficence (doing good), non-malfeasance (doing no harm), respecting the rights of individuals to make their own decisions, justice (to treat other’s fairly), and fidelity (to follow-through and keep promises).
- e. Interdisciplinary and Inter-organizational Collaboration - The case manager is the leader of the team and must take charge of the coordination of client services through team meetings with representatives of all agencies providing services to that one client.
- f. Person Centered - Client participation must be included in the case management process. Client preferences and participation in decision making must be a priority for CHFS case management.
- g. Plan, Implement, Monitor, Amend - The case management process must involve a constant recognition of what is working and what is not working in the client’s plan of care. Changing what is not working must be a priority in addition to keeping parts of the plan that are providing for the needs of the client.
- h. Documentation - Client interactions, communication with other agencies, and personal observations must be recorded in compliance with the Cabinet and Agency specific policies and procedures.
- i. Advocacy for Individuals (within state guidelines) - Case managers must advocate for clients at the service delivery and benefits administration levels. When appropriate, case managers should assist in making policy changes as allowed by their employer.
- j. Accountability - The case manager must be accountable to their client for assurance that the client’s needs are being met. The case manager must be accountable to the team to provide leadership and follow through. The case manager must also be accountable to their employer for following the policies and procedures of the agency.
- k. Resource Management – Case Management of the client’s benefits and financial assets must contribute to the successful implementation of the plan of care. This involves assessing the quality of services, as well as the safety and cost-effectiveness of the services being provided.
- l. Professional Development – Case managers must keep current with practice changes and research related to their area of practice.

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

Billed as one monthly unit

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:
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: 
SCL certified or licensed agency
Provider Qualifications
License (specify):
Certificate (specify):
Other Standard (specify):
meets all DDID personnel and training requirements

Verification of Provider Qualifications
Entity Responsible for Verification:
Certified providers-DBHDID
Licensed providers-Office of Inspector General
Frequency of Verification:
Certified-initially and at least every two years thereafter
Licensed-annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service
Service:
Psychosocial Rehabilitation
Alternate Service Title (if any):
Consultative Clinical and Therapeutic Services

HCBS Taxonomy:

<table>
<thead>
<tr>
<th>Category</th>
<th>Sub-Category 1:</th>
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<tbody>
<tr>
<td>10 Other Mental Health and Behavioral Services</td>
<td>10090 other mental health and behavioral services</td>
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</tbody>
</table>

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):**
Service provides expertise, training and technical assistance to improve the ability of paid and unpaid caregivers to carry out therapeutic interventions. Through this service, a professional may complete an assessment of the individual, the environment and the system of supports, develop a home treatment plan to facilitate improvement, maintain skills or to prevent decline, provide recommendations and participate in development/revision of components of a participant's person-centered plan. Individuals may need this service to coordinate program wide support addressing assessed needs, conditions or symptoms affecting their ability to fully participate in their community.

This service is provided by licensed or certified professionals in psychology, nutrition or counseling; OR a positive behavior specialist. These service providers must also have at least two years of direct service experience with individuals with intellectual or developmental disabilities.

The service may include consultation, assessment, the development of a home treatment/support plan, training and technical assistance to carry out the plan and monitoring of the individual and the provider in the implementation of the plan. This service may be delivered in the individual's home and in the community as described in the service plan. This service also encompasses psychological treatment as indicated by the condition of the individual. Participation is expected at Plan of Care meeting which is not a separate billable service.

This service may also include direct monitoring of implementation of the home treatment/support plan and/or the person-centered plan as well as direct supervision of the Person Centered Coach by the supervising Positive Behavior Specialist.

The plan of care shall specify the scope of consultative clinical and therapeutic services that are needed and shall identify the type of professional(s) required.

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

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

Unit is 15 minutes
Limited to 160 units per year

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>Home Health Agency</td>
</tr>
<tr>
<td>Agency</td>
<td>Approved Waiver providers</td>
</tr>
<tr>
<td>Agency</td>
<td>Adult Day Health Care Agency</td>
</tr>
</tbody>
</table>

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Consultative Clinical and Therapeutic Services**

https://wms-mmdl.cdsydc.com/WMS/faces/protected/35/print/PrintSelector.jsp

4/29/2015
Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications
License (specify):
902 KAR 20:066
Certificate (specify):

Other Standard (specify):
All standards identified in program regulations and services manual AND employs professionals qualified to provide service

Verification of Provider Qualifications
Entity Responsible for Verification:
Office of Inspector General
Frequency of Verification:
Initially and annually thereafter

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

Service Type: Statutory Service
Service Name: Consultative Clinical and Therapeutic Services

Provider Category:
Agency
Provider Type:
Approved Waiver providers
Provider Qualifications
License (specify):
Certificate (specify):

Other Standard (specify):
All standards identified in program regulations and services manual, AND employs professionals qualified to provide the service

Verification of Provider Qualifications
Entity Responsible for Verification:
DBHDID
Frequency of Verification:
initially and at least every 2 years thereafter

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

Service Type: Statutory Service
Service Name: Consultative Clinical and Therapeutic Services

Provider Category:
Agency
Provider Type:
Adult Day Health Care Agency
Provider Qualifications
License (specify):
902 kar 20:081
Certificate (specify):
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).

<table>
<thead>
<tr>
<th>Service Type:</th>
<th>Statutory Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service:</td>
<td>Day Habilitation</td>
</tr>
</tbody>
</table>

Alternate Service Title (if any): Day Training

HCBS Taxonomy:

<table>
<thead>
<tr>
<th>Category 1:</th>
<th>Sub-Category 1:</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Category 4:</th>
<th>Sub-Category 4:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

DT services can be provided at a fixed location, or in community settings. Services provided in a fixed location are typically provided on a regularly scheduled basis, no more than five days per week. The hours must be spent in training and program...
activities and must be based on the person’s Plan of Care. Support services lead to the acquisition, improvement, and/or retention of skills and abilities to prepare the person for work and/or community access or transition from school to adult responsibilities and community integration. DT may be provided as an adjunct to other services included on a person’s support plan. For example: a person may receive supported employment or other services for part of a day or week and DT services at a different time of the day or week. DT services will only be billable for the time that the person actually received the service. DT may also include group approaches to work related training that occur in community settings (mobile work crews, enclaves, entrepreneurial models). Any person receiving DT services that are performing productive work that benefits the organization, or would have to be performed by someone else if not performed by the person, must be paid. People who are working must be paid commensurate with members of the general work force doing similar work per wage and hour regulations of the U.S. Department of Labor.

In addition to work-related training, DT may include involvement in community based activities that assist the person in increasing his/her ability to access community resources and being involved with other members of the general population. DT can be used to provide access to community-based activities that cannot be provided by natural or other unpaid supports, and is defined as activities designed to result in increased ability to access community resources without paid supports.

These services may not supplant educational services available under the IDEA (20 U.S.C. 1401 et seq.). Specify applicable (if any) limits on the amount, frequency, or duration of this service: 15 minute units. Day Training is limited to 160 units per week alone or in combination with Supported Employment.

Any combination of community access, day training, supported employment and personal assistance service, plus hours the person spends performing paid employment may not exceed 64 units (16 hours) per day.

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:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>Qualified DT Staff</td>
</tr>
<tr>
<td>Agency</td>
<td>SCL certified provider agency employing qualified day training staff</td>
</tr>
</tbody>
</table>

Appendix C: Participant Services

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

Provider Category:
- Individual

Provider Type:
- Qualified DT Staff

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):
Day training staff
Is at least:
1. Eighteen (18) years old and has a high school diploma or GED; or
2. Twenty-one (21) years old;
(d) Meets the personnel and training requirements established in Section 3 of this administrative regulation;
(e) Has the ability to:
1. Communicate effectively with a participant and the participant’s family; 
2. Read, understand, and implement written and oral instructions; 
3. Perform required documentation; and 
4. Participate as a member of the participant’s person centered team if requested by the participant; and 
   (f) Demonstrates competence and knowledge on topics required to safely support the participant as described in the participant’s person centered plan of care. 
5. Is legally licensed to operate the transporting vehicle to which the individual is assigned or owns, and has proof of current liability insurance for the vehicle in which the participant is transported.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Case Manager

**Frequency of Verification:**
Prior to service delivery

---

### Appendix C: Participant Services

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

<table>
<thead>
<tr>
<th>Service Type:</th>
<th>Statutory Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Name:</td>
<td>Day Training</td>
</tr>
</tbody>
</table>

**Provider Category:**
Agency

**Provider Type:**
SCL certified provider agency employing qualified day training staff

**Provider Qualifications**

- **License (specify):**
- **Certificate (specify):**
- **Other Standard (specify):**
  Meets all applicable DDID standards for a waiver provider agency and employs staff with the following qualifications:
  - Is at least:
    - 1. Eighteen (18) years old and has a high school diploma or GED; or
    - 2. Twenty-one (21) years old;
  - (d) Meets the personnel and training requirements established in Section 3 of this administrative regulation;
  - (e) Has the ability to:
    - 1. Communicate effectively with a participant and the participant’s family;
    - 2. Read, understand, and implement written and oral instructions;
    - 3. Perform required documentation; and
    - 4. Participate as a member of the participant’s person centered team if requested by the participant; and
  - (f) Demonstrates competence and knowledge on topics required to safely support the participant as described in the participant’s person centered plan of care.
  - 5. Is legally licensed to operate the transporting vehicle to which the individual is assigned or owns, and has proof of current liability insurance for the vehicle in which the participant is transported.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
DBHDID

**Frequency of Verification:**
initially and at least every two years thereafter

---

**Appendix C: Participant Services**

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

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

**Service:**
Personal Care

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

**HCBS Taxonomy:**

**Category 1:**
08 Home-Based Services

**Sub-Category 1:**
08030 personal care

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

---

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

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

**Service Definition (Scope):**
Personal assistance services enable waiver participants to accomplish tasks that they normally would do for themselves if they did not have a disability. This assistance may include hands-on assistance (actually performing a task for the person), reminding, observing, guiding, and/or training a waiver participant in ADLs (such as bathing, dressing, toileting, transferring, maintaining continence) and IADLs (more complex life activities such as personal hygiene, light housework, laundry, meal planning and preparation, transportation, grocery shopping, using the telephone, money management, and medication administration). This service may also include assisting the waiver participant in managing his/her medical care including making medical appointments, and accompanying the waiver participant during medical appointments. Transportation to access community services, activities and appointments shall not duplicate State plan transportation services. Personal assistance services take place in the waiver participant’s home, and in the community as appropriate to the individual’s need.

Personal assistance services are available only to a waiver participant who lives in his/her own residence or in his/her family residence. Personal assistance supports are not available to any waiver participant receiving paid residential supports.

Personal assistance services are not available to individuals under the age of 21 when medically necessary personal assistance services are covered by EPSDT. Personal assistance services may not supplant educational services available under the IDEA (20 U.S.C. 1401 et seq.).

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Unit of service: 15 minutes
Any combination of community access, day training, supported employment, personal assistance and the hours a person spends performing paid employment may not exceed 64 units (16 hours) per day

**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
Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Assistance

Provider Category: Individual
Provider Type: Qualified Personal Assistance staff

Provider Qualifications

License (specify):
Certificate (specify):
Other Standard (specify):

Is at least:
1. Eighteen (18) years old and has a high school diploma or GED; or
2. Twenty-one (21) years old;
(d) Meets the personnel and training requirements established in Section 3 of this administrative regulation;
(e) Has the ability to:
1. Communicate effectively with a participant and the participant’s family;
2. Read, understand, and implement written and oral instructions;
3. Perform required documentation; and
4. Participate as a member of the participant’s person centered team if requested by the participant; and
(f) Demonstrates competence and knowledge on topics required to safely support the participant as described in the participant’s person centered plan of care.
5. Is legally licensed to operate the transporting vehicle to which the individual is assigned or owns, and has proof of current liability insurance for the vehicle in which the participant is transported.

Verification of Provider Qualifications
Entity Responsible for Verification:
case manager
Frequency of Verification:
prior to service delivery

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Assistance

Provider Category: Agency
Provider Type: SCL certified agency
Provider Qualifications

License (specify):
Certificate (specify):
Other Standard (specify):
Meets all DDID standards for a waiver provider agency and employs staff with following qualifications:
Is at least:
1. Eighteen (18) years old and has a high school diploma or GED; or
2. Twenty-one (21) years old;
(d) Meets the personnel and training requirements established in Section 3 of this administrative regulation;
(e) Has the ability to:
1. Communicate effectively with a participant and the participant’s family;
2. Read, understand, and implement written and oral instructions;
3. Perform required documentation; and
4. Participate as a member of the participant’s person centered team if requested by the participant; and
(f) Demonstrates competence and knowledge on topics required to safely support the participant as described in the participant’s person centered plan of care.
5. Is legally licensed to operate the transporting vehicle to which the individual is assigned or owns, and has proof of current liability insurance for the vehicle in which the participant is transported.

Verification of Provider Qualifications
Entity Responsible for Verification:
DBHDID
Frequency of Verification:
Initially and at least every two years thereafter

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

| Service Type: Statutory Service |
| Service Name: Personal Assistance |
| Provider Category: |
| Agency |
| Provider Type: |
| Adult Day Healthcare agency |
| Provider Qualifications |
| License (specify): |
| 902 KAR 20:081 |
| Certificate (specify): |

Other Standard (specify):
Meets all applicable DDID standards for a waiver provider agency and employs staff with the following qualifications:
Is at least:
1. Eighteen (18) years old and has a high school diploma or GED; or
2. Twenty-one (21) years old;
(d) Meets the personnel and training requirements established in Section 3 of this administrative regulation;
(e) Has the ability to:
1. Communicate effectively with a participant and the participant’s family;
2. Read, understand, and implement written and oral instructions;
3. Perform required documentation; and
4. Participate as a member of the participant’s person centered team if requested by the participant; and
(f) Demonstrates competence and knowledge on topics required to safely support the participant as described in the participant’s person centered plan of care.
5. Is legally licensed to operate the transporting vehicle to which the individual is assigned or owns, and has proof of current liability insurance for the vehicle in which the participant is transported.

Verification of Provider Qualifications
Entity Responsible for Verification:
Office of Inspector General
Frequency of Verification:
Initially and annually thereafter
C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Personal Assistance

Provider Category:
Agency

Provider Type:
Home Health Agency

Provider Qualifications
License (specify):
907 KAR 20:066
Certificate (specify):

Other Standard (specify):
Meets all applicable DDID standards for a waiver provider agency and employs staff with the following qualifications:
Is at least:
1. Eighteen (18) years old and has a high school diploma or GED; or
2. Twenty-one (21) years old;
(d) Meets the personnel and training requirements established in Section 3 of this administrative regulation;
(e) Has the ability to:
1. Communicate effectively with a participant and the participant’s family;
2. Read, understand, and implement written and oral instructions;
3. Perform required documentation; and
4. Participate as a member of the participant’s person centered team if requested by the participant; and
(f) Demonstrates competence and knowledge on topics required to safely support the participant as described in the participant’s person centered plan of care.
5. Is legally licensed to operate the transporting vehicle to which the individual is assigned or owns, and has proof of current liability insurance for the vehicle in which the participant is transported.

Verification of Provider Qualifications
Entity Responsible for Verification:
Office of Inspector General
Frequency of Verification:
Initially and annually thereafter

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

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

Service Type:
Statutory Service

Service:
Residential Habilitation

Alternate Service Title (if any):
Residential Support Level I

HCBS Taxonomy:

Category 1:
02 Round-the-Clock Services

Sub-Category 1:
02011 group living, residential habilitation

Category 2:

Sub-Category 2:
Service Definition (Scope):
Level I Residential Supports are targeted for people who require 24 hour intense level of support and are individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, adult educational supports, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs. Residential services also include protective oversight and supervision, transportation, personal assistance and the provision of medical and health care services that are integral to meeting the daily needs of residents.

Residential support may include the provision of up to five (5) unsupervised hours per day per person as identified in the person centered Plan of Care (POC) to promote increased independence which shall be based on the individual needs of a person as determined with the person centered team and reflected in the POC. Unsupervised hours are based upon the Plan of Care developed in the person centered planning process. Those who cannot safely be unsupervised would not be unsupervised. The supports required for each participant will be outlined in their Person Centered Plan which includes a Crisis Prevention Plan.

For each participant approved for any unsupervised time, a safety plan will be created based upon their assessed needs. The Case Manager, as well as other team members, will ensure the participant is able to implement the safety plan. On-going monitoring of the safety plan, procedures or assistive devices required would be conducted by the Case Manager to ensure relevance, ability to implement and functionality of devices if required.

If an individual experiences a change in support needs or status, adjustments in Residential Services shall be made to meet the support needs. If changes are anticipated to be chronic (lasting more than 3 months), the residential provider may request reassessment to determine if needs have changed. Any increase in funding based on assessed needs shall be used for provision of additional supports as outlined in a revised POC. The residential provider is responsible for informing DDID once the person has returned to previous status so that Residential Service Level can return to previous status. When Residential services are authorized for an individual, the determination of the level is based on information from the individual’s Supports Intensity Scale (SIS), Health Risk Screening Tool (HRST), and approved POC.

The agency providing residential supports is responsible to arrange for or provide transportation between the participant's place of residence and other service sites and community locations.

Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. The method by which the costs of room and board are excluded from payment for Residential Services is specified in Appendix J.

Level I Residential supports are furnished in a provider owned residence with variable rates based on three or fewer persons in the residence; vs. four or more persons in the residence. Provider owned or leased residences where residential services are furnished must be compliant with the Americans with Disabilities Act based on the needs of the persons supported.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
There is a separate rate for residential provided to more than 3 persons in one location.

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:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>SCL certified residential provider-staffed residence</td>
</tr>
<tr>
<td>Agency</td>
<td>Certified Group Home Provider</td>
</tr>
</tbody>
</table>

Appendix C: Participant Services

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

Service Type: Statutory Service  
Service Name: Residential Support Level I

Provider Category:  
Agency

Provider Type:  
SCL certified residential provider-staffed residence

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Meets all applicable DDID standards for a waiver provider agency and employs staff with the following qualifications:

Is at least:

1. Eighteen (18) years old and has a high school diploma or GED; or
2. Twenty-one (21) years old;
(d) Meets the personnel and training requirements established in Section 3 of this administrative regulation;
(e) Has the ability to:
1. Communicate effectively with a participant and the participant’s family;
2. Read, understand, and implement written and oral instructions;
3. Perform required documentation; and
4. Participate as a member of the participant’s person centered team if requested by the participant; and
(f) Demonstrates competence and knowledge on topics required to safely support the participant as described in the participant’s person centered plan of care.
5. Is legally licensed to operate the transporting vehicle to which the individual is assigned or owns, and has proof of current liability insurance for the vehicle in which the participant is transported.

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

Verification of Provider Qualifications

Entity Responsible for Verification:  
DBHDID

Frequency of Verification:  
initially and at least every two years thereafter

Appendix C: Participant Services

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

Service Type: Statutory Service  
Service Name: Residential Support Level I

Provider Category:  
Agency

Provider Type:  
Certified Group Home Provider

Provider Qualifications

License (specify):

902 KAR 20:078

Certificate (specify):
Other Standard (specify):
Meets all applicable DDID standards for a waiver provider agency; employs staff with the following qualifications:
1. Is eighteen (18) years or older; and Has a high school diploma or GED; or is at least twenty-one (21) years old; and
2. Meets all applicable DDID personnel and training requirements;
3. Has a valid Social Security number or a valid work permit if not a citizen of the U.S.; and
4. Has the ability to: a) communicate effectively with the person/family; b) understand and carry out instructions; c) perform required documentation.
5. Driver Is at least eighteen (18) years of age and legally licensed to operate the transporting vehicle to which the individual is assigned or owns, and has proof of current liability insurance for the vehicle in which the participant will be transported.

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

Verification of Provider Qualifications

Entity Responsible for Verification:
OIG

Frequency of Verification:
Initially and annually thereafter

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

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

Service Type:
Statutory Service

Service:
Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1: 09 Caregiver Support
Sub-Category 1: 09011 respite, out-of-home

Category 2: 09 Caregiver Support
Sub-Category 2: 09012 respite, in-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):
Respite Services are provided to individuals living in their own or family’s home who are unable to independently care for themselves. Respite services are provided on a short term basis due to the absence of or need for relief of the primary caregiver.

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

A provider may not use another person’s bedroom or another person’s belongings in order to provide respite for a different person. Respite care may not be furnished for the purpose of compensating relief or substitute staff for a waiver residential service. The costs of such staff are met from payments for the waiver residential service.

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

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Unit of service: 15 minutes
Limited to 830 hours per year

Service Delivery Method (check each that applies):
- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):
- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>Certified agency that employs qualified respite staff</td>
</tr>
<tr>
<td>Individual</td>
<td>Qualified respite staff</td>
</tr>
</tbody>
</table>

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Certified agency that employs qualified respite staff

Provider Qualifications
License (specify):
Certificate (specify):
Other Standard (specify):
Meets all applicable DDID standards for a waiver provider agency and employs staff with the following qualifications:
Is at least:
1. Eighteen (18) years old and has a high school diploma or GED; or
2. Twenty-one (21) years old;
(d) Meets the personnel and training requirements established in Section 3 of this administrative regulation;
(e) Has the ability to:
1. Communicate effectively with a participant and the participant’s family;
2. Read, understand, and implement written and oral instructions;
3. Perform required documentation; and
4. Participate as a member of the participant’s person centered team if requested by the participant; and
   (f) Demonstrates competence and knowledge on topics required to safely support the participant as described in the participant’s person centered plan of care.
5. Is legally licensed to operate the transporting vehicle to which the individual is assigned or owns, and has proof of current liability insurance for the vehicle in which the participant is transported.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
DBHID

**Frequency of Verification:**
Initially and at least every two years thereafter

### Appendix C: Participant Services

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

**Service Type:** Statutory Service

**Service Name:** Respite

**Provider Category:**
Individual

**Provider Type:**
Qualified respite staff

**Provider Qualifications**

- **License (specify):**

- **Certificate (specify):**

- **Other Standard (specify):**
  Is at least:
  1. Eighteen (18) years old and has a high school diploma or GED; or
  2. Twenty-one (21) years old;
  (d) Meets the personnel and training requirements established in Section 3 of this administrative regulation;
  (e) Has the ability to:
  1. Communicate effectively with a participant and the participant’s family;
  2. Read, understand, and implement written and oral instructions;
  3. Perform required documentation; and
  4. Participate as a member of the participant’s person centered team if requested by the participant; and
  (f) Demonstrates competence and knowledge on topics required to safely support the participant as described in the participant’s person centered plan of care.
  5. Is legally licensed to operate the transporting vehicle to which the individual is assigned or owns, and has proof of current liability insurance for the vehicle in which the participant is transported.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Case manager

**Frequency of Verification:**
prior to service delivery

### Appendix C: Participant Services

#### C-1/C-3: 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:
Live-in Caregiver (42 CFR §441.303(f)(8))

Alternate Service Title (if any):
Shared Living

HCBS Taxonomy:

Category 1:
02 Round-the-Clock Services

Sub-Category 1:
02023 shared living, other

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):
This service is designed as an alternative to residential services and allows a person to live in their own home with a roommate/live-in caregiver to provide some of their supports. The caregiver may provide overnight supervision and necessary personal assistance, or may provide assistance during waking hours depending on the need of the person. Persons receiving shared living service may also receive other approved waiver services.

Caregiver living expenses are the portion of the room and board that may be reasonably attributed to a live-in caregiver who also provides unpaid assistance with the acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, supervision required for safety and the social and adaptive skills necessary to enable the participant to reside safely and comfortably in his or her own home. The service must be provided to an enrollee, living in his or her own home and the live-in caregiver must reside in the same home. For purposes of this service, “food” includes three meals a day. If two waiver recipients choose to live together in a home, they may share a live in caregiver.

Allowable Activities:
• Under Medicaid and § 1634 and SSI criteria rules, in order for the payment not to be considered income to the recipient, payment for the portion of the costs of rent and food attributable to an unrelated live-in personal caregiver must be routed through the provider specifically for the reimbursement of the waiver participant
• Room and board for the unrelated live-in caregiver (who is not receiving any other financial reimbursement for the provision of this service)
• Room: shelter type expenses including all property related costs such as rental or purchase of real estate and furnishings, maintenance, utilities and related administrative services
• Board: three meals a day or other full nutritional regimen
• Unrelated: unrelated by blood or marriage to any degree including 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.
• Caregiver: An individual providing service determined by a person centered process and documented in the Plan of Care to meet the physical, social or emotional needs of the participant receiving services.

Service Standards:
• Room and board for an Unrelated Live-in Caregiver should be reflected in the prior approved Plan of Care for the individual, or in the case of a live in caregiver providing support to two individuals, the plan of care for each will be taken into consideration in determining the total amount of room and board.
• Services must address needs identified in the person centered planning process and be outlined in the Plan of Care and specified in contractual agreement between the waiver recipient(s) and the live in caregiver.
• Services must complement other services the participant receives and enhance increasing independence for the participant
• The person centered planning team will decide and assure that the individual who will serve as a live-in caregiver has the experience, skills, training and knowledge appropriate to the participant and the type of support needed

Documentation Standards:
Room and board documentation for the Unrelated Live-in Caregiver must:

• Be identified in the Service Plan and specified in contractual agreement between the waiver recipient and live in caregiver.
• Include documentation of how amount of Room and board expenditure was determined
• Show receipt that funds were paid to the live-in caregiver
• Include a monthly summary note that indicates services were provided according to the Plan of Care.

Payment will not be made when the SCL individual lives in the caregiver’s home or in a residence that is owned or leased by the provider of Medicaid services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Not exceed $600.00 per month

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:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
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</thead>
<tbody>
<tr>
<td>Agency</td>
<td>SCL waiver approved case management agency</td>
</tr>
<tr>
<td>Individual</td>
<td>Individual hired by participants who self direct service</td>
</tr>
</tbody>
</table>

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

Provider Type:
SCL waiver approved case management agency

Provider Qualifications
License (specify):

Certificate (specify):

Other Standard (specify):
the agency ensures that the caregiver meets the following qualifications:
Meets all applicable DDID standards for a waiver provider agency and employs staff with the following qualifications:
Is at least:
1. Eighteen (18) years old and has a high school diploma or GED; or
2. Twenty-one (21) years old;
(d) Meets the personnel and training requirements established in Section 3 of this administrative regulation;
(e) Has the ability to:
1. Communicate effectively with a participant and the participant’s family;
2. Read, understand, and implement written and oral instructions;
3. Perform required documentation; and
4. Participate as a member of the participant’s person centered team if requested by the participant; and
(f) Demonstrates competence and knowledge on topics required to safely support the participant as described in the participant’s person centered plan of care.

5. Is legally licensed to operate the transporting vehicle to which the individual is assigned or owns, and has proof of current liability insurance for the vehicle in which the participant is transported.

Verification of Provider Qualifications
Entity Responsible for Verification:
DBHID
Frequency of Verification:
initially and at least every two years thereafter

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

Service Type: Statutory Service
Service Name: Shared Living

Provider Category:
Individual

Provider Type:
Individual hired by participants who self direct service

Provider Qualifications
License (specify):

Certificate (specify):

Other Standard (specify):
The Case manager ensures that the live in caregiver meets the following qualifications prior to employment:
Meets all applicable DDID standards for a waiver provider agency and employs staff with the following qualifications:
Is at least:
1. Eighteen (18) years old and has a high school diploma or GED; or
2. Twenty-one (21) years old;
   (d) Meets the personnel and training requirements established in Section 3 of this administrative regulation;
   (e) Has the ability to:
       1. Communicate effectively with a participant and the participant’s family;
       2. Read, understand, and implement written and oral instructions;
       3. Perform required documentation; and
       4. Participate as a member of the participant’s person centered team if requested by the participant; and
   (f) Demonstrates competence and knowledge on topics required to safely support the participant as described in the participant’s person centered plan of care.
5. Is legally licensed to operate the transporting vehicle to which the individual is assigned or owns, and has proof of current liability insurance for the vehicle in which the participant is transported.

Verification of Provider Qualifications
Entity Responsible for Verification:
case manager
Frequency of Verification:
prior to service delivery

Appendix C: Participant Services
C-1/C-3: 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:
Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1: 03 Supported Employment
Sub-Category 1: 03010 job development

Category 2: 03 Supported Employment
Sub-Category 2: 03021 ongoing supported employment, individual

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):
Supported employment is paid, competitive employment at or above minimum wage for an SCL recipient who has demonstrated an inability to gain and maintain traditional employment. Supported Employment occurs in a variety of integrated business environments. Phases of Supported Employment include: Job Development, Job Acquisition, Successful Placement and Long Term Follow up. Supported employment is a one to one service that shall be person specific.

Job Development must begin with Discovery (Person-Centered Job Selection), where job goal/features of desired employment are selected based on spending time with the person in non-standardized non-standardized/non-testing situations to learn his gifts, talents and support needs.
Person Centered Job Selection is achieved by completing a “Person Centered Employment Plan” (PCEP), and includes job planning meetings and job analysis. The job planning meetings involve convening and networking with trusted people; matching job characteristics with job tasks and then with types of employers and finally with specific employers - mapping a way for effective job development. Job analysis is conducted to determine the culture of the business, possibilities for customized employment, how people typically learn their jobs, who teaches them and how long training typically takes. Job development may also focus on interviewing skills/interview support, resume development and assistance with filling out applications. Customized employment is essential to individualize the employment relationship between the employer and the supported employee in ways that meet the needs for both.

Acquisition is the actual acceptance of a position by the individual. During this phase, the individual will receive training on how to perform the job tasks. Natural Supports available in the workplace should be developed and utilized from the beginning. Other training could include, but is not limited to the following: social interaction, medication scheduling, chain of command, documentation of time (timesheets, clocks) hygiene issues, mobility, conflict resolution, when and from whom it is appropriate to seek assistance, and personnel policies. Additional training in exploring transportation options, utilization and schedule may also be needed. These trainings can occur both on and off the job site. The expectation is for systemic fading of the Employment Specialist to begin as soon as possible without jeopardizing job placement. Successful placement shall be when natural supports are relied on more fully and fading of the employment specialist from the worksite begins. Additionally, before a successful placement can be determined there must be confirmation that the employee is functioning well at the job. Consideration should include not only the person’s general satisfaction, but also the number of hours worked, performance of job duties and other basics, his/her comfort level on the job, and interaction with coworkers and supervisors. Other less visual, but essential aspects of the job, which if unattended, could jeopardize the employee’s future must also be considered. The development of natural supports in the work environment is a critical role of the Employment Specialist during this phase and it may be necessary to write Impairment Related Work Expense (IRWE) plans or Plans for Achieving Self Support (PASS) for the employee or access other waiver services to address individualized needs. The expectation is for systemic fading of the Employment Specialist to begin as soon as possible without jeopardizing job placement.
Long Term Follow-up is support provided to maintain the job placement and the continued success after the individual is fully integrated into the workplace and the Employment Specialist is no longer needed at the job site on a regular basis. The Employment Specialist must continue to be available, if and when needed for support or assistance with job changes/job advancements. Activities could include, but are not limited to the following: problem-solving, retraining, regular contact with employer, employee, family, co-workers, other SCL staff and reassessment of an employee with regard to career changes or position upgrades. During this phase the Employment Specialist is required to make at least two contacts per month, one of which should be at the worksite.

Services do not include services that are available under Section 110 of the Rehabilitation Act of 1973 (or, in the case of youth, under the provisions of IDEA, (20 U.S.C.1401 et seq.). The state will determine that such services are not available to the participant before authorizing their provision as a waiver service. Documentation that services are not otherwise available is maintained in the file of each participant receiving this service.

Waiver funding is not available for the provision of Supported Employment services (e.g., sheltered work performed in a facility) where individuals are supervised in producing goods or performing services under contract to third parties.

Transportation provided through Supported Employment service is included in the cost of doing business and incorporated in the administrative overhead cost.

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

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Unit of service: 15 minutes

For SCL Person Centered Job Selection funding, the participant may access up to 120 units
For SCL Job Development Services, the participant and their employment specialist may access up to 90 units.
For SCL Job Acquisition and Stabilization Services, the participant and their SE Specialist may access up to 800 units
For SCL Long-Term Employment Supports, the participant and their SE Specialist may access up to twenty-four (24) units of SE per month
Any combination of community access, adult day training, supported employment and personal assistance service, plus hours the person spends performing paid employment may not exceed 64 units (16 hours) per day. Supported employment plus day training may not exceed 160 units per 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:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type</th>
<th>Provider Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td></td>
<td>Supported Employment Specialist</td>
</tr>
<tr>
<td>Agency</td>
<td></td>
<td>SCL certified agency employing supported employment specialists</td>
</tr>
</tbody>
</table>

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
[Individual]

Provider Type:
Supported Employment Specialist

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

https://wms-mmdl.cdssvc.com/WMS/faces/protected/35/print/PrintSelector.jsp

4/29/2015
Other Standard (specify):
(89) "Supported employment specialist" means an individual who:

(a) Provides ongoing support services to eligible participants in supported employment jobs in accordance with Section 4 of this administrative regulation;

(b) Has:
1. A bachelor’s degree from an accredited college or university, plus at least one (1) year of experience in the field of intellectual or developmental disability; or
2. A minimum of one year of prior experience in the field of intellectual or developmental disability and the completion of a Department approved credential within one (1) year of application, while providing supported employment services under the direct supervision of a qualified employment specialist; or
3. A minimum of five years of prior experience in the field of intellectual or developmental disability;

(c) Meets the personnel and training requirements established in Section 3 of this administrative regulation; and

(d) Completes, in sequence, the Kentucky Supported Employment Training Project curriculum from the Human Development Institute at the University of Kentucky within eight (8) months of the date of employment as an employment specialist.

Verification of Provider Qualifications
Entity Responsible for Verification: case manager
Frequency of Verification: prior to service delivery

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Agency
Provider Type:
SCL certified agency employing supported employment specialists

Provider Qualifications
License (specify):

Certificate (specify):
Completion of the UK HDI KY Supported Employment Training Project or comparable training approved by DDID, within 6 months of the date the specialist begins providing SCL SE services.

Other Standard (specify):
Meets all applicable DDID standards for a waiver provider agency.

Employs staff with the following qualifications:

DDID standards for SE Specialist are:
(89) "Supported employment specialist" means an individual who:

(a) Provides ongoing support services to eligible participants in supported employment jobs in accordance with Section 4 of this administrative regulation;

(b) Has:
1. A bachelor’s degree from an accredited college or university, plus at least one (1) year of experience in the field of intellectual or developmental disability; or
2. A minimum of one year of prior experience in the field of intellectual or developmental disability and the completion of a Department approved credential within one (1) year of application, while providing supported employment services under the direct supervision of a qualified employment specialist; or
3. A minimum of five years of prior experience in the field of intellectual or developmental disability;

(c) Meets the personnel and training requirements established in Section 3 of this administrative regulation; and

(d) Completes, in sequence, the Kentucky Supported Employment Training Project curriculum from the Human Development Institute at the University of Kentucky within eight (8) months of the date of employment as an employment specialist.

Verification of Provider Qualifications
Entity Responsible for Verification: DBHDID
Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

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

Support for Participant Direction:

Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):

Community Guide

HCBS Taxonomy:

<table>
<thead>
<tr>
<th>Category 1:</th>
<th>Sub-Category 1:</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 Services Supporting Self-Direction</td>
<td>12020 information and assistance in support of self-direction</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>Category 2:</th>
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<table>
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<tr>
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<th>Sub-Category 4:</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

Service Definition (Scope):

Community Guide services are designed to empower individuals to define and direct their own services and supports. These services are only for persons who opt for self-directed supports for either some or all of their support services. The person determines the amount of Community Guide services, if any, and the specific services that the Community Guide will provide. Community Guide Services include direct assistance to persons in brokering community resources and in meeting their consumer directed responsibilities. Community Guides provide information and assistance that help the person in problem solving and decision making and in developing supportive community relationships and other resources that promote implementation of the Plan of Care. The Community Guide service includes providing information to ensure the person understands the responsibilities involved with directing his or her services. The exact direct assistance provided by the Community Guide to assist the person in meeting consumer directed responsibilities depends on the needs of the person and includes assistance, if needed with recruiting, hiring, training, managing, evaluating, and changing employees, scheduling and outlining the duties of employees, developing and managing the individual budget, understanding provider qualifications, record keeping, and other requirements.

Community Guide services do not duplicate Case Management services. Case managers facilitate the team in development of the Person Centered Service Plan (PCSP), link the person to medical and waiver services including community guide services, ensure services in the plan are properly implemented, and monitor the delivery of services including Community Guide...
services. The specific Community Guide services to be received by a person are specified in the PCSP. Community Guide services must be authorized prior to service delivery at least annually in conjunction with the PCSP and with any PCSP revisions.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Unit of service: 15 minutes
Limit: 576 units per year

• Community Guides may not provide other direct waiver services, including Case Management, to any waiver participant. Community Guide agencies cannot provide Case Management services.
• A person serving as a representative for a waiver participant receiving participant directed services is not eligible to be a Community Guide for that person.

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:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>Qualified Community Guide</td>
</tr>
<tr>
<td>Agency</td>
<td>Certified SCL provider agency</td>
</tr>
</tbody>
</table>

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Community Guide

Provider Category: Individual
Provider Type: Qualified Community Guide

Provider Qualifications
License (specify):
Certificate (specify):
Other Standard (specify):
Qualified Community Guide has:
1. A bachelor’s degree from an accredited college or university plus at least one (1) year of experience in the field of intellectual or developmental disability; or
2. experience or credentialing that will substitute for the educational requirements stated on a year-for-year basis;
3. Meets the personnel and training requirements established in Section 3 of this administrative regulation;
4. Completes a community guide training curriculum approved by DBHDID within six (6) months of being employed by the first participant supported;

Verification of Provider Qualifications
Entity Responsible for Verification:
Case Manager
Frequency of Verification:
prior to service delivery
C-1/C-3: Provider Specifications for Service

| Service Type: Supports for Participant Direction |
| Service Name: Community Guide |

Provider Category:
- Agency

Provider Type:
- Certified SCL provider agency

Provider Qualifications
- License (specify): 
- Certificate (specify): 
- Other Standard (specify):
  Meets all applicable DDID standards for a waiver provider agency and employs staff with the following qualifications:
  - Qualified Community Guide has:
    1. A bachelor’s degree from an accredited college or university plus at least one (1) year of experience in the field of intellectual or developmental disability; or
    2. experience or credentialing that will substitute for the educational requirements stated on a year-for-year basis;
    3. Meets the personnel and training requirements established in Section 3 of this administrative regulation;
    4. Completes a community guide training curriculum approved by DBHDID within six (6) months of being employed by the first participant supported;

Verification of Provider Qualifications
- Entity Responsible for Verification:
  DBHDID
- Frequency of Verification:
  initially and at least every two years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
- Supports for Participant Direction

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

Support for Participant Direction:
- Financial Management Services

Alternate Service Title (if any):

HCBS Taxonomy:

<table>
<thead>
<tr>
<th>Category 1</th>
<th>Sub-Category 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 Services Supporting Self-Direction</td>
<td>12010 financial management services in support of self-direction</td>
</tr>
</tbody>
</table>

| Category 2 | Sub-Category 2 |

https://wms-mmdl.cdsydc.com/WMS/faces/protected/35/print/PrintSelector.jsp
Service Definition (Scope):
Management and direction of funds in the participant's approved person centered plan of care. The provider shall perform the employer responsibilities of payroll processing which includes: 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 participant, their representative, the case manager and the Department for Medicaid Services. The provider shall maintain a separate account for each participant while continually tracking and reporting funds, disbursements and the balance of the participant's budget. The provider shall process and pay for invoices for all participant directed services approved in the participant's plan of care. FMS is a required service for participants who elect to direct any service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Fiscal Management is defined as a fifteen (15) minute unit and limited to eight (8) units per member per calendar month. Financial management services are limited to members who opt to participant direct some or all of their non-medical services and apply only to participant directed services.

Service Delivery Method (check each that applies):
- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):
- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
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<tr>
<td>Agency</td>
<td>Area Development District</td>
</tr>
<tr>
<td>Agency</td>
<td>Community Mental Health Center</td>
</tr>
</tbody>
</table>

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

Service Type: Supports for Participant Direction
Service Name: Financial Management Services

Provider Category:
- Agency

Provider Type:
- Area Development District

Provider Qualifications
License (specify):

Certificate (specify):

Other Standard (specify):
both federal and state statutory authority, independent board of directors

Verification of Provider Qualifications
Entity Responsible for Verification:
Department for Aging and Independent Living
Frequency of Verification:
annually

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

Provider Category:
Agency
Provider Type:
Community Mental Health Center
Provider Qualifications
License (specify):
Certificate (specify):
Other Standard (specify):
authorized by KY statute and regulation 907 KAR chapter 2

Verification of Provider Qualifications
Entity Responsible for Verification:
Department for Medicaid Services
Frequency of Verification:
Annually

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

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

Service Type:
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:
Alternate Service Title (if any):
Natural Supports Training

HCBS Taxonomy:
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):
Natural Supports Training Services (NST) provides training and education to individuals who provide unpaid support, training, companionship or supervision to participants for the purpose of accomplishing or improving provision of supports. For purposes of this service, individual is defined as any person, family member, neighbor, friend, companion, or co-worker who provides uncompensated care, training, guidance, companionship or support to a person served on the waiver. This service may not be provided in order to train paid caregivers. Training includes instruction about treatment regimens and other services specified in the person centered Service Plan (PCSP), and includes updates as necessary to safely maintain the participant at home. NST Services include the costs of registration and training fees associated with formal instruction in areas relevant to participant needs identified in the POC. Natural Supports Training Services do not include the costs of travel, meals and overnight lodging to attend a training event or conference. All training for individuals who provide unpaid support to the participant must be included in the participant’s PCSP.

Natural Supports Training Services do not include services reimbursable by any other source. NST Services must not be duplicative of any education or training provided through Adult Physical Therapy Services, Adult Occupational Therapy Services, Adult Speech and Language Therapy Services, or Behavioral Supports Consultation Services. Natural Supports Training Services may not occur simultaneously with Adult Physical Therapy Services, Adult Occupational Therapy Services, Adult Speech and Language Therapy Services, or Behavioral Supports Consultation Services. An individual serving as a representative for a waiver participant in self-directed services is not eligible to be a participant-directed individual provider of Natural Supports Training Services. Training and consultation services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the service plan development and with any PCSP revisions.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
$1000 per year

Service Delivery Method (check each that applies):
- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):
- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
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<tbody>
<tr>
<td>Individual</td>
<td>Independent Contractor</td>
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Appendix C: Participant Services

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

<table>
<thead>
<tr>
<th>Service Type: Supports for Participant Direction</th>
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</thead>
<tbody>
<tr>
<td>Service Name: Natural Supports Training</td>
</tr>
</tbody>
</table>

Provider Category:
- Individual

Provider Type:
- Independent Contractor

Provider Qualifications:
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:**
- Community Access

**HCBS Taxonomy:**

- **Category 1:** 04 Day Services
- **Sub-Category 1:** 04070 community integration
- **Category 2:**
- **Sub-Category 2:**
- **Category 3:**
- **Sub-Category 3:**
- **Category 4:**
- **Sub-Category 4:**

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

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

**Service Definition (Scope):**
Community Access services are designed to support the SCL individual to participate in meaningful routines, events, and organizations in the community. The service stresses training that assists the person in acquiring, retaining, or improving skills related to independent functioning, self-advocacy, socialization, community participation, personal and financial responsibility, and other skills related to optimal well-being as defined in the Person Centered Plan of Care (POC). Community Access services are designed to result in increased ability to access community resources by natural or unpaid supports. Community Access services shall have an emphasis on the development of personal social networks for the waiver...
participant. They are provided outside the person’s home or family home. These services may occur during the day, in the evenings and on weekends. Community Access services may not duplicate residential or other day habilitation services or authorized therapies. Considering the preferences of the person/family, the planning team recommends the content, location(s), and mode(s) of learning that will best meet the needs of each person. Community Access Services are provided to a person with a one-to-one staff to participant ratio and shall take place in an integrated community setting. Community Access is an impact service and should decrease in need as the person becomes more independent in accessing and becoming a part of the community.

While the service is typically provided 1:1, planning team may authorize 1 staff for a small group of no more than 2 on case by case basis.

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

**Unit of service:** 15 minutes

Any combination of community access, day training, supported employment, personal assistance and the hours a person spends performing paid employment may not exceed 64 units (16 hours) per day

**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:**

<table>
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<th>Provider Category</th>
<th>Provider Type Title</th>
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</thead>
<tbody>
<tr>
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<td>Community Access Specialist</td>
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<tr>
<td>Agency</td>
<td>SCL certified agency</td>
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</table>

**Appendix C: Participant Services**

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

**Service Type:** Other Service

**Service Name:** Community Access

**Provider Category:**

- [ ] Individual

**Provider Type:**

- Community Access Specialist

**Provider Qualifications**

- **License** *(specify):*

- **Certificate** *(specify):*

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

  "Community access specialist” means an individual who:
  
  (a) Provides support and training that enables a participant to develop a network of natural supports to:
      
      1. Participate in meaningful routines or events; and
      2. Be a member of a club, group, association, church, business, or organization in the community;
  
  (b) Has:
      
      1. A bachelor’s degree from an accredited college or university plus at least one (1) year of experience in the field of intellectual or developmental disability; or
      2. A minimum of one year of prior experience in the field of intellectual or developmental disability and the completion of a Department approved credential, and
  
  (c) Meets the personnel and training requirements established in Section 3 of this administrative regulation.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

- case manager
Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Access

Provider Category: Agency
Provider Type: SCL certified agency
Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):
Meets all applicable DDID standards for a waiver provider agency

Employs staff that meet the following:
"Community access specialist" means an individual who:
(a) Provides support and training that enables a participant to develop a network of natural supports to:
   1. Participate in meaningful routines or events; and
   2. Be a member of a club, group, association, church, business, or organization in the community;
(b) Has:
   1. A bachelor’s degree from an accredited college or university
   plus at least one (1) year of experience in the field of intellectual or developmental disability; or
   2. A minimum of one year of prior experience in the field of intellectual or developmental disability and the completion of a Department approved credential, and
   (c) Meets the personnel and training requirements established in Section 3 of this administrative regulation.

Verification of Provider Qualifications

Entity Responsible for Verification:
DBHID

Frequency of Verification:
Initially and at least two years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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:
Community Transition

HCBS Taxonomy:

Category 1: 16 Community Transition Services
Sub-Category 1: 16010 community transition services
Service Definition (Scope):
Community Transitions Services are non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include: (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the individual’s health and safety such as pest eradication and one-time cleaning prior to occupancy; (e) moving expenses; (f) necessary home accessibility adaptations; (g) activities to assess need, arrange for and procure needed resources; and (h) caregiver training. Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the person centered plan of care development process, clearly identified in the person centered plan of care and the person is unable to meet such expense or when the services cannot be obtained from other sources. Community Transition Services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

When Community Transition Services are furnished to individuals returning to the community from a Medicaid institutional setting through entrance to the waiver, the costs of such services are considered to be incurred and billable when the person leaves the institutional setting and enters the waiver. The individual must be reasonably expected to be eligible for and to enroll in the waiver. If for any unforeseen reason, the individual does not enroll in the waiver (e.g., due to death or a significant change in condition), transitional services may be billed to Medicaid as an administrative cost.

Community Transition Services may not be used to pay for furnishing living arrangements that are owned or leased by a waiver provider where the provision of these items and services are inherent to the service they are already providing.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Community Transition Services are limited to one time set-up expenses. Shall not exceed $2,000 per qualified transition.

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:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
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<tr>
<td>Agency</td>
<td>SCL Case Management Provider</td>
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</tbody>
</table>
Appendix C: Participant Services

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

<table>
<thead>
<tr>
<th>Service Type: Other Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Name: Community Transition</td>
</tr>
</tbody>
</table>

**Provider Category:**

Agency

**Provider Type:**

SCL Case Management Provider

**Provider Qualifications**

License (specify):

Certificate (specify):

Other Standard (specify):

SCL waiver provider certified to provide case management services

**Verification of Provider Qualifications**

Entity Responsible for Verification:

DBHID

Frequency of Verification:

Initially and at least every 2 years thereafter

---

Appendix C: Participant Services

C-1/C-3: Service Specification

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

**Service Type:**

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 Accessibility Adaptation Services

**HCBS Taxonomy:**

**Category 1:**

14 Equipment, Technology, and Modifications

14020 home and/or vehicle accessibility adaptations

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:*
Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):
Environmental Accessibility Adaptation services consist of adaptations which are designed to enable individuals to interact more independently with their environment thus enhancing their quality of life and reducing their dependence on physical support from others. Environmental Accessibility Adaptation Services consist of physical adaptations to the waiver participant's or family's home which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and without which, the waiver participant would require institutionalization. Such adaptations consist of the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver participant, but exclude those adaptations or improvements to the home which are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). All services shall be provided in accordance with applicable state and local building codes.

Environmental Accessibility Adaptation services will not be approved for homes that are provider owned. Environmental Accessibility Adaptation services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Service Plan development and with any revisions.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Lifetime limit of $8000.00

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:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>Independent Contractor</td>
</tr>
</tbody>
</table>

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptation Services

Provider Category:
Individual

Provider Type:
Independent Contractor

Provider Qualifications
License (specify):

Certificate (specify):

Other Standard (specify):
Registered and in good standing with Kentucky Secretary of State

Verification of Provider Qualifications
Entity Responsible for Verification:
Case Manager

Frequency of Verification:
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: 14 Equipment, Technology, and Modifications  Sub-Category 1: 14031 equipment and technology

Category 2: Sub-Category 2:

Category 3: Sub-Category 3:

Category 4: Sub-Category 4:

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

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

Service Definition (Scope):

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

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

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

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

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

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
not exceed $1,800 per one (1) year authorized POC period

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:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>Agency Vendor</td>
<td></td>
</tr>
</tbody>
</table>

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:
Agency Vendor
Provider Qualifications
License (specify):
Applicable business license as required by the local, city, or county government in which the service is provided.
Certificate (specify):

Other Standard (specify):
Must have employees providing services that:
Have an applicable business license for goods or services provided
Understands and agrees to comply with the participant directed services and goods delivery requirements.

Verification of Provider Qualifications
Entity Responsible for Verification:
Case Manager
Frequency of Verification:
Prior to service delivery

Appendix C: Participant Services

C-1/C-3: 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:**
Person Centered Coach

**HCBS Taxonomy:**

<table>
<thead>
<tr>
<th>Category 1:</th>
<th>Sub-Category 1:</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 Other Mental Health and Behavioral Services</td>
<td>10090 other mental health and behavioral services</td>
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<table>
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<tr>
<th>Category 2:</th>
<th>Sub-Category 2:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Category 3:</th>
<th>Sub-Category 3:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Category 4:</th>
<th>Sub-Category 4:</th>
</tr>
</thead>
</table>

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):**
Person Centered Coaching is an individualized service of monitoring, training, and assessing effectiveness of person centered planning. These services provide modeling, monitoring, assessing and implementing the person centered plan. The service is delivered by a Person Centered Coach who assists the person and the team in implementing and assessing effectiveness of the Person Centered Service Plan (PCSP). The coach models person centered thinking. The Person Centered Coach is responsible for training the individual, family, guardian, natural and paid supports as well as other team members who are recognized as an integral part of person centered planning when barriers challenge the success of the individual in achieving their goals.

Staff training developed by the Person Centered Coach shall be developed in conjunction with appropriately qualified personnel. For example, if challenge or barrier is related to sensory integration issue then the OT who evaluates or treats the participant should participate at least in development of the training. If the participant’s targeted behavior is related to a mental illness, such as depression, then a mental health professional who is knowledgeable of the participant’s manifestation of the mental illness, should participate in at least the development of the training.

The Person Centered Coach operates independently of a residential or Day Training provider and must be under the supervision of a Positive Behavior Specialist. This service may include development of a structured coping plan, wellness plan or recovery plan. Dependent on the assessed needs of the individual, the Person Centered Coach may complete assigned duties related to completion of a functional assessment of behavior which would be utilized to make modifications to the environment, person centered plan, coping plan, and/or crisis prevention plan. A Person Centered Coach is not to be considered as part of staffing ratio, plan or pattern since the coaching duties are separate from those of a Direct Support Professional.

The service is not intended to be an indefinite part of an individual’s support system but may come in and out of their circle of supports as needed, i.e. utilized when there is a significant change in status or the person centered plan. The service shall be outcome based and documented.. When developing outcomes, a plan for the gradual withdrawal of the services shall be established. This service shall not duplicate case management or any other service. These services may not supplant educational services available under the IDEA (20 U.S.C. 1401 et seq.).

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Unit of service is 15 minutes
Limited to 1320 units per year

**Service Delivery Method (check each that applies):**
- Participant-directed as specified in Appendix E
Provider managed

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

- [ ] Legally Responsible Person
- [ ] Relative
- [ ] Legal Guardian

Provider Specifications:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>Certified SCL waiver provider</td>
</tr>
</tbody>
</table>

Appendix C: Participant Services

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

<table>
<thead>
<tr>
<th>Service Type: Other Service</th>
<th>Service Name: Person Centered Coach</th>
</tr>
</thead>
</table>

Provider Category:
- Agency
- Certified SCL waiver provider

Provider Type:
- Certified SCL waiver provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Meets all applicable DDID standards for a waiver provider agency; employs qualified staff who shall have:
- Assists a participant and the participant’s person centered team in implementing and monitoring the effectiveness of the participant’s person centered plan of care;
  - (b) Models person centered thinking;
  - (c) Is responsible for training a participant, family, guardian, natural and unpaid supports, and other members of the person centered team when barriers challenge the success of the participant in achieving his or her goals;
  - (d) Has:
    - 1. A high school diploma or GED; and
    - 2. (a) Two (2) years of experience in the field of intellectual or developmental disabilities; or
    - b. Completed twelve (12) hours of college coursework in a human services field;
  - (e) Meets all personnel and training requirements established in Section 3 of this administrative regulation; and
  - (f) Performs required documentation.

Verification of Provider Qualifications

Entity Responsible for Verification:
- DBHID

Frequency of Verification:
- initially and at least every two years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
- 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:
Positive Behavior Supports

HCBS Taxonomy:

Category 1: 10 Other Mental Health and Behavioral Services
Sub-Category 1: 10040 behavior support

Category 2:
Sub-Category 2:

Category 3:
Sub-Category 3:

Category 4:
Sub-Category 4:

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

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

Service Definition (Scope):
Positive Behavior Supports is a service to assist the individual with significant, intensive challenges that interfere with activities of daily living, social interaction, work or volunteer situations. These services provide for the utilization of data collected during the functional assessment of behavior; this is the basis for development of a positive behavior support plan for the acquisition or maintenance of skills for community living and behavioral intervention for the reduction of maladaptive behaviors. The plan is intended to be implemented across service settings and by individuals assisting the person in meeting their dreams and goals. Intervention modalities described in plans must relate to the identified behavioral needs of the individual, and specific criteria for remediation of the behavior must be established and specified in the plan. The need for the plan shall be evaluated and revisions made as needed and at least annually. It is expected that need for this service will be reduced over time as an individual’s skills develop.

Prior authorization is required prior to the commencement of services. Revisions to the positive behavior support plan may be covered through the service consultative clinical and therapeutic services when recommended by the planning team and approved by the prior authorization authority.

These services are provided by professionals with at least a Master’s Degree in behavioral science and one (1) year of experience in behavioral programming in addition to one (1) years of direct experience with individuals with intellectual or developmental disabilities. Completion of state approved trainings is also mandatory.

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

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Unit of service is one item (Positive Behavior Support Plan) and is reimbursed at a standard fixed rate.

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:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>Approved SCL waiver providers</td>
</tr>
</tbody>
</table>
Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Positive Behavior Supports

Provider Category:
Agency

Provider Type:
Approved SCL waiver providers

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):
All standards identified in program regulations and services manual.
Services are provided by professionals with at least a master's degree in a behavioral science and one year experience in behavioral programming; AND one year of direct service experience with individuals with intellectual or developmental disabilities; AND completes state approved training annually.

Verification of Provider Qualifications

Entity Responsible for Verification:
DBHID

Frequency of Verification:
initially and at least every two years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
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:
Residential Support Level II

HCBS Taxonomy:

Category 1: 02 Round-the-Clock Services
Sub-Category 1: 02011 group living, residential habilitation

Category 2: 02 Round-the-Clock Services
Sub-Category 2: 02031 in-home residential habilitation

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):
Level II Residential supports are furnished in a non-provider owned residence with variable rates based on required hours of support. Level II Residential Supports are targeted for people who require up to 24 hour levels of support and are individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, adult educational supports, social and leisure skill development, that assist the person to reside in the most integrated setting appropriate to his/her needs. Residential services also include protective oversight and supervision, transportation, personal assistance and the provision of medical and health care services that are integral to meeting the daily needs of the recipients.

Residential support Level II may include the provision of on-call support with a minimum of one face-to-face contact per day in the residence to promote increased independence as identified in the Person Centered Service Plan developed with the person centered team. Residential Level II provides support up to 24 hours a day service; therefore, if an individual experiences a change in support needs or status, adjustments in Residential Services shall be made to meet the support needs. If changes are anticipated to be chronic (lasting more than 3 months), the residential provider may request reassessment to determine if needs have changed as reflected in a revised POC. Any increase in funding based on assessed needs shall be used for provision of additional supports. The residential provider is responsible for informing DDID once the person has returned to previous status so that Residential Level can return to previous status. When Residential services are authorized for an individual, the determination of the level is based on information from the individual’s Supports Intensity Scale (SIS), health screen, and approved Person Centered Service Plan.

The agency providing residential supports is responsible to arrange for or provide transportation between the participant's place of residence and other service sites and community locations. Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. The method by which the costs of room and board are excluded from payment for Residential Services is specified in Appendix J.

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

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:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>Certified SCL waiver provider to include Family Home or Adult Foster Care provider</td>
</tr>
</tbody>
</table>

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Residential Support Level II

Provider Category:

Provider Type:
Certified SCL waiver provider to include Family Home or Adult Foster Care provider

Provider Qualifications
License (specify):

Certificate (specify):

Other Standard (specify):
Meets all applicable DDID standards for a waiver provider agency and employs staff with the following qualifications:
Is at least:
1. Eighteen (18) years old and has a high school diploma or GED; or
2. Twenty-one (21) years old;
(d) Meets the personnel and training requirements established in Section 3 of this administrative regulation;
(e) Has the ability to:
   1. Communicate effectively with a participant and the participant’s family;
   2. Read, understand, and implement written and oral instructions;
   3. Perform required documentation; and
4. Participate as a member of the participant’s person centered team if requested by the participant; and
   (f) Demonstrates competence and knowledge on topics required to safely support the participant as described in the participant’s person centered plan of care.
5. Is legally licensed to operate the transporting vehicle to which the individual is assigned or owns, and has proof of current liability insurance for the vehicle in which the participant is transported.

Verification of Provider Qualifications

Entity Responsible for Verification:
DBHID

Frequency of Verification:
initially and at least every two years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
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:
Specialized Medical Equipment and Supplies

HCBS Taxonomy:

<table>
<thead>
<tr>
<th>Category 1:</th>
<th>Sub-Category 1:</th>
</tr>
</thead>
<tbody>
<tr>
<td>14 Equipment, Technology, and Modifications</td>
<td>14031 equipment and technology</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Category 2:</th>
<th>Sub-Category 2:</th>
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</thead>
<tbody>
<tr>
<td>14 Equipment, Technology, and Modifications</td>
<td>14032 supplies</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category 3:</th>
<th>Sub-Category 3:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Category 4:</th>
<th>Sub-Category 4:</th>
</tr>
</thead>
</table>
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 Medical Equipment and Supplies consists of devices, controls or appliances specified in the Plan of Care, which are necessary to ensure the health, welfare and safety of the individual or which enable the person to function with greater independence in the home, and without which, the member would require institutionalization. Services may also consist of assessment or training needed to assist waiver participants with mobility, seating, bathing, transferring, security or other skills such as operating a wheelchair, locks, doors openers or side lyres. Equipment consists of computers necessary for operating communication devices, scanning communicators, speech amplifiers, control switches, electronic control units, wheelchairs, locks, door openers, or side lyres. These services also consist of customizing a device to meet a waiver participant’s needs.

Supplies consist of food supplements, special clothing, adult protective briefs, bed wetting protective chucks, and other authorized supplies that are specified in the Individual Service Plan. Ancillary supplies necessary for the proper functioning of approved devices are also included in this service.

When equipment and supply needs are covered under State Plan services such as but not limited to Durable Medical Equipment (DME), EPSDT, Orthotics and Prosthetics and Hearing Services programs, the equipment and supplies must be accessed through these programs to the extent the need can be met. All items covered through these programs must be requested through the respective programs.

The need for specialized medical equipment and supplies must be identified in the Plan of Care and must be recommended by a qualified rehabilitation technician or engineer, occupational therapist, physical therapist, augmented communication therapist or other qualified therapist whose signature also verifies the type of specialized equipment or supply that is necessary to meet the individual’s need. Specialized Medical Equipment and Supplies must be authorized prior to service delivery by the operating agency in conjunction with the annual Plan of Care or an amended Plan of Care.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
no 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:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>Certified waiver providers</td>
</tr>
</tbody>
</table>

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:

- Agency

Provider Type:
Certified waiver providers

Provider Qualifications

License (specify):

Certificate (specify):
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:
Technology Assisted Residential

HCBS Taxonomy:

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):
Technology assisted residential supports are targeted for people who require up to 24 hour support but are able to increase their independence with reduced need for onsite staff. The use of technology is to assist the participant to reside in the most integrated setting appropriate to his/her needs as determined with the team in the Person Centered Plan of Care (POC). TA Residential support must also include, to the extent required, protective oversight and supervision, transportation, personal assistance and the provision for or arrangement for necessary medical and health care services that are integral to meeting the daily needs of recipient. The intent of this service is to increase independence without undue risk to a person’s health and safety. Careful consideration must be given regarding a person’s medical, behavioral and psychiatric condition(s) when considering this service.

Use of available technology to reduce the need for residential staff support in the home may be utilized if there is an individualized plan developed to promote increased independence based on the individual needs as determined by the Supports
Intensity Scale (SIS), Health Risk Screening Tool (HRST), and the individual’s circle of supports. The SIS would indicate how often the monitoring is needed and an estimate of how much time during a 24 hour would be devoted to the monitoring. Because the SIS is designed to review life domains, typical of most folks living in the community, the tool would be able to validate whether the support needed is an actual person or technology. It would further offer information on frequency and daily support time required. Individual plans of care will also identify 3-5 questions from the SIS assessment to support the service request, a support team would have valuable information from the SIS to determine if a support could be provided via technology.

The Health Risk Screening Tool (HRST) is used to determine where a participant is likely to be most vulnerable in terms of the potential for health risks. It is understood that the greatest vulnerability to health risk is exhibited or experienced among those participants whose services are periodic or less intense than for someone who needs daily nursing care.

Technology assisted residential supports includes a communication system linking the waiver recipients home to a centralized monitoring station. This may include the use of electronic sensors, speakers and microphones, video cameras (not in bedrooms or bathrooms), smoke detectors, temperature detectors, and personal emergency response systems. These devices link each individual’s home to remote staff that provides electronic support. The participant's privacy will be ensured through planning by the person centered team and incorporated into their plan of care.

The residential provider must have a plan in place to ensure staff are available to be on site if needed twenty four hours a day seven days a week and demonstrate the ability to respond timely to emergencies, and to assess the situation, and ensure health, safety and welfare. In the case of a true emergency the monitoring staff would utilize the 911 response system. A recipient who is able to live in a technology assisted environment shall be capable of calling 911 in an emergency. Provider staff should be able to respond on site within 15 minutes for any situation that requires an on-site response. Technology supported assistance is not intended for a recipient who requires one to one hands on assistance. This is intended for someone who may need reminders related to activities of daily living, or the security of staff either on site or remotely and have the ability to either call or use the computer button to alert staff to their needs.

Technology assisted Residential support is available up to 24 hours a day based on the person's individual needs; therefore, if an individual experiences a change in support needs or status, the provider shall immediately adjust supervision (up to and including going on-site to the residence) to meet acute needs and shall reassess the appropriateness of these supports and adjustments shall be made to meet chronic support needs. If an individual receiving technology assisted residential has a change in support where they no longer require this communication system and are able to live more independently, the person centered team should consider other service options including residential level 2 provided in the recipients own home or shared living.

The agency providing residential supports is responsible to ensure that all staff including remote monitoring staff are trained on each recipients individual programmatic and medical needs prior to providing the support. The agency is also required to arrange for or provide transportation between the participant's place of residence and other service sites and community locations.

Technology assisted residential supports are furnished in a provider owned residence or a person's own home with no more than three persons receiving these supports in a residence. If this service is used for multiple individuals in a home, it will be individualized based on their identified needs. Provider owned or leased residences where residential services are furnished must be compliant with the Americans with Disabilities Act based on the needs of the person supported.

Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. The method by which the costs of room and board are excluded from payment for Residential Services is specified in Appendix J. Payment is based on a per day rate that incorporates both remote and on site monitoring as detailed in the person’s service plan.

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

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:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
</table>

https://wms-mmdl.cdsydc.com/WMS/faces/protected/35/print/PrintSelector.jsp
Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Technology Assisted Residential

Provider Category:
Agency
Provider Type:
Certified SCLwaiver residential provider

Provider Qualifications
License (specify):

Certificate (specify):

Other Standard (specify):
Meets all applicable DDID standards for a waiver provider agency and employs staff with the following qualifications:
Is at least:
1. Eighteen (18) years old and has a high school diploma or GED; or
2. Twenty-one (21) years old;
(d) Meets the personnel and training requirements established in Section 3 of this administrative regulation;
(e) Has the ability to:
1. Communicate effectively with a participant and the participant’s family;
2. Read, understand, and implement written and oral instructions;
3. Perform required documentation; and
4. Participate as a member of the participant’s person centered team if requested by the participant; and
(f) Demonstrates competence and knowledge on topics required to safely support the participant as described
in the participant’s person centered plan of care.
5. Is legally licensed to operate the transporting vehicle to which the individual is assigned or owns, and has
proof of current liability insurance for the vehicle in which the participant is transported.

Verification of Provider Qualifications
Entity Responsible for Verification:
DBHIDID
Frequency of Verification:
initially and at least every two years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the
Medicaid agency or the operating agency (if applicable).
Service Type:
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:
Transportation
HCBS Taxonomy:
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):
Transportation Services enable waiver participants who choose to self-direct their services to gain access to waiver and other community services, activities, resources, and organizations typically utilized by the general population. Transportation services are only provided as independent waiver services when transportation is not otherwise available as an element of another waiver service. Whenever possible, family, neighbors, friends, or community agencies, which can provide this service without charge, are to be utilized. Transportation services are not intended to replace available formal or informal transit options for participants. The need for Transportation services and the unavailability of other resources for transportation must be documented in the Person Centered Service Plan (PCSP).

Transportation Services exclude transportation to and from Community Access Services that entail activities and settings primarily utilized by people with disabilities. Persons receiving Residential Services are not eligible to receive participant directed Transportation Services. Transportation services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Plan of Care development and with any PCSP revisions.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
maximum of $265.00 per month

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:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>Licensed driver</td>
</tr>
</tbody>
</table>

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:
Individual

Provider Type:
Licensed driver
Provider Qualifications

License (specify):
KY driver's license

Certificate (specify):

Other Standard (specify):
Driver must be at least 18 years of age and legally licensed to operate the transporting vehicle to which the individual is assigned or owns, and has proof of current liability insurance for the transporting vehicle.

Driver must agree to or provide required documentation of criminal background check, and have the training or skills necessary to meet the participant's needs as demonstrated by documented prior experience or training on providing services to individuals with I/DD and in addressing any disability specific needs of the participant.

Verification of Provider Qualifications

Entity Responsible for Verification:
Case manager

Frequency of Verification:
prior to service delivery

Appendix C: Participant Services
C-1/C-3: 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:
Vehicle Adaptations

HCBS Taxonomy:

Category 1:
14 Equipment, Technology, and Modifications

Sub-Category 1:
14020 home and/or vehicle accessibility adaptations

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service Definition (Scope):
Vehicle Adaptation services enable individuals to interact more independently with their environment thus enhancing their quality of life and reducing their dependence on physical support from others. These adaptations are limited to a waiver participant's or his or her family’s privately owned vehicle and include such things as a hydraulic lift, ramps, special seats and
other interior modifications to allow for access into and out of the vehicle as well as safety while moving.

SCL is the payer of last resort for vehicle adaptations. The need for Vehicle Adaptation must be documented in the plan of care. Repair or replacement costs for vehicle adaptations of provider owned vehicles are not allowed. Vehicle adaptations will not be replaced in less than three years except in extenuating circumstances and authorized by the DMS. Vehicle Adaptation must be authorized prior to service delivery by the operating agency in conjunction with the person centered service plan and with any PCSP revisions.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Limited to $6000.00 per 5 years per participant

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:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>Independent Contractor</td>
</tr>
</tbody>
</table>

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vehicle Adaptations

Provider Category: Individual
Provider Type: Independent Contractor
Provider Qualifications
License (specify):
Certificate (specify):
Other Standard (specify):
Registered and in good standing with the Kentucky Secretary of State

Verification of Provider Qualifications
Entity Responsible for Verification: Case manager
Frequency of Verification: prior to service delivery

Appendix C: Participant Services

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

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (select one):
- Not applicable - Case management is not furnished as a distinct activity to waiver participants.
- Applicable - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:
- As a waiver service defined in Appendix C-3. Do not complete item C-1-c.
As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option). Complete item C-1-c.

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

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

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

Appendix C: Participant Services

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

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

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

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

All employees of enrolled waiver providers and employees of members participating in participant direction are required to submit to a state criminal background check and drug screen. DMS or DBHID conduct initial certification and at least every two years thereafter of all waiver providers. During the provider certification, employee records are reviewed to verify compliance with the criminal history check requirement. Licensed providers are inspected annually by the Office of Inspector General and employee records are reviewed to ensure compliance.

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

- No. The State does not conduct abuse registry screening.
- Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.

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

All employees of the waiver providers and employees of participants directing non-medical waiver services are required to submit to screening through state registries which are the Child Abuse and Neglect (CAN) registry and the Caregiver Misconduct registry, both maintained by the Department for Community Based Services (DCBS), and the Nurse Aide Registry maintained by the Kentucky Board of Nursing (KBN). DMS or DBHID conduct initial and recertifications of all waiver providers. During the recertification, employee records are reviewed to ensure that mandatory registry screenings have been completed. Licensed providers are inspected annually by the Office of Inspector General and employee records are reviewed to ensure compliance.

Appendix C: Participant Services

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

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

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

<table>
<thead>
<tr>
<th>Facility Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Home</td>
</tr>
</tbody>
</table>

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

When four or more individuals unrelated to the proprietor reside in a facility, a home and community character is maintained as evidenced by:

a. each person has an individualized person centered plan;
b. the individual plan addresses individual resources or activities each person will access in the community;
c. facilities have a kitchen with cooking facilities and small dining areas;
d. individuals have access to the kitchen area to store and eat personal snacks, there are general times for meals, but an individual may eat anytime they choose;
e. individuals assist with meal planning, preparation or shopping if this is included in their plan;
f. individuals have access to unscheduled activities in the community;
g. individuals have the opportunity to have visitors at times they prefer and at their convenience;
h. individuals are afforded privacy, are able to lock their own doors. Staff have access to key in case of emergency;
i. individuals have their own bedroom and have full access to their own personal property.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:
Group Home

Waiver Service(s) Provided in Facility:

<table>
<thead>
<tr>
<th>Waiver Service</th>
<th>Provided in Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Transition</td>
<td></td>
</tr>
<tr>
<td>Community Access</td>
<td></td>
</tr>
<tr>
<td>Goods and Services</td>
<td></td>
</tr>
<tr>
<td>Personal Assistance</td>
<td></td>
</tr>
<tr>
<td>Community Guide</td>
<td></td>
</tr>
<tr>
<td>Respite</td>
<td></td>
</tr>
<tr>
<td>Shared Living</td>
<td></td>
</tr>
<tr>
<td>Consultative Clinical and Therapeutic Services</td>
<td></td>
</tr>
<tr>
<td>Transportation</td>
<td></td>
</tr>
<tr>
<td>Natural Supports Training</td>
<td></td>
</tr>
<tr>
<td>Residential Support Level I</td>
<td></td>
</tr>
<tr>
<td>Positive Behavior Supports</td>
<td></td>
</tr>
<tr>
<td>Day Training</td>
<td></td>
</tr>
<tr>
<td>Person Centered Coach</td>
<td></td>
</tr>
<tr>
<td>Environmental Accessibility Adaptation Services</td>
<td></td>
</tr>
<tr>
<td>Vehicle Adaptations</td>
<td></td>
</tr>
<tr>
<td>Supported Employment</td>
<td></td>
</tr>
<tr>
<td>Technology Assisted Residential</td>
<td></td>
</tr>
<tr>
<td>Residential Support Level II</td>
<td></td>
</tr>
<tr>
<td>Specialized Medical Equipment and Supplies</td>
<td></td>
</tr>
</tbody>
</table>
Facility Capacity Limit:

8

Scope of Facility Standards. For this facility type, please specify whether the State's standards address the following topics (check each that applies):

<table>
<thead>
<tr>
<th>Standard</th>
<th>Topic Addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission policies</td>
<td>☑</td>
</tr>
<tr>
<td>Physical environment</td>
<td>☑</td>
</tr>
<tr>
<td>Sanitation</td>
<td>☑</td>
</tr>
<tr>
<td>Safety</td>
<td>☑</td>
</tr>
<tr>
<td>Staff : resident ratios</td>
<td>☑</td>
</tr>
<tr>
<td>Staff training and qualifications</td>
<td>☑</td>
</tr>
<tr>
<td>Staff supervision</td>
<td>☑</td>
</tr>
<tr>
<td>Resident rights</td>
<td>☑</td>
</tr>
<tr>
<td>Medication administration</td>
<td>☑</td>
</tr>
<tr>
<td>Use of restrictive interventions</td>
<td>☑</td>
</tr>
<tr>
<td>Incident reporting</td>
<td>☑</td>
</tr>
<tr>
<td>Provision of or arrangement for necessary health services</td>
<td>☑</td>
</tr>
</tbody>
</table>

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Facility standards address all of the topics listed.

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.

The member chooses a legally responsible individual to provide this service. The member choice is documented in the client
file and retained by the Case Manager. Documentation of services provided shall be submitted to the Case manager. The
member/representative shall sign the employee’s timesheet verifying the accuracy of the time reported. The Case Manager is
responsible for monitoring service provision.

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

© The State does not make payment to relatives/legal guardians for furnishing waiver services.

© The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian
is qualified to furnish services.

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

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. Extended family members that are
employed by an SCL provider may provide services.

For participant directed services, the Financial Management Services provider only pays for services specified in the Individual
Service Plan, and case managers additionally monitor 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 person’s wishes and desires,
  ii. Increases the person’s quality of life in measurable ways,
  iii. Increases the person’s level of independence,
  iv. Increases the person’s 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.
f. **Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Provider enrollment is continuous and open to any willing and qualified individual or entity. A potential provider may make application by contacting provider enrollment through a toll-free phone number on the Department for Medicaid Services (DMS) website, completing the application process and obtaining an agency license or certification. These provider enrollment forms, along with new provider information are also accessible through Internet web access.

The Division of Developmental and Intellectual Disabilities (DBHID) also has information for providers on their website and provides orientation training for new waiver providers six times a year, and potential providers are required to attend this training. Once the orientation process is complete, provider enrollment information is forwarded to the state Medicaid agency, provider enrollment branch, to complete the process of enrollment as a State Medicaid provider.

Appendix C: Participant Services

**Quality Improvement: Qualified Providers**

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

a. **Methods for Discovery: Qualified Providers**

   The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

   i. **Sub-Assurances:**

      a. **Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.**

      **Performance Measures**

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

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

      **Performance Measure:**

      Percent of waiver providers that 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): |
      |--------------------------------|--------------------------------|--------------------------------|
      | State Medicaid Agency         | Weekly                       | 100% Review                   |
      | Operating Agency              | Monthly                      | Less than 100% Review         |
      | Sub-State Entity              | Quarterly                    | Representative Sample         |
### Data Aggregation and Analysis:

**Responsible Party for data aggregation and analysis** (check each that applies):
- ✔ State Medicaid Agency
- ✔ Operating Agency
- ✔ Sub-State Entity
- ✔ Other
  - Specify: QIO

**Frequency of data aggregation and analysis** (check each that applies):
- ✔ Annually
- ✔ Continuously and Ongoing
- ✔ Other
  - Specify: QIO

### Performance Measure:
Percent of waiver providers with a corrective action plan completed within the required timeframe. N= Number of waiver providers that completed a corrective action plan within the required timeframe D= Number of waiver providers required to complete a corrective action plan

**Data Source** (Select one):
- Other
  - If 'Other' is selected, specify:
    - Corrective action plans submitted to the operating agency

**Responsible Party for data collection/generation** (check each that applies):
- ✔ State Medicaid Agency
- ✔ Operating Agency
- ✔ Sub-State Entity

**Frequency of data collection/generation** (check each that applies):
- ✔ Weekly
- ✔ Monthly
- ✔ Quarterly

**Sampling Approach** (check each that applies):
- ✔ 100% Review
- ✔ Less than 100% Review
- ✔ Representative Sample
  - Confidence Interval
### Data Aggregation and Analysis:

**Responsible Party for data aggregation and analysis** (check each that applies):
- State Medicaid Agency
- Operating Agency
- Sub-State Entity
- Other
  - Specify:

**Frequency of data aggregation and analysis** (check each that applies):
- Weekly
- Monthly
- Quarterly
- Annually
- Continuously and Ongoing

### Performance Measure:

Percent of waiver providers with approved corrective action plans that have been implemented successfully. 

\[ N = \text{Number of providers whose approved corrective action plans have been implemented correctly} \]
\[ D = \text{Number of providers required to submit a corrective action plan.} \]

### Data Source (Select one):

Provider performance monitoring

**Responsible Party for data collection/generation** (check each that applies):
- State Medicaid Agency
- Operating Agency
- Sub-State Entity
- Other
  - Specify:

**Frequency of data collection/generation** (check each that applies):
- Weekly
- Monthly
- Quarterly

**Sampling Approach** (check each that applies):
- 100% Review
- Less than 100% Review
- Representative Sample
  - Confidence Interval
Data Aggregation and Analysis:

<table>
<thead>
<tr>
<th>Responsible Party for data aggregation and analysis (check each that applies):</th>
<th>Frequency of data aggregation and analysis (check each that applies):</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Medicaid Agency</td>
<td>Weekly</td>
</tr>
<tr>
<td>Operating Agency</td>
<td>Monthly</td>
</tr>
<tr>
<td>Sub-State Entity</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Other</td>
<td>Annually</td>
</tr>
<tr>
<td>Other</td>
<td>Continuously and Ongoing</td>
</tr>
</tbody>
</table>

Performance Measure:
Percentage of Providers with no repeat citations at recertification review. N=Number of providers with no repeat citations D=Number of providers that received a recertification review

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

<table>
<thead>
<tr>
<th>Responsible Party for data collection/generation (check each that applies):</th>
<th>Frequency of data collection/generation (check each that applies):</th>
<th>Sampling Approach (check each that applies):</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Medicaid Agency</td>
<td>Weekly</td>
<td>100% Review</td>
</tr>
<tr>
<td>Operating Agency</td>
<td>Monthly</td>
<td>Less than 100% Review</td>
</tr>
<tr>
<td>Sub-State Entity</td>
<td>Quarterly</td>
<td>Representative Sample</td>
</tr>
<tr>
<td>Other</td>
<td>Annually</td>
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</table>

Describe Group:
Data Aggregation and Analysis:

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<th>Responsible Party for data aggregation and analysis (check each that applies):</th>
<th>Frequency of data aggregation and analysis (check each that applies):</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Medicaid Agency</td>
<td>Weekly</td>
</tr>
<tr>
<td>Operating Agency</td>
<td>Monthly</td>
</tr>
<tr>
<td>Sub-State Entity</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Other Specify:</td>
<td>Annually</td>
</tr>
<tr>
<td>Other Specify:</td>
<td>Continuously and Ongoing</td>
</tr>
</tbody>
</table>

Performance Measure:
Percentage of OIG licensed providers that meet OIG licensing requirements at review (KRS 216.520) N=Number of OIG licensed providers that meet requirements at review D=number of OIG licensed providers

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

<table>
<thead>
<tr>
<th>Responsible Party for data collection/generation (check each that applies):</th>
<th>Frequency of data collection/generation (check each that applies):</th>
<th>Sampling Approach (check each that applies):</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Medicaid Agency</td>
<td>Weekly</td>
<td>100% Review</td>
</tr>
<tr>
<td>Operating Agency</td>
<td>Monthly</td>
<td>Less than 100% Review</td>
</tr>
<tr>
<td>Sub-State Entity</td>
<td>Quarterly</td>
<td>Representative Sample</td>
</tr>
<tr>
<td>Other Specify: OIG</td>
<td>Annually</td>
<td>Stratified</td>
</tr>
<tr>
<td>Other Specify:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Confidence Interval =
Describe Group:
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:**
Percent of participant directed employees who comply with personnel requirements.

N=number participant directed employees who comply with all personnel requirements
D=total number of participant directed employee records reviewed.

**Data Source** (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

<table>
<thead>
<tr>
<th>Responsible Party for data collection/generation (check each that applies):</th>
<th>Frequency of data collection/generation (check each that applies):</th>
<th>Sampling Approach (check each that applies):</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Medicaid Agency</td>
<td>Weekly</td>
<td>100% Review</td>
</tr>
<tr>
<td>Operating Agency</td>
<td>Monthly</td>
<td>Less than 100% Review</td>
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<td>Sub-State Entity</td>
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### Data Aggregation and Analysis:

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<tr>
<th>Responsible Party for data aggregation and analysis (check each that applies):</th>
<th>Frequency of data aggregation and analysis (check each that applies):</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Medicaid Agency</td>
<td>Weekly</td>
</tr>
<tr>
<td>Operating Agency</td>
<td>Monthly</td>
</tr>
<tr>
<td>Sub-State Entity</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Other</td>
<td>Anually</td>
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<td>Specify: DAIL</td>
<td>Continuously and Ongoing</td>
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</tbody>
</table>

### 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:**
Percent of reviewed providers in which staff have successfully completed mandatory training annually. N= All reviewed providers whose staff have successfully completed mandatory training. D= Total number of reviewed providers

**Data Source (Select one):**
On-site observations, interviews, monitoring
If ‘Other’ is selected, specify:

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<th>Responsible Party for data collection/generation (check each that applies):</th>
<th>Frequency of data collection/generation (check each that applies):</th>
<th>Sampling Approach (check each that applies):</th>
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</tr>
<tr>
<td>Operating Agency</td>
<td>Monthly</td>
<td>Less than 100% Review</td>
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</table>
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 SCL waiver providers are qualified, certified and licensed prior to rendering services. Providers who have completed the SCL new provider training/evaluation or are licensed by OIG are eligible to become Medicaid providers. The States’ OIG monitors and re-licenses annually. Through the DDID SCL recertifies at least every two years. The state does not contract with non-licensed or non-certified providers. All State policy and procedure updates, additions, and/or changes are communicated through letters, DMS website or DDID website.

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.

DDID performs trainings upon request of providers and provides technical assistance whenever requested. Should an enrolled provider not meet requirements to provide services, DBHID would recommend termination of the provider. DDID also provides technical assistance to providers.

ii. Remediation Data Aggregation

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

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**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, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.*

The SCL waiver enrolls both residential and non-residential providers to render services to participants. 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 the main appendix, part 8, attachment 2.

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:

1. All settings assure the individual has, but is not limited to:
   a. Rights of privacy, dignity, respect, and freedom from coercion and restraint;
   b. Freedom of choice, as defined by the experience of independence, individual initiative, or autonomy in making life choices, both in small everyday matters (what to eat or what to wear), and in large, life-defining matters (where and with whom to live and work);
      i. The service, provider and setting are selected by the individual from among setting options including non-disability specific settings;
      ii. The individual must be provided with the choice of where to live with as much independence as possible, and in the most community-integrated environment;
   c. Privacy in the sleeping/living unit in a residential setting;
   d. An option for a private unit in a residential setting;
   e. A unit with lockable entrance doors, and with only the individual and appropriate staff having keys to those doors;
   f. Visitors of their choosing at any time and access to a private area for visitors;
   g. Physical accessibility, defined as being easy to approach, enter, operate, or participate, in a safe manner and with dignity, by a person with or without a disability. Settings considered to be physically accessible must also meet the ADA standards of accessibility for all participants served in the setting. All communal areas are accessible to all participants, as well as having a means to enter the building (i.e. keys, security codes, etc.). Bedrooms are to be accessible to the appropriate persons;
   h. Any modification of the additional residential conditions except for the setting being physically accessible requirement, must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:
      Identify a specific and individualized assessed need.
      Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
      Document less intrusive methods of meeting the need that have been tried but did not work.
      Include a clear description of the condition that is directly proportionate to the specific assessed need.
      Include regular collection and review of data to measure the ongoing effectiveness of the modification.
      Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
Include the informed consent of the individual.  
Include an assurance that interventions and supports will cause no harm to the individual.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
Participant Centered Service Plan (PDSP) or 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:

[Blank]

Social Worker

Specify qualifications:

[Blank]

Other

Specify the individuals and their qualifications:

[Blank]

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:

Case management shall be conflict free. Conflict-free case management requires that 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 (30 miles from the participant’s residence).

For recipients who request an exception to this based on lack of qualified case managers in remote areas of the state DDID will ensure on an individual basis that persons who choose not to have a conflict-free case manager will be free from undue influence regarding choice of providers.

If an exemption is approved, the case management agency shall document conflict of interest protections, separating case management and service provision functions within the provider entity. Individuals must be provided with a clear and accessible alternative dispute resolution process.

Exemptions for conflict free case management shall be requested upon reassessment or at least annually.

Department waiver program staff conduct provider billing and service reviews to assure that provided services meet regulatory requirements, are provided as identified in the person centered service plan, and are delivered by qualified staff.

All Case Managers will participate in a summary rating system for case management reviews designed to reflect a point-in-
time status of an individual's services related to health, safety and service issues. The primary focus is on health and safety issues but the case manager must also evaluate the appropriateness and adequacy of services.

Issues identified that are not within the funded services of this provider will not contribute to the summary rating of services for the individual. If health and safety problems are identified that are not related to the services rendered by the provider, the case manager should document the problem on the review form and refer it to the regional office for follow up even though the rating is "1" or "2" for services provided. The provider, case manager and regional DDID team have joint responsibility for assuring that all problems are identified and addressed.

If a person is receiving vehicle adaptations, Special Medical Equipment, Medical Supplies, Environmental Accessibility case manager notes are written to reflect that the request for service was processed and a final note to indicate acquisition and implementation of the approved service is in place.

Person Centered planning training is occurring across the state for waiver providers. Case management training is ongoing and educates case managers about identifying the needs of the person and locating appropriate activities that address the needs of each person. Service Plan review will be conducted through the prior authorization process and on-site monitoring and sampling of records will be reviewed at provider sites.

Information gathered from case reviews are used to develop quality improvements focused on system-wide changes, bolstering the provider’s approach to reducing medical errors, which emphasizes a culture of learning, person centeredness, and accountability.

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.

1. A person-centered service plan shall be an individualized plan that is led by the participant, where possible, and:
   a. Is developed by:
      i. A waiver participant or a waiver participant’s guardian/representative;
      ii. The case manager;
      iii. The participant’s Person-centered Team;
      iv. Any other person chosen by the waiver participant
   b. Uses a process that:
      i. Provides necessary information and support to empower the participant, or the participant’s guardian, to direct the planning process to empower the waiver participant to have the freedom and support to control their own schedules and activities without coercion or restraint;
      ii. Is timely and occurs at times and locations of convenience to the individual
      iii. Reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b)
      iv. Offers informed choice, defined as choosing from options based on accurate and thorough knowledge and understanding, to the individual regarding the services and supports they receive and from whom.
      v. Includes a method for the individual to request updates to the plan as needed
      vi. Achieves understanding of how the participant
         1. Learns;
         2. Makes decisions; and
         3. Chooses to live and work in the community;
      vii. Discovers the participant’s needs, likes and dislikes; and
      viii. Empowers the person-centered team to create a person-centered service plan for the participant that meets the following requirements:
           1. Is based on the participant’s assessed clinical and support needs, strengths, preferences, and ideas;
           2. Encourages and supports the participant’s rehabilitative needs, habilitative needs, and long-term satisfaction;
           3. Is based on reasonable costs, given the participant’s support needs;
           4. Includes the participant’s goals and desired outcomes, and what is important to the individual;
           5. Includes a range of supports, including funded, community, and natural supports that will assist the individual to achieve identified goals;
           6. Includes information necessary to support a participant during times of crisis and risk factors and measures in place to prevent them;
           7. Assists the participant in making informed choices by facilitating knowledge of and access to services and supports;
           8. Records the alternative home and community-based settings that were considered by the individual;
           9. Reflects that the setting in which the individual resides is chosen by the individual;
           10. Is understandable to the individual receiving services and supports, and to the people important in supporting him or her;
           11. Identifies the individual and/or entity responsible for monitoring the plan;
           12. Is finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers
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).

The participant’s Person Centered Service Plan (PCSP) is developed utilizing the Supports Intensity Scale (SIS); an adaptive behavior questionnaire and a screening to assess health risk. The SIS includes information about the member’s support needs in the areas of home living, community living, learning, employment, health and safety, advocacy, behavioral, and medical needs. State staff are trained on a regional basis as SIS interviewers. The health screen identifies overall health risk related to disability and aging, and provides the case manager and support team with guidance in determining the person’s need for further assessment and evaluation to address identified health risks.

The PCSP shall include all identified needs (from the assessment) as well as identify goals, objectives/interventions and outcomes. The PCSP is developed at the direction of the member and/or guardian as well as their identified person centered team. All individuals participating in the development of the PCSP must sign the document to indicate their involvement. It is the responsibility of the case manager to provide detailed information to the person centered team regarding available waiver and non-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. The PCSP shall include all needed services and supports both paid and non-paid, waiver and non-waiver, paid and unpaid, and shall address the following:

1. How can we help expand and deepen the person’s relationships?
2. How can we increase the person’s presence in local community life?
3. How can we help the person to have more choice and control in their life?
4. How can we enhance the person’s reputation and increase the # of valued ways the person contributes to community life?
5. How can we help the person’s competency or appearance of competency?

Appendix D: Participant-Centered Planning and Service Delivery

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

The PCSP shall include all identified needs (from the assessment) as well as identify goals, objectives/interventions and outcomes. The PCSP is developed at the direction of the member and/or guardian as well as their identified person centered team. All individuals participating in the development of the PCSP must sign the document to indicate their involvement. It is the responsibility of the case manager to provide detailed information to the person centered team regarding available waiver and non-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. The PCSP shall include all needed services and supports both paid and non-paid, waiver and non-waiver.

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

The participant's case manager is responsible for the coordination and monitoring all of the participant's services including non-waiver services. The case manager shall conduct monthly face-to-face contacts to make arrangements for activities which ensure: the desires and needs of individual are determined; the supports and services desired and needed by the member are identified and implemented; housing and employment issues are addressed; social networks are developed; appointments and meetings are scheduled; a person-centered approach to planning is provided; informal and community supports are utilized; the quality of 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 PCSP 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 member’s needs shall be identified by the case manager during the monthly face-to-face contact. All PCSP 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 completion of the SIS and the health screening. All health, safety and welfare risks are required to be identified and addressed in the person-centered planning meeting and on the PCSP. Providers are required to have agency emergency plans and person specific crisis and safety issues incorporated into their person centered service plan. the QIO reviews the submitted assessments through prior authorization process, plan of care review, to ensure all identified risks are appropriately addressed. If QIO determines an identified risk has not been addressed in the PCSP, they will issue written notification to the case manager requiring additional information as to how these risks will be addressed. 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.

The member’s case manager is responsible for notification of available waiver service providers. Documentation of this notification is required to be maintained within the member’s chart and shall contain the member or guardian’s signed acknowledgement. The case manager is responsible for assisting the member in choosing his or her providers of services specified in the POC. 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. DDID will ensure on an individual basis that persons who choose not to have a conflict-free case manager will be free from undue influence regarding choice of providers.

All waiver participants are ensured freedom of choice as defined by the experience of independence, individual initiative, or autonomy in making life choices, both in small everyday matters (what to eat or what to wear), and in large, life-defining matters (where and with whom to live and work);

The service, provider and setting are selected by the individual from among setting options including non-disability specific settings;

The individual must be provided with the choice of where to live with as much independence as possible, and in the most community-integrated environment;

The setting options are identified and documented in the person-centered service plan and are based on the individual's needs and preferences, and, for residential settings, resources available for room and board;

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):

Upon the case manager’s completion of the Person Centered Service Plan (PCSP) it is the responsibility of the case manager to submit the PCSP and SIS to the QIO for review and service prior authorization. A prior authorization shall not be issued without appropriate review and approval.

The state medicaid agency monitors performance of the QIO through their contract with the fiscal agent.

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:

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**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 case manager for the person receiving SCL funding is responsible for the coordination and monitoring of all of the person’s services including non-waiver and non-paid supports. If the person chooses to participate direct services, the case manager is responsible for ensuring the person is enrolled in and educated about the option of Participant Direction and has a free and informed choice of a Community Guide if they are interested in that service. Case managers facilitate the development of the Person Centered Service Plan (PCSP) and they monitor the delivery of supports to ensure that waiver services are furnished in accordance with the PCSP, meet the needs of the person, and achieve their intended outcomes. Case managers conduct monthly face-to-face visits with SCL person and make monthly contacts with each chosen SCL provider to ensure: the desires and needs of the person are determined; the supports and services desired and needed by the person are identified and implemented; housing and employment issues are addressed; social networks are developed; appointments and meetings are scheduled; a person-centered approach to planning is provided; informal and community supports are utilized; the quality of the supports and services as well as the health, safety, and welfare of the person are monitored; activities and services are documented; and support strategies are reviewed at such intervals as are indicated during planning. The case manager is responsible for ensuring the waiver person makes a free and informed choice of providers, services, and resources. It is the responsibility of the case manager to provide detailed information to the person regarding available services and providers, whether those are waiver services, health services, or natural and community resources to meet needs identified by the Supports Intensity Scale (SIS), a health screening, and the person centered planning process. For people who choose to participant direct services, the case manager is responsible for ensuring health, safety, and welfare of the recipient and for ensuring the effectiveness of the back-up plan. The Case Manager will communicate with the participant, representative, and the person’s team as needed.

Case managers are responsible for ensuring services provided meet the person’s needs. If services are not meeting the needs of the waiver person, the case manager is responsible for working with the person and their support team to ensure different or additional supports are identified and provided and that a Person Centered Service Plan modification is submitted.

Case managers are required to document findings from their monthly visits and monitoring in a monthly summary note which is maintained by the agency in the person’s record. If issues related to health, safety and welfare, services, or satisfaction are noted, the case manager is responsible for prompt follow up toward resolution or remediation. For persons who choose to direct their own services, the Case Manager is responsible for ensuring health, safety, and welfare. The Case Manager will communicate with the participant, representative, and the person’s team as needed.

In addition to the on-going monitoring of PCSP implementation that is conducted by the case manager, the following strategies are employed.

All providers of SCL services are required to establish policies concerning the health, safety, and welfare of the person supported by the agency. Agencies, policies, and documentation records are reviewed by DDID to ensure compliance with these requirements. If deficiencies are noted, a corrective action plan is required.

Positive Behavior Support Plans are reviewed by a Behavior Intervention Committee (BIC) prior to implementation and monitored at least annually to assess technical adequacy and appropriateness of the service. Right restrictions are reviewed by a Human Rights Committee (HRC) prior to implementation and monitored at least annually. HRC and BICs will be established regionally.

All Person Centered Service Plans are submitted to QIO for prior approval. If information is insufficient or the plan is inadequate, notification is provided to the case manager.

A random sample of records of people receiving waiver funding including case management notes are reviewed by DDID during certification reviews. Issues identified are either addressed through technical assistance and follow up or by citation requiring a plan of correction. The state Medicaid agency also performs second line monitoring of a 20% sample of providers reviewed by DDID.

All certification reviews completed by DDID are submitted to the Medicaid agency.

Health, safety, and welfare issues are monitored by DDID through a risk management process in which critical incidents are...
reported directly to and reviewed by DDID staff. Additionally, non-critical incidents are reviewed on-site by DDID field staff. Issues identified are addressed through technical assistance and follow up, investigation, and/or citations requiring a corrective action plan.

All findings regarding the implementation of the PCSP including health, safety, and welfare, are expected to be addressed by the supporting agency. If citations are issued, the agency must submit a corrective action plan that addresses both the specific individual issue and the systemic issue that resulted in the citation. Acceptable corrective action plans are monitored by DDID field staff to ensure implementation and effectiveness. Upon completion of all investigations, findings reports are prepared and sent to the provider and State Medicaid Agency is copied on all correspondence with a recommendation that any indication of fraud or abuse is forwarded to the Office of Inspector General or Attorney General for further review.

Furthermore, the National Core Indicators (NCI) is used to determine overall satisfaction with services. Results from the NCI are used to direct DDID's continuous quality improvement process.

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:

Case management shall be conflict free in that case management shall not include provision of direct services. Agencies providing case management services to a person may not also provide other waiver services to that same person. For recipients who request an exception to this based on lack of qualified case managers in remote areas of the state DDID will ensure on an individual basis that persons who choose not to have a conflict-free case manager will be free from undue influence regarding choice of providers. If an exemption is approved, the case management agency shall document conflict of interest protections, separating case management and service provision functions within the provider entity. Individuals must be provided with a clear and accessible alternative dispute resolution process. Exemptions for conflict free case management shall be requested upon reassessment or at least annually.

Department waiver program staff conduct provider billing and service reviews to assure that provided services meet regulatory requirements, are provided as identified in the person centered service plan, and are delivered by qualified staff.

All Case Managers will participate in a summary rating system for case management reviews designed to reflect a point-in-time status of an individual's services related to health, safety and service issues. The primary focus is on health and safety issues but the case manager must also evaluate the appropriateness and adequacy of services. To some extent, deficiencies should be considered relative to an individual's strengths and needs.

While it is recognized that the absence of deficiencies does not equate to quality in services, assurance of individuals' health and safety is an essential component of program quality. The state's first responsibility is to assure the health and safety of individuals receiving state services. The process of conducting routine individual reviews is of prime importance in assuring health and safety through the identification and correction of problems in health, safety and services for any individual.

If a person is receiving vehicle adaptations, Special Medical Equipment, Medical Supplies, Environmental Accessibility notes are written until services are in place.

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:**
Percent of service plans in which services and supports align with assessed needs of what is important for the person. N= Total number of service plans reviewed that reflect assessed needs D= Total number of service plans reviewed

**Data Source** (Select one):
- Other
  If ‘Other’ is selected, specify:
  - QIO system

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**Performance Measure:**
Percent of families who are satisfied with the services and supports their family member currently receives

\[ N = \text{All family members who stated that their family member always/almost always gets what he or she needs per NCI data} \]
\[ D = \text{All survey respondents to that question} \]

**Data Source** (Select one):
- Other
  - If ‘Other’ is selected, specify: National Core Indicator data

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**Performance Measure:**
Percent of service plans reviewed that include a risk assessment. N-number of plans that include a risk assessment. D-number of plans reviewed.
### Data Source (Select one):
- **Other**

If 'Other' is selected, specify:

#### Personal Narrative

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#### Performance Measure:

Percent of services plans indicating appropriate change in service related to documented change in needs. N= Total number of service plans reviewed that reflect appropriate change in service related to documented change in needs. D= All service plans reviewed that reflect documented change in needs.

**Data Source (Select one):**
- **Record reviews, off-site**
If ‘Other’ is selected, specify:

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Performance Measure:
Percent of service plans that reflect personal goals and preferences of what is important to the person

\[
\frac{N}{D} \times 100\%
\]

Data Source (Select one): Other
If ‘Other’ is selected, specify:

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Performance Measure:
Percent of service plans with appropriate risk mitigation. N=number of service plans with a risk assessment that also have appropriate risk mitigation. D=number of service plans reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Personal narrative

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#### Performance Measure:

Percent of respondents who said their case manager gets them what they need. 
N=number of respondents who said their case manager gets them what they need.
D=number of respondents

#### Data Source (Select one):

Other
If 'Other' is selected, specify:

**National Core Indicator data**

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<td>□ Representative Sample Confidence Interval =</td>
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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.

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:**
Percent of service plans indicating appropriate change in service related to documented change in participants needs within the year. N= Total number of person centered plans that were revised to address needed changes. D= Total number of person centered plans reviewed with evidence of change needed.

**Data Source** (Select one):
- Other
  If ‘Other’ is selected, specify:
  - QIO system

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### Performance Measure:
Percent of service plans revised at least annually. \( N \) = number of service plans revised at least annually \( D \) = number of service plans reviewed.

### Data Source (Select one):
- Record reviews, off-site
  - If 'Other' is selected, specify:

#### Responsible Party for data collection/generation (check each that applies):
- State Medicaid Agency
- Operating Agency
- Sub-State Entity
- Other
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  - Specify:

#### Frequency of data collection/generation (check each that applies):
- Weekly
- Monthly
- Quarterly
- Annually
- Continuously and Ongoing
- Other
  - Specify:

#### Sampling Approach (check each that applies):
- 100% Review
- Less than 100% Review
- Representative Sample
  - Confidence Interval
  - Describe Group:
- Stratified
  - Describe Group:
- Other
  - Specify:

### Data Aggregation and Analysis:

#### Responsible Party for data aggregation and analysis (check each that applies):
- State Medicaid Agency
- Operating Agency
- Sub-State Entity
- Other
  - Specify: QIO
  - Specify:

#### Frequency of data aggregation and analysis (check each that applies):
- Weekly
- Monthly
- Quarterly
- Annually
- Continuously and Ongoing
- Other
  - Specify:
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:**
The percent of providers that demonstrate that services are delivered in accordance with the service plan, including the type, amount, scope, duration and frequency. N-the number of records reviewed that demonstrate that services are delivered in accordance with the service plan, including the type, amount, scope, duration and frequency. D-total number of records reviewed.

**Data Source** (Select one):
- Other
  If 'Other' is selected, specify:

  **QIO system**

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|                        | □ Continuously and Ongoing                                            |

**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:**
Percent of participants/guardians who were offered choice between/among services and providers. N=number of participants/guardians who were offered choice between/among services and providers. D=number of participant records reviewed

**Data Source (Select one):**

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**Sampling Approach (check each that applies):**

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Confidence Interval =

Describe Group:
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 PCSP, the QIO will issue written notification to the provider requiring additional information as to how these risks will be addressed.

DMS performs an annual second (2nd) line monitoring of a random sample of enrolled active SCL waiver providers. Monitoring the POC 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 is required. The enrolled provider submits the corrective action plan with supporting evidence of the implementation and remediation.

A follow-up survey/review will be performed after DMS’ acceptance of the provider’s corrective action plan to determine whether it has been implemented.

The DBHDID submits a report to DMS which includes which participant’s chart was reviewed and if the submission of the forms and the services requested were appropriate. If services are not appropriate, DBHDID may reflect in the report that a Corrective Action Plan (CAP) is needed. The enrolled provider submits a CAP with supporting evidence of the implementation of the corrective action.

DMS performs a second (2nd) line monitoring which ensures DBHDID is performing monitoring according to the guidelines of the contract.

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 individual problems are researched and addressed by the Medicaid 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 caregivers. Issues may require policy clarification.

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 a timely manner, the number not turned in timely and the responsible provider. DMS is able to request corrective action plans and recoupment of paid claims from the provider. 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)

<table>
<thead>
<tr>
<th>Responsible Party</th>
<th>Frequency of data aggregation and analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Medicaid Agency</td>
<td>Weekly</td>
</tr>
<tr>
<td>Operating Agency</td>
<td>Monthly</td>
</tr>
<tr>
<td>Sub-State Entity</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Other</td>
<td>Annually</td>
</tr>
</tbody>
</table>

Specify:

---

**Data Aggregation and Analysis:**

**Responsible Party for data aggregation and analysis (check each that applies):**

- [x] State Medicaid Agency
- [ ] Operating Agency
- [ ] Sub-State Entity
- [x] Other

**Frequency of data aggregation and analysis (check each that applies):**

- [ ] Weekly
- [ ] Monthly
- [ ] Quarterly
- [x] Annually
- [ ] Continuously and Ongoing

Specify:
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.

The Supports for Community Living (SCL) waiver program promotes personal choice and control over the delivery of waiver
services by affording opportunities for participant direction. SCL participants have the opportunity to direct some or all of their non-
residential, non-medical waiver services. Traditional service delivery methods are available for participants who decide not to
direct their services. Case managers provide assistance for informed decision-making by individuals and their
families/representatives about the election of participant direction with information and training on the roles, risks, and
responsibilities assumed by those who choose participant direction. The following entities will provide supports to participants
choosing to direct their own services:

- Case Management agencies will be independent of service delivery. Case Managers will assist with the development of a person
centered team and service plan.
- If appropriate, the Community Guide will provide direct assistance to the participant in brokering community resources and
directing their services. This can include assistance with inclusion, recruiting employees, and plan development. Community Guide
is an optional service.
- Financial Management Services agency will manage the budget, ensure wage and hour laws are met, and issue checks for services
authorized in the Service Plan.
- Participants can choose agencies who will train and support qualified staff for services of the person’s choosing.
- Participants can hire their own employees that meet qualifications. If needed, the case manager or community guide will assist the
participant in recruiting alternate or additional providers.
Kentucky’s participant-directed option is based on the principles of Self-Determination and Person Centered thinking. A person-centered system acknowledges the role of families or guardians in planning for children/youth and for adults who need assistance in making informed choices.

The principles and tools of Self-Determination are used to assist people in the creation of meaningful, culturally appropriate lives embedded in our communities and suffused with real relationships. These principles are Freedom, Responsibility, Authority, Support, and Confirmation. Tools include Community Guide, Financial Management Services, and Individualized Budgets, which will be developed annually based on assessments and the Person-Centered plan of care.

Supports that facilitate independence 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 such as bathing, eating, dressing, personal hygiene, shopping and the use of money; reminding, observing, and/or monitoring of medications; respite; socialization, relationship building, leisure choice and participation in generic community activities.

For participant directed services, the Financial Management Services provider only pays for services specified in the Individual Service Plan, and case managers additionally monitor 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 shall 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 person’s wishes and desires,
  ii. Increases the person’s quality of life in measurable ways,
  iii. Increases the person’s level of independence,
  iv. Increases the person’s choices, and
  v. Increases access to the amount of service hours for needed supports.

All participants are afforded the opportunity to direct all non-residential, non-medical waiver services as long as provider qualifications and background checks as defined in waiver regulations are met. A member may receive a combination of participant directed and traditional waiver services. Services shall be prior authorized and payment for these services shall not exceed the member’s budget as established by the Medicaid contracted entity.

The case manager is responsible for educating participants regarding participant directed opportunities. Case managers meet with participants to detail the participant directed service options; provide guidance regarding community guide services, which will assist with employee recruitment and hiring procedures; develop the new Person Centered Service Plan to include participant directed services; establish the budget allowance; and, assist the member with any other question they may have regarding participant direction.

A monthly face-to-face contact is required between the case manager and the participant and representative (if applicable) to ensure the needs are being met in an appropriate manner and monitor health, safety and welfare. Community Guides will meet with members as needed.

Appendix E: Participant Direction of Services
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

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 case managers will be required to provide information about participant direction opportunities to the participants at the time of initial Person Centered Service Plan meeting, at least annually thereafter, and at any point of recipient or guardian inquiry. Case managers will complete the person centered service plan, and provide detailed information regarding the participant direction opportunities available through the waiver program. The case manager will be responsible for explaining the recipient's responsibilities related to participant direction opportunities.
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 representative may be freely chosen by an adult waiver recipient to direct waiver services. This representative may not be hired as an employee to provide any of the participant-directed waiver services. The Representative shall act in accordance with the needs and preferences of the participant, as documented in the SIS and the person centered planning process. The case manager will be responsible for monitoring the member’s Person Centered Service Plan (PCSP) and ensuring needed services are being appropriately provided to the recipient. The Case Manager will ensure that services are carried out accordingly and that the participant remains satisfied with services over time.

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.

<table>
<thead>
<tr>
<th>Waiver Service</th>
<th>Employer Authority</th>
<th>Budget Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Access</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Goods and Services</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Personal Assistance</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Community Guide</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Respite</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Shared Living</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Transportation</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Natural Supports Training</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Day Training</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Environmental Accessibility Adaptation Services</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Vehicle Adaptations</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Supported Employment</td>
<td>☑</td>
<td>☑</td>
</tr>
</tbody>
</table>

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:
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: Financial management
- 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:

Financial Management Services will be provided by the Area Development Districts and the Community Mental Health Centers

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

The FMS entities are compensated through their contracts with DMS. The Department for Medicaid Services (DMS) will compensate the agent an administrative fee per member utilizing participant directed opportunities, per month.

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

<table>
<thead>
<tr>
<th>Supports furnished when the participant is the employer of direct support workers:</th>
</tr>
</thead>
<tbody>
<tr>
<td>✅ Assist participant in verifying support worker citizenship status</td>
</tr>
<tr>
<td>✅ Collect and process timesheets of support workers</td>
</tr>
<tr>
<td>✅ Process payroll, withholding, filing, and payment of applicable federal, state and local employment-related taxes and insurance</td>
</tr>
<tr>
<td>✅ Other</td>
</tr>
</tbody>
</table>

**Specify:**

<table>
<thead>
<tr>
<th>Supports furnished when the participant exercises budget authority:</th>
</tr>
</thead>
<tbody>
<tr>
<td>✅ Maintain a separate account for each participant’s participant-directed budget</td>
</tr>
<tr>
<td>✅ Track and report participant funds, disbursements, and the balance of participant funds</td>
</tr>
<tr>
<td>✅ Process and pay invoices for goods and services approved in the service plan</td>
</tr>
<tr>
<td>✅ Provide participant with periodic reports of expenditures and the status of the participant-directed budget</td>
</tr>
<tr>
<td>✅ Other services and supports</td>
</tr>
</tbody>
</table>

**Specify:**

<table>
<thead>
<tr>
<th>Additional functions/activities:</th>
</tr>
</thead>
<tbody>
<tr>
<td>✅ Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency</td>
</tr>
<tr>
<td>✅ Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency</td>
</tr>
<tr>
<td>✅ Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget</td>
</tr>
</tbody>
</table>
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 entities are subject to an annual on-site review by DMS and DAIL. 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. Participant 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:

  The case manager is responsible for educating participants regarding participant directed opportunities. Case managers meet with participants to detail the participant directed service options; develop the new PCSP to include participant directed services; establish the budget allowance; and, assist the member with any other question they may have regarding participant direction.

  A monthly face-to-face contact is required between the case manager and the participant and member’s representative (if applicable) to ensure the member’s needs are being met in an appropriate manner and 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):

<table>
<thead>
<tr>
<th>Participant-Directed Waiver Service</th>
<th>Information and Assistance Provided through this Waiver Service Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Transition</td>
<td></td>
</tr>
<tr>
<td>Community Access</td>
<td></td>
</tr>
<tr>
<td>Goods and Services</td>
<td></td>
</tr>
<tr>
<td>Personal Assistance</td>
<td></td>
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<tr>
<td>Community Guide</td>
<td></td>
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<tr>
<td>Respite</td>
<td></td>
</tr>
<tr>
<td>Shared Living</td>
<td></td>
</tr>
<tr>
<td>Consultative Clinical and Therapeutic Services</td>
<td></td>
</tr>
<tr>
<td>Transportation</td>
<td></td>
</tr>
<tr>
<td>Natural Supports Training</td>
<td></td>
</tr>
<tr>
<td>Residential Support Level I</td>
<td></td>
</tr>
<tr>
<td>Positive Behavior Supports</td>
<td></td>
</tr>
<tr>
<td>Day Training</td>
<td></td>
</tr>
<tr>
<td>Person Centered Coach</td>
<td></td>
</tr>
</tbody>
</table>
Participant-Directed Waiver Service Information and Assistance Provided through this Waiver Service Coverage

| Environmental Accessibility Adaptation Services |  |
| Vehicle Adaptations |  |
| Supported Employment |  |
| Technology Assisted Residential |  |
| Residential Support Level II |  |
| Specialized Medical Equipment and Supplies |  |
| Conflict Free Case Management |  |
| Financial Management Services |  |

- **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.

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 person may voluntarily dis-enroll from the participant direction opportunities at any time. The case manager shall assist the member and/or guardian prior to day of the termination to assist the person in locating traditional waiver service providers of their choice. Participant Direction is not terminated until the traditional service agency is ready to provide services. To ensure continuity of services within one business day, the Case Manager will coordinate the completion of the required documentation to ensure there is no lapse in service.

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 Case manager monitors all services provided for the participant and ensures that the health and welfare of participant is guarded.

If the CM determines that the participant is in immediate danger or the health, safety and welfare of the participant is at risk, the
CM will immediately assist the participant in transferring the participant to a qualified traditional waiver provider, and notify the Department for Aging and Independent Living (DAIL) of the transfer. In addition, the CM 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 CM will work with the consumer or the designated representative to discuss the issue and develop a corrective action plan. The CM will monitor the progress of the corrective action plan. If the member is unable or unwilling to resolve the issue, the CM will request that DAIL proceed with involuntary termination of the PDS option. If DAIL approves, the participant will be provided by the CM with written information regarding the traditional program and available traditional providers and will be given thirty (30) days to obtain a traditional provider. The CM 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 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 CM will work with the participant or the designated representative to resolve the issues and develop a corrective action plan. The CM will monitor the progress of the corrective action plan and resulting outcomes. If the participant 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 CM will request approval from DAIL to proceed with involuntary termination of the PDS option. If approved, the participant will be provided by the CM with written information regarding the traditional program and available providers and will be given thirty (30) days to obtain a traditional provider. The CM shall document the reason for the PDS option withdrawal, actions taken to assist the participant to develop a corrective action plan and the outcomes.

The case manager shall begin to assist the member and/or guardian within one (1) business day of the termination to assist the person in locating traditional waiver service providers of their choice. Participant Direction is not terminated until the traditional service agency is ready to provide services. To ensure continuity of services within one business day, the Case Manager will coordinate the completion of the required documentation to ensure there is no lapse in service.

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>
<thead>
<tr>
<th>Table E-1-n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiver Year</td>
</tr>
<tr>
<td>Year 1</td>
</tr>
<tr>
<td>Year 2</td>
</tr>
<tr>
<td>Year 3</td>
</tr>
<tr>
<td>Year 4</td>
</tr>
<tr>
<td>Year 5</td>
</tr>
</tbody>
</table>

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.

The QIO shall establish an individualized budget based on needs as identified in the Supports Intensity Scale (SIS), health screening, and the prior authorized services in the Person-Centered Service Plan. The budget can be adjusted as needs change. The participant may negotiate wage rates with employees however the hourly rate shall not exceed the rate reimbursed to traditional waiver providers for a similar 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 conflict free case manager 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 CM shall submit a modification to the service plan for approval by 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 conflict free case manager and the QIO monitor service usage and budget for each participant. The Department for Aging and Independent Living conducts monitoring reviews of all participants who direct their services and are in contact with DDID and the case managers 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 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 Behavioral Health, Developmental and Intellectual Disabilities 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, or DBHDD 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).

All individuals/entities providing services shall manage incidents according to the following requirements and the program regulations:

Incident: Any occurrence that impacts the health, safety, welfare, or lifestyle choices of an individual. Incidents are minor injuries, medication errors without any serious outcomes, behaviors or types of situations that do not meet the definition of a Critical Incident.

• Incidents shall be:
  a. Maintained on prescribed form in the record at the provider site.
  b. Immediately assessed for potential abuse, neglect and/or exploitation. If assessment is positive for potential abuse, neglect and/or exploitation, incident must be immediately redefined as a Critical Incident and reported to the Department for Community Based Services. Person discovering the incident must take immediate action to ensure the health, safety, and welfare of the at-risk individual. Redefined incidents must follow procedures for Critical Incident.
  c. Reported to the individual’s Case Manager and/or guardian within twenty-four (24) hours of the discovery of the incident.
  d. Recorded by the discovery agency staff on an incident report form.

Critical Incidents: An alleged, suspected, or actual occurrence of an incident that can reasonably be expected to result in harm to the individual.

Abuse, neglect, and exploitation as defined by KRS Chaper 209: “Abuse” means the infliction of injury, sexual abuse, unreasonable confinement, intimidation, or punishment that results in physical pain or injury, including mental injury;

"Neglect" means a situation in which an adult is unable to perform or obtain for himself or herself the goods or services that are necessary to maintain his or her health or welfare, or the deprivation of services by a caretaker that are necessary to maintain the health and welfare of an adult;

"Exploitation" means obtaining or using another person's resources, including but not limited to funds, assets, or property, by deception, intimidation, or similar means, with the intent to deprive the person of those resources;

Critical Incidents also include, but are not limited to:
- Death
- Homicidal/Suicidal Ideation
- Missing person: An incident not considered neglect and the individual cannot be located for a period of time longer than specified in the person centered plan and crisis prevention plan and the individual cannot be located after actions specified are taken; or circumstances indicate that the individual may be in immediate jeopardy; or law enforcement has been called to assist in the search for the individual.
- Loss of limb

Critical Incidents shall be:
Maintained on prescribed form in the record at the provider site.
Immediately reported to Department for Community Based Services, Adult Protective Services, the case manager, and guardian by person discovering the critical incident if the potential for abuse, neglect and/or exploitation is suspected. Person discovering the incident must take immediate action to ensure the health, safety, and welfare of the at-risk individual. If not potential abuse, neglect, or exploitation, reported to the individual’s case manager, guardian and DDID Regional nurse within eight (8) hours of the discovery of the critical incident.
Recorded by the discovery agency staff on a critical incident report form. Report must include:
  i. Identifying Information.
  ii. Details of the Incident.
  iii. Relevant Consumer Information including, but not limited to:
1. Axis I Diagnoses
2. Axis II Diagnoses
3. Axis II Diagnoses
4. Listing of Recent Medical Concerns
iv. Analysis of Causal Factors

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.

DDIDD provides on-line training for providers regarding the statutory and regulatory reporting requirements and identification and prevention of abuse, neglect and exploitation. This training is available online through the College of Direct Support. SCL Providers are required to educate all consumers at least annually and more often as needed, regarding recognition of abuse, neglect, and exploitation and the process to report same. Training is tailored to each individual’s learning style and can be provided in a variety of formats either on line or face to face. Each provider is required to assist and support the consumer’s ability to communicate freely with family members, guardians, friends, and case managers. For consumers who choose to direct their own services, it is the responsibility of the case manager to ensure that the consumer and all employees are trained on abuse, neglect and exploitation and reporting requirements.

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.

Critical events/incidents are received by the DDIDD regional nurse and a follow-up assignment is generated through the risk management system. Assignments involving immediate health, safety or welfare concerns require on-site follow-up immediately to ensure safety. A report of issues causing concern is due within 48 hours of assessment. Assignments not involving immediate health, safety, or welfare concerns require follow-up within 20 calendar days. Follow-up reports are documented in the Risk Management database. If the issue cannot be effectively addressed through standard follow-up procedures, an investigation is initiated by the Risk Management Supervisor. Investigations may be conducted as desk level or on-site; depending on the nature of the complaint or incident. Investigation assignment is made by Risk Management Supervisor using the database. Investigator assigned will make contact with DCBS to coordinate investigation activities. The investigation and written report are to be completed within 45 calendar days. The investigator periodically consults with the Risk Management Supervisor regarding the status of the investigation. If the investigation report results in documentation of regulatory non-compliance, a findings letter including citations is generated and forwarded to the provider agency. All completed investigations are sent to DMS for review.

There are the same reporting requirements when individuals choose to direct any or all of their services.

Incidents are:
Reviewed by the Case Manager on a monthly basis to determine if appropriate remediation occurred.

Reviewed by agency staff on a quarterly basis to analyze data on trends or patterns, agency performance and remediation as documented in the agency’s quality improvement plan.

Critical Incidents are:
Reviewed by Case Manager on a monthly basis to determine appropriate remediation occurred.
Reviewed by agency staff on a quarterly basis to analyze data on trends or patterns, agency performance and remediation as documented in the agency’s quality improvement plan.

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.

A Memorandum of Agreement between the Department for Community Based Services (DCBS), the Department for Medicaid Services and the Department for Behavioral Health, Developmental and Intellectual Disabilities includes reporting and conducting collaborative investigations when incidents of abuse, neglect or exploitation occur when participants are enrolled in the SCL waiver.

Upon receipt of critical incident notifications and/or final reports each incident is immediately screened to ensure that the provider agency has taken appropriate steps to ensure the health, safety, and welfare of the individual(s) involved. If concerns are identified the issue(s) are referred to a DDIDD regional staff member for immediate follow-up.

Following the health, safety, and welfare screening, all critical incident reports are screened for the appropriateness of provider analysis and reaction.

When questions arise that make effective evaluation of the provider’s activities impossible, provider staff members are contacted for immediate clarification.

Concerns that do not put individuals at needless risk are referred to the DDIDD regional staff member responsible for providing technical assistance to the provider for in-depth follow-up during their next scheduled technical assistance visit with the provider.
All complaints received by DDID are followed up by appropriate DDID staff members.

If at any point during the process it is determined that the follow-up of an incident or complaint is complex, the incident or complaint is assigned to a certified investigator for on-site or desk level investigation. All findings require the submission of an acceptable corrective action plan that is monitored by DDID field staff for effectiveness. As the oversight of this process moves towards utilizing a web-based system, accessed at all levels (local, regional, and state), the processes will become more streamlined and efficient:

For Incidents:
Audited through random sample process by regional nurse monthly or more frequently for health, safety and welfare of individual to:
  o Ensure that necessary notifications have been made;
  o Coordinate follow-up and technical assistance with additional DDID staff as necessary;
  o Make referrals for investigations when needed.

Audited through random sample by DDID staff regionally and at Central Office as part of the Continuous Quality Improvement process in support of person centered planning and individual’s satisfaction with their health, safety and welfare needs.

Audited through random sample by DDID staff regionally and at Central Office as part of the Continuous Quality Improvement process related to agency certification surveys, investigations, monitoring and technical assistance.

For Critical Incidents:
Audited through random sample process by regional nurse monthly or more frequently for health, safety and welfare of individual to:
  o Ensure that necessary notifications have been made;
  o Coordinate follow-up and technical assistance with additional DDID staff as necessary;
  o Make referrals for investigations when needed.
  o Audited through random sample by DDID staff regionally and at Central Office as part of the Continuous Quality Improvement process in support of person centered planning and individual’s satisfaction with their health, safety and welfare needs.
Audited through random sample by DDID staff regionally and at Central Office as part of the Continuous Quality Improvement process related to agency certification surveys, investigations, monitoring and technical assistance.

All completed investigations shall be sent to DMS for review.

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:

DDID 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.

DDID 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 individual’s 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 and a WRAP plan if indicated.
The state operating agency-DDID, is responsible for oversight of the person centered planning process which includes monitoring of case management reports, incident reports, 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 a Human Rights Committee that is organized by provider agencies with DDID oversight. 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 a Human Rights Committee (HRC). The HRC 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.

  DDID staff also monitor individual’s plan of care implementation and supports as a routine part of their visits to providers. Through this process, DDID 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 DDID staff.
Restrictive measures prohibit 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.

DDID staff also monitor individual’s plan of care implementation and supports as a routine part of their visits to providers. Through this process, DDID 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 DDID staff.

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, DIDD, is responsible for monitoring and overseeing the use of restrictive interventions. At a minimum, rights restrictions are reviewed by DDID staff members during the provider’s certification process. In addition, human rights restrictions are reviewed by risk management through the incident and complaint process. Issues found with rights restrictions through this screening process are referred to DDID field 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:

DDID 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.

DDID 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-DDID, 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.

Each SCL certified provider agency is required by the regulation to have policies in place specific to medication management and administration to ensure the health, safety, and welfare of the individual’s they support.

Provider agencies receive technical assistance from DDID field staff to utilize Best Practice when providing supports. Individuals may choose multiple agency’s to provide their waiver services. The monitoring of their medication administration can be conducted by multiple staff, who have met all training requirements as set forth in the SCL regulations, at each agency.

The second line/ongoing monitoring of the individual’s medication regimes in the Waiver, is the responsibility of the administration, management, and quality assurance staff at the SCL certified agency to include the case manager, registered nurse, program director, quality manager, incident manager, contracted pharmacist, and positive behavioral specialist.

While some monitoring responsibilities may overlap, the scope, focus, or extent by which any of the identified person’s can provide the monitoring of medication management is determined by their credentials.

Focus areas would include reviewing for poly pharmacy usage, follow up with doctor appointments and prescriptions, review of laboratory values, overall health, appearance, and affect, an individual’s compliance with their medications, staff competency of medication administration, documentation of medical diagnosis and need for the medication, medication reduction plans, reaction and interaction with other meds, documentation of need and effectiveness of PRN medications, due process, timely reordering of medications; staff training, reporting medication errors correctly, compliance with state and federal laws, and agency quality improvement measures.

Monitoring can be conducted by direct observation, assessment, and interview of the individuals’ and/or by reviewing MAR’s, PRN reports, incident reports, laboratory reports, doctor’s orders, medication error reports, actual pill counts, appropriate behavior support plan implementation, daily notes, individual’s health status, review of health logs and interviews with direct support staff.

SCL provider agency specific policies describe the frequency of monitoring. Based on regulatory reporting requirements monitoring of medication administration is done at least monthly. However, more frequent monitoring may occur as part of the agency’s quality improvement process or based on the individual’s support needs.

Each agency is required by the regulation to have quality improvement policies. This includes methods for tracking and trending issues and incidents. When reoccurring incidents or potentially harmful practices are identified, the agency must implement measures to prevent them from happening, this may include, personnel reassignments, training/education, policy or system changes, and updates to the plans of care.

When routine behavior modification medications are used, the agency ensures monitoring of the medication management and administration by review of Axis 1 diagnosis or justifications of medication if there is not an Axis I diagnosis; a review of the medication, usage, and reported need for the medication by the Human Resource Committee and the Behavior Intervention Committee with due process afforded to all individuals. If needed, a behavior support plan should be reviewed.
for proper implementation. PRN medication protocols should be reviewed for appropriate processes and the agencies' quality improvement plan should reflect all necessary changes and timelines for which they should be achieved.

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.

Through an interagency agreement with DMS, DDID is the state agency responsible for administering the SCL waiver program which includes monitoring and oversight of second-line medication management processes.

DDID Central office staff includes pharmacists and nurses who review medication practices, monitoring, and administration by the provider agency, for regulatory compliance, and best practice. SCL providers can request additional assistance as needed.

Data from assessments, incident reports and monthly medication error reports and complaints are entered into the DDID risk management database. Further development of this database system will enable DDID staff to perform trend analysis and use that information to proactively address issues with SCL providers. Technical assistance is provided by DDID staff when a potentially harmful practice is identified. If the potential hazard puts the individual in immediate risk, the DDID field staff will conduct onsite visits to monitor and evaluate the situation and provide technical assistance to the agency. The agency must provide DDID their plan to address the situation and what measures they will implement to prevent it from happening again.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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).

DDID, in collaboration with the Department for Public Health and the Kentucky Board of Nursing (KBN) have developed a standardized curriculum for training medication administration to non-licensed personnel.

This course is intended for non-licensed personnel who provide direct care of individuals. Upon successful completion of this course, the non-licensed personnel would prove competency in administration of an individual's medication for those who are unable to self-administer, and when appropriate, observation of an individual's self-administration of medications.

The SCL provider agency must utilize a DDID trained RN to provide medication administration training for agency direct support staff. This is a KBN approved curriculum for staff that will administer or assist with administering medication to individuals in SCL.

Registered Nurses will train direct support professionals by direct observation, auditing medication counts, review of MAR and prescriptions, laboratory values and by monitoring the health of the individual’s supported by ensuring the 6 RIGHTS of Medication administration.

Quality assurance measures that will be utilized by DDID RN’s would include assessing staff’s ability to identify and report medication errors made by self or others, obtain emergency services when needed, and would be able to recognize and report side effects or adverse reactions to medications. DDID RN’s may audit the MAR and supporting documentation to track trends in errors, staff, times, medications, and individuals. The provider will be required to have policies in place that follow the regulation and contain agency specific protocol when retraining of staff is needed.

DDID will maintain a listing of DDID qualified RN trainers and a roster of direct support professionals who have completed the training and DDID RN’s will periodically observe the curriculum being taught while onsite at SCL provider agencies.

Self administration of medication documentation such as MAR’s, medical appointment visits and individual interviews will
be utilized by DDID RN staff to determine if self-administration practices are safe. Technical assistance will be provided to agency staff as needed.

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:

  Medication errors are reported to the state operating agency, DDID.

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

  A monthly medication error reporting tool was developed to ensure a more consistent, accurate manner of identifying medication error incidents. All medication errors are documented on an approved form and maintained at the provider agency for review by DDID, case managers, DCBS and DMS.

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

  Medication errors that meet the criteria for a critical incident shall be reported to the state operating agency-DDID and DCBS.

- 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.

Through an interagency agreement with DMS, DDID is the state agency responsible for administering the SCL waiver program which includes monitoring and oversight of second-line medication management processes.

DDID has developed a computerized medication error system to manage medication error data. The development of the risk management data system has enabled DDID to perform trend analysis and use that information to proactively address issues with SCL providers.

Monitoring of medication administration and agency policy’s are included when DDID field staff conducts certification reviews. All citations require a plan of correction from the SCL provider agency.

SCL providers who do not submit the monthly medication error report are required to submit a plan of correction to DDID within 30 days detailing measures to be implemented that will correct the citation.

SCL providers who receive technical assistance, but continue to have repeat occurrences of medication errors and/or classification errors, will receive citations and possible sanction recommendations by DDID. DDID will notify DMS in writing if an SCL provider does not implement the necessary processes to ensure the health, safety and welfare of the individual’s they support.

DDID Central office staff includes pharmacists and nurses who review medication practices, monitoring, and administration by the provider agency, for regulatory compliance, and best practice. SCL providers can request additional assistance as needed.

DDID provides Medicaid information regarding the monitoring and oversight with copies of provider letters, certification review schedules and modifications, certification and investigation findings reports, recommendations pertaining to decertification, certification and moratorium. A variety of ad hoc reports, trend analyses, risk management data, and other requested documentation is provided to DMS as required.

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.

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:

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

Data Source (Select one):

Other

If ‘Other’ is selected, specify:

Operating agency database or MWMA-Medicaid Waiver Management Application

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- Operating Agency
- Sub-State Entity
- Other
  Specify:

Frequency of data aggregation and analysis (check each that applies):
- Weekly
- Monthly
- Quarterly
- Annually
- Continuously and Ongoing

Performance Measure:
Percent of critical incident reports of potential abuse, neglect, and exploitation that were submitted within the required timeframes. N=Number of Critical incident reports of abuse, neglect and exploitation that were submitted within the required timeframes D= Total number of critical incident reports submitted

Data Source (Select one):
- Other
If ‘Other’ is selected, specify:
Operating agency database or Medicaid Waiver Management Application data

Responsible Party for data collection/generation (check each that applies):
- State Medicaid Agency
- Operating Agency
- Sub-State Entity
- Other
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Frequency of data collection/generation (check each that applies):
- Weekly
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Sampling Approach (check each that applies):
- 100% Review
- Less than 100% Review
- Representative Sample
  Confidence Interval

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Data Aggregation and Analysis:
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- Other
  Specify:

Frequency of data aggregation and analysis (check each that applies):
- Weekly
- Monthly
- Quarterly
- Annually
- Continuously and Ongoing

Other
Specify:

Other
Specify:
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:

**Percent of incidents in which staff training needs were identified.**

\[ \text{N} = \text{number of incidents in which staff training needs were identified.} \]

\[ \text{D} = \text{total number of incidents reviewed} \]

### Data Source (Select one):

- **Other**
  - If 'Other' is selected, specify: Operating agency database or MWMA

### Responsible Party for data collection/generation (check each that applies):

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- Operating Agency
- Sub-State Entity
- Other
  - Specify: 

### Frequency of data collection/generation (check each that applies):

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### Sampling Approach (check each that applies):

- 100% Review
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- Stratified
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### Other

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Performance Measure:
Percent of incidents in which needed changes were identified. \(N=\) number of incidents in which needed changes were identified \(D=\) number of incidents reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:

Operating agency database or MWMA

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Other Specify:

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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:
Percent of participants with no restrictive interventions including restraints and seclusions, reported. \( N = \) number of participants with no restrictive interventions including restraints and seclusions, reported \( D = \) number of participants

Data Source (Select one):
Other
If 'Other' is selected, specify:

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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:**
Percent of participants who had a physical examination within the last year. \( N = \text{number of participants who had a physical examination within the last year} \)
\( D = \text{number of participant records reviewed} \)

**Data Source** (Select one):
- Other
  If 'Other' is selected, specify:
- QIO system

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**Other**

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Performance Measure:
Percent of participants receiving residential supports who have had a health risk screening
N=number of participants receiving residential supports who have had a health risk screening
D=number of participants receiving residential supports

Data Source (Select one):
Other
If 'Other' is selected, specify:
operating agency data

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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.
Provider agencies are licensed annually by OIG or certified by SCL at least every two years, which includes monitoring of the employee records for criminal checks and abuse registry checks.
DDID performs first line monitoring and identifies deficiencies of the SCL waiver provider and requires a corrective action plan to address the deficiencies identified. Findings are reported to DMS. During the recertification process, policy and procedures for training provider staff are reviewed and review of incident reports for the period of the review are completed to ensure health, safety and welfare.
DDID monitors the complaint process by examining the complaint logs and the results of client satisfaction surveys, National Core Indicators data. By analyzing the trends from incident database on abuse, neglect, exploitation, and injuries reported due to restraint DDID will monitor agency reporting and remediation of critical incidents both on an individual and agency levels.
Require providers to post the toll-free fraud and abuse hotline telephone number of the office inspector general for all staff, waiver participants, and their caregivers or legal representatives and other interested parties to have access to. The purpose of this hotline is to enable complaints or other concerns to be reported to the Office of the 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.
DDID performs monitoring and certification of the SCL providers. Should an enrolled provider not meet requirements DMS would terminate the provider enrollment. DDID performs the first line monitoring and audit reviews. Should the auditing reveal that documentation is not present or does not support the services provided as required, DDID will recommend recoupment to DMS.

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

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**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.

- 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 II: 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.

During 2009, the Department of Behavioral Health, Developmental and Intellectual Disabilities adopted a new planning process. Effort was made to involve more families, advocates and consumers than ever before. This effort has continued. Participants, families and advocates identify needs, recommend potential solutions to the needs, and help decide the priorities for the coming years.

The identified priorities and the results of the National Core Indicators (NCI) Consumer and Family Surveys are reviewed and compared to the Division’s Core Values and Vision: People receiving support are safe, healthy and respected in their community; live in the community with effective, individualized assistance; and enjoy living and working in their community to evaluate where we are toward its fulfillment.

Based upon the result of the NCI surveys, a quality improvement committee meets twice per year to review the NCI data and the goals recommended to BHIDID to determine whether or not the goals need to be revised. The committee is comprised of University of Kentucky staff who administer Kentucky’s participation in NCI, family members, consumers, and BHIDID staff. The goals recommended to BHIDID are:

1. Employment- The new recommendation of the QI committee is for employment rates for Kentucky SCL recipients to meet or exceed the NCI average.

This goal is based on the gains that have already been made in this area along with the initiatives that have been put in place with the SCL waiver changes. Given the generally poor employment rates for people with disabilities, the committee would like to see Kentucky exceed the national average within the next few years. The committee will make specific suggestions for bringing this goal to fruition later in 2015.

2. Health & Wellness- The recommendation is for the average number of Kentucky SCL recipients who moderately exercise regularly to 1) meet the NCI average in 2014/2015 and then, 2) exceed the NCI average by at least 5% in 2015/2016.

The previous goal of increasing the exercise rate by 5% was exceeded and the committee believes that this trend will continue. The Health Matters project at the Human Development Institute is beginning its second year and expanding its reach. This project is designed to improve the general wellness of people with disabilities by offering a program that promotes healthy lifestyles.

3. Psychotropic Medication- The QI committee recommends decreasing the percentage to 61%.

The NCI data will be shared with medical director at the Kentucky Division of Developmental and Intellectual Disabilities. The Kentucky NCI project will also look at diagnosis rates and compare them to medication usage. This is an area in which no progress has been made and, in fact, the data shows movement in a negative direction.

In the most recent committee meeting it was agreed that in addition to making goal recommendations, the committee will also strategize ways to accomplish the recommendations.

Reports are posted on the Belonging in the Community website: http://www.belongingky.org/?page_id=19

The Kentucky Commission on Services and Supports for Individuals with Intellectual and Other Developmental Disabilities was created and established through the enactment of House Bill 144 by the 2000 General Assembly. The Commission, referred to as the HB 144 Commission, serves in an advisory capacity to the Governor and the General Assembly concerning the service system that impacts the lives of people with intellectual and developmental disabilities. The House Bill 144 Committee, which includes Legislators, self-advocates, family members, professionals, and providers, developed a list of short and long-term goals for BHIDID which included initiatives focusing on workforce development, quality and best practices. The subcommittees (Community Integration, Health & Wellness, and Participant Directed Supports) incorporated the NCI Committee goals into their committee work.
BHDID staff conducts quarterly Quality Improvement (QI) meetings. The principles followed are:
• Meaningful participant quality of life (as opposed to merely freedom from abuse and neglect)
• Efficacy of services and supports
• Efficiency of service and support provision
• Quality outcomes relative to expenditures (return on public dollar)
The structure for the meetings is:
1. Review data to drive decisions
   • What are the facts?
   • What improved? How?
   • What declined? Why? What is being done about it?
2. Identify strategies for improving processes
3. Test strategies to hone system changes
Action items are determined during each meeting. The committee is comprised staff with management responsibilities for:
Provider Development and Training
Day to Day Provider Quality
Risk Management
Direct Support Professional Training and Credentialing
Supports Intensity Scale Assessments
Exceptional Support Request and Delivery
Applications and Allocations to SCL
Special Initiatives (current initiatives are “Community Belonging”, “Endeavor for Excellence”, and “Health Matters”)

PROCESS FOR TRENDING: The Regional Team shall assist each provider in aggregation and analysis of data from all incidents, expenditure/service reports, prior authorization of services, and monitoring and implementation of person centered service plans at least quarterly but as often as needed to identify trends and generate action steps to manage identified issues. Each Regional Team will provide no less than quarterly reports of identified trends and progress on corrective action plans audited by random sample to the CQI Committee. In turn, the CQI Committee shall present findings and recommendations based on statewide data analysis and information from Risk Management and HB 144 Commission advisory committees and Mortality Review Committee at least quarterly to each Regional Team. This information will be made available for review by stakeholders through existing venues such as the Department web site, HB 144 Committee and sub-committee meetings and videoconferences.

All waiver providers, individuals and families participate in the National Core Indicators (NCI) Consumer Satisfaction Survey which captures data regarding participant choice and satisfaction. At the state level, the CQI committee will examine the survey results, noting trends, and integrate data from the other sources to obtain an overarching view of progress toward priorities.

PRIORITIZING: While contemplating waiver revisions, BHDID reviewed provider certification data, NCI data, gathered stakeholder input and integrated information from Mortality Review Committee and the Risk Management Advisory Committee. Based upon all of the data gathered, DMS and BHDID partnered in setting the following priorities with the implementation of the revised waiver: 1) Person Centered Plans are based upon an individual’s assessed preferences and needs. The plans reflect both what is important for and important to the individual; 2) Case managers and direct support professionals complete required training and demonstrate skills necessary to assist an individual in attaining what is important to and for them; 3) individuals feel safe and secure in their own homes and neighborhoods and 4) Supports are delivered in a fiscally responsible and effective manner. BHDID believes the data related to achieving these priorities are essential to using person centered thinking to achieve a person centered system that offers individualized supports in a holistic fashion. Noted trends from the various data sets will be coupled with NCI results and expected/best practices to establishing future priorities.

IMPLEMENTATION OF SYSTEM IMPROVEMENTS
An area for improvement noted through analysis of quality assurance discovery and remediation is in regard to the sub-assurance that providers continually meet certification standards. The primary areas of non-compliance have been identified as mediation administration, day training providing diversional activity, and health, safety, welfare concerns. Each area is being addressed. Data will continue to be collected, reviewed and action plans will be revised as needed. Provider certification lengths are determined by findings related to health, safety and welfare citations, and repeat citations from past reviews.

Quality Improvement strategies will be implemented at various levels as guided by data trends to include individual level; provider level; regional level; over more than one region when indicated; and statewide. Progress toward achieving outcomes shall be monitored at these levels as well with data flowing through all quality improvement efforts. Any training needed to assist with strategy implementation may be held face-to-face, videoconferencing or online learning modules.

### ii. System Improvement Activities

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<tr>
<th>Responsible Party (check each that applies):</th>
<th>Frequency of Monitoring and Analysis (check each that applies):</th>
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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.

Electronic System Design Changes: The Commonwealth has just implemented an electronic Medicaid Waiver Management system (MWMA) to streamline processes across waivers. MWMA will provide automated capabilities around the intake, assessment, eligibility determination, plan of care, case management, incident management, timesheet, and reporting functions performed by waiver service providers. MWMA will eventually integrate with kynect, Kentucky's healthcare connection, providing individuals and families with self-service access to manage their waiver program applications, service plans, services and timesheets. Information about the system can be found here: http://chfs.ky.gov/dms/mwma.htm#what

Commonwealth staff across all waivers as well as technology staff will be involved in suggesting and designing any applicable system changes. During the first two weeks of implementation of the system there were twice daily status updates to keep abreast of any issues with implementation of the system as well as statistics of individuals being on-boarded into the system.

System of Practice Design Changes: The Commonwealth is in the process of working toward compliance with the final rule. Three areas where considerable strides have been made over the past couple of years have been toward compliance with conflict-free case management, service plans reflecting what is important to and important for each person, and the planning process including both risk assessment and risk mitigation. The targeted standards for improvement are person-centered planning and setting requirements. Commonwealth staff across all waivers is involved in these efforts.

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

The Quality Improvement Strategy shall be reviewed for progress and needed revisions at least annually by the BHDID Quality Improvement committee with updates and recommendations provided to the BHDID Management team. The focus of these reviews shall be utility of quality initiatives; validity of data; determination of best course of action; alterations needed; and information gained. This information will be communicated to all quality improvement stakeholders so that cycle continues.

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).

The Department for Medicaid Services (DMS) or the designated state operating agency-DDID shall conduct annual utilization 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. DMS or its designee 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 Person Centered Service Plan (PCSP) shall be conducted. If any payments were issued without the appropriate documentation or not in accordance with approved PCSP, DMS will initiate recoupment of the monies. Additional billing reviews are conducted based on issues identified during certification surveys or investigations.

DMS shall conduct annual audits of the financial management services (FMS) entities. These audits shall include a post-payment
review of Medicaid reimbursement to the financial management agency for payment to the member’s employees through participant
directed opportunities. Auditing will be conducted through random sample of all participant directed member records. DMS shall
utilize reports generated from MMIS reflecting each service billed for each member by financial management agency. Comparison of
payments to member records, documentation and approved POC’s shall be conducted. If any payments were issued without the
appropriate documentation or not in accordance with the approved PCSP, DMS will 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.


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:
Percent of system defects identified and corrected in the Supports for Community Living (SCL) waiver program. N=number of system defects corrected in the SCL program D=number
of system defects identified in the SCL program.

Data Source (Select one):
Other
If ‘Other’ is selected, specify:

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<tr>
<th>Responsible Party for data collection/generation (check each that applies):</th>
<th>Frequency of data collection/generation (check each that applies):</th>
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**Performance Measure:**
Percent of waiver service claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. N=number of waiver claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered D=number of waiver claims rendered

**Data Source (Select one):**

- Financial audits
  - If 'Other' is selected, specify:
    - MMIS claims

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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:
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 the approved rate methodology D=number of service rates

Data Source (Select one):
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<td>MMIS claims</td>
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b. Methods for Remediaion/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. DBHDID provides technical assistance to certified providers on an ongoing basis. Providers found out of compliance submit and are held to a corrective action plan (CAP). DMS and/or DDID perform trainings upon request of providers and provides technical assistance whenever requested. Should an enrolled provider fail to meet their CAP, the Office of Inspector General (OIG) would terminate the provider license and DMS would terminate the provider Medicaid enrollment.

ii. Remediation Data Aggregation

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

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Other Specify: MMIS

Annually

Stratified Describe Group:

Continuously and Ongoing

Other Specify:

Other Specify:
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 states 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.

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 Department for Medicaid Services (DMS) or its designee shall conduct annual 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. DMS 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. If any payments were issued without the appropriate documentation or not in accordance with approved POC, DMS shall initiate recoupment of the monies.

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:
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:

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

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:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

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) (MCOs) 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:

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.

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

  - 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:

Four entities in Kentucky pay health-care related taxes: hospitals, nursing facilities, home health agencies, and mental retardation service providers. These are broad-based taxes which apply to all Medicaid and non-Medicaid providers within the specified groups.

Through the biennium budget process, the Kentucky General Assembly allocates funds generated through these health-care related taxes to the Department for Medicaid Services as one funding source which contributes to the overall Medicaid budget. Health-care related tax receipts are not designated to be used for a particular program or purpose within the Medicaid budget.

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:

Fixed rates for these services do not include any margin for room and board related expenses. The provider contracts specify that room and board expenses must be covered from sources other than Medicaid. Providers of waiver services are contractually prohibited from billing for room and board expenses through Medicaid. Operating agency staff review individual records during
both certification and utilization reviews to verify that the costs for room and board are in fact, excluded. Medicaid agency staff also verify during second level reviews.

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:

The rent and food expenses of an unrelated live-in caregiver, who does not hold the lease or own the residence, will be determined by dividing total household rent and food expenses by the number of residents in the home, including the caregiver. In other words, the caregiver is considered a resident in the home, and food and rent expenses are apportioned equally among all persons residing in the home. It is the responsibility of the Case Manager to document and report any waiver funds used to pay rent and food expenses of an unrelated live-in caregiver.

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 inCols. 3, 5 and 6 in the following table for each waiver year. The fields inCols. 4, 7 and 8 are auto-calculated based on entries inCols 3, 5, and 6. The fields inCol. 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: ICF/IID

<table>
<thead>
<tr>
<th>Col. 1</th>
<th>Col. 2</th>
<th>Col. 3</th>
<th>Col. 4</th>
<th>Col. 5</th>
<th>Col. 6</th>
<th>Col. 7</th>
<th>Col. 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year</td>
<td>Factor D</td>
<td>Factor D'</td>
<td>Factor G</td>
<td>Factor G'</td>
<td>Total: D+D'</td>
<td>Factor G</td>
<td>Factor G'</td>
</tr>
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<td>339501.00</td>
<td>6658.00</td>
<td>356159.00</td>
<td>281811.67</td>
</tr>
</tbody>
</table>

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>
<thead>
<tr>
<th>Waiver Year</th>
<th>Total Unduplicated Number of Participants (from Item B-3-a)</th>
<th>Distribution of Unduplicated Participants by Level of Care (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Level of Care:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ICF/IID</td>
</tr>
<tr>
<td>Year 1</td>
<td>4941</td>
<td>4941</td>
</tr>
<tr>
<td>Year 2</td>
<td>4941</td>
<td>4941</td>
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<tr>
<td>Year 3</td>
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<td>4941</td>
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<td>4941</td>
<td>4941</td>
</tr>
<tr>
<td>Year 5</td>
<td>4941</td>
<td>4941</td>
</tr>
</tbody>
</table>

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.

The Average Length of Stay is based on data from the CMS 372 Lag Report for the period 09/01/2013 through 08/31/2014. Total days of Waiver coverage was 1,169,813. Total Unduplicated Waiver Members was 4,050. Dividing total days of enrollment for all participants by the number of unduplicated participants yields an average days per waiver Member of 288.8, resulting in an Average Length of Stay of 9.5 months.

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:

Due to changes in SCL waiver that have been implemented over the past year, beginning in 1/1/2014, as well as the lag between claim incurrence and claim payment, full year of representative claims data is not available. Examined all claims paid under SCL 2 from 1/1/2014 through 1/1/2015, as well as the number of service users in each month of service, to determine monthly users, monthly cost per user, and monthly units per user. Those amounts were converted to annual amounts, based on a percentage of percentage of SCL enrollees using each service. Some of the new services had very low utilization since providers are just beginning to use those services. Due to low current utilization and lack of historical data, DMS assumed at least 10 users per service line as a floor and 10% annual utilization growth.

Cost per Unit Calculation: Overall cost per unit calculations were obtained in the same manner described above. In the state payment regulations some services have multiple rate options depending on the specific nature of the provider. In those cases DMS used a weighted average of rate based on current utilization and membership distribution. For example, Residential Level 1 can be performed in a 4-8 resident setting at $130.35 per diem or a <= 3 resident setting at a $172.46 per diem. The actual current weighted average over the period under observation was $167.51 and therefore the weighted average cost per unit was chosen rather than any specific rate.

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:

Total costs for each waiver service were calculated as the product of users, units per user and cost per unit. All waiver service costs for each waiver year were totaled and divided by the unduplicated Waiver Participants resulting in Factor D estimates.

The Factor D’ is based on data from the CMS 372 Lag Report for the period 09/01/2013 through 08/31/2014. The average per capita acute care services expenditures for acute care services to Waiver Members was calculated to be $4,662.87. To this total was added costs for physical therapy, occupational therapy, and speech therapy which are being removed from the waiver and included in the state plan as a acute care service. The resulting per capita total was trended forward to each Waiver Year using an annual medical costs trend factor of 1.04.

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:
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.

<table>
<thead>
<tr>
<th>Waiver Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict Free Case Management</td>
</tr>
<tr>
<td>Consultative Clinical and Therapeutic Services</td>
</tr>
<tr>
<td>Day Training</td>
</tr>
<tr>
<td>Personal Assistance</td>
</tr>
<tr>
<td>Residential Support Level I</td>
</tr>
<tr>
<td>Respite</td>
</tr>
<tr>
<td>Shared Living</td>
</tr>
<tr>
<td>Supported Employment</td>
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<tr>
<td>Community Guide</td>
</tr>
<tr>
<td>Financial Management Services</td>
</tr>
<tr>
<td>Natural Supports Training</td>
</tr>
<tr>
<td>Community Access</td>
</tr>
<tr>
<td>Community Transition</td>
</tr>
<tr>
<td>Environmental Accessibility Adaptation Services</td>
</tr>
<tr>
<td>Goods and Services</td>
</tr>
<tr>
<td>Person Centered Coach</td>
</tr>
<tr>
<td>Positive Behavior Supports</td>
</tr>
<tr>
<td>Residential Support Level II</td>
</tr>
<tr>
<td>Specialized Medical Equipment and Supplies</td>
</tr>
<tr>
<td>Technology Assisted Residential</td>
</tr>
<tr>
<td>Transportation</td>
</tr>
<tr>
<td>Vehicle Adaptations</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Waiver Year: Year 1</th>
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<tbody>
<tr>
<td>Waiver Service/ Component</td>
</tr>
<tr>
<td>Conflict Free Case Management Total:</td>
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<tr>
<td>Total Estimated Unduplicated Participants:</td>
</tr>
<tr>
<td>Factor D (Divide total by number of participants):</td>
</tr>
<tr>
<td>Average Length of Stay on the Waiver:</td>
</tr>
<tr>
<td>Waiver Service/ Component</td>
</tr>
<tr>
<td>-----------------------------------</td>
</tr>
<tr>
<td>Conflict Free Case Management</td>
</tr>
<tr>
<td>Consultative Clinical and Therapeutic Services Total:</td>
</tr>
<tr>
<td>Consultative Clinical and Therapeutic Services</td>
</tr>
<tr>
<td>Day Training Total:</td>
</tr>
<tr>
<td>Day Training</td>
</tr>
<tr>
<td>Personal Assistance Total:</td>
</tr>
<tr>
<td>Personal Assistance</td>
</tr>
<tr>
<td>Residential Support Level I Total:</td>
</tr>
<tr>
<td>Residential Support Level I</td>
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<tr>
<td>Respite Total:</td>
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<td>Respite</td>
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<tr>
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<tr>
<td>Shared Living</td>
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<tr>
<td>Supported Employment Total:</td>
</tr>
<tr>
<td>Supported Employment</td>
</tr>
<tr>
<td>Community Guide Total:</td>
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<tr>
<td>Community Guide</td>
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<tr>
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<tr>
<td>Financial Management Services</td>
</tr>
<tr>
<td>Natural Supports Training Total:</td>
</tr>
<tr>
<td>Natural Supports Training</td>
</tr>
<tr>
<td>Community Access Total:</td>
</tr>
<tr>
<td>Community Access</td>
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<tr>
<td>Community Transition Total:</td>
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<td>Total Estimated Unduplicated Participants:</td>
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<tr>
<td>Average Length of Stay on the Waiver:</td>
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</tbody>
</table>

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**

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<th>Avg. Units Per User</th>
<th>Avg. Cost/ Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict Free Case Management Total:</td>
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Average Length of Stay on the Waiver: 11
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<th>Waiver Service/ Component</th>
<th>Unit</th>
<th># Users</th>
<th>Avg. Units Per User</th>
<th>Avg. Cost/ Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
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GRAND TOTAL: 327218356.64

Total Estimated Unduplicated Participants: 4941
Factor D (Divide total by number of participants): 66225.13
Average Length of Stay on the Waiver: 11
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Total Estimated Unduplicated Participants: 4941
Factor D (Divide total by number of participants): 66225.13
Average Length of Stay on the Waiver: 11

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

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Total Estimated Unduplicated Participants: 4941
Factor D (Divide total by number of participants): 66894.42
Average Length of Stay on the Waiver: 11
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GRAND TOTAL: 330525314.48

Total Estimated Unduplicated Participants: 4941
Factor D (Divide total by number of participants): 66894.42
Average Length of Stay on the Waiver: 11
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Factor D (Divide total by number of participants): 11

Average Length of Stay on the Waiver: 11

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.

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Total Estimated Unduplicated Participants: 4941

Factor D (Divide total by number of participants): 67643.37

Average Length of Stay on the Waiver: 11

https://wms-mmdl.cdsvdc.com/WMS/faces/protected/35/print/PrintSelector.jsp
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Total Estimated Unduplicated Participants: 4941
Factor D (Divide total by number of participants): 67643.37
Average Length of Stay on the Waiver: 11
### 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.

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**GRAND TOTAL:**

| Total Estimated Unduplicated Participants: | 4941 |
| Factor D (Divide total by number of participants): | 67643.37 |
| Average Length of Stay on the Waiver: | 11 |

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https://wms-mmdl.cdsvdc.com/WMS/faces/protected/35/print/PrintSelector.jsp
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Total Estimated Unduplicated Participants: 4941
Factor D (Divide total by number of participants): 68462.33

Average Length of Stay on the Waiver: 11

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4/29/2015
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GRAND TOTAL: 338272382.75
Total Estimated Unduplicated Participants: 4941
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