

STATEMENT OF CONSIDERATION RELATING TO
907 KAR 12:020

Department for Medicaid Services
Amended After Comments

(1) A public hearing regarding 907 KAR 12:020 was held on September 21, 2012 at 9:00 a.m. in the Health Services Auditorium of the Health Services Building at 275 East Main Street in Frankfort, KY.

(2) The following individuals spoke at the hearing:

<u>Name and Title</u>	<u>Organization/Agency/Other Entity</u>
Steve Shannon, executive director	The Kentucky Association of Regional Mental Health/Mental Retardation Programs, Inc. (KARP)
Thomas P. Laurino, provider	Choices Unlimited, Inc.; Paducah, KY
Christopher George, board certified behavior analyst and licensed behavior analyst	Applied Behavior Advancements
Amber Durham, a licensed behavior analyst	Applied Behavioral Advancements
Jerry McDonald, program director	Links of Kentucky; Somerset, KY
Johnny Callebs, executive director	Independent Opportunities; Richmond, KY
Dr. Laura Young, licensed clinical Psychologist	Apple Patch; Crestwood, KY
Steve Zaricki, president	Kentucky Association of Private Providers (KAPP)
Dr. Adreanna Bartholome Spears, a licensed clinical psychologist	Louisville, KY
Susan Stokes, owner	Access Community Assistance and HMR Associates
Stephanie Sharp, chairperson	The Commonwealth Council on Developmental Disabilities
Oyo Fummilayo, member	The Commonwealth Council on Developmental Disabilities
Jerry McDonald, program director	Links of Kentucky; Somerset, KY
Johnny Callebs, executive director	Independent Opportunities;

William S. Dolan, staff attorney supervisor
Judy Erwin, director of compliance
Amber Durham, a licensed behavior analyst

Richmond, KY
P & A
Zoom Group; Louisville, KY
Applied Behavioral
Advancements

(3) The following individuals submitted written comments regarding 907 KAR 12:010:

<u>Name and Title</u>	<u>Organization/Agency/Other Entity</u>
Annelle S. Fulmer, sister of an SCL participant Robert C. Reifsnyder, President	United Way of Greater Cincinnati; Cincinnati, OH
Leshia Lyman, Director of the Northern Kentucky Area Center	United Way of Greater Cincinnati; Cincinnati, OH
Dr. Adreanna Bartholome Spears, a licensed clinical psychologist Shelly Buntain, President	Louisville, KY Independent Industries, Inc.; Louisville, KY
Diana Wall, executive director	Marshall County Exceptional Center (MCEP)
Shirley Don Haws, a board member Susan Stokes, owner	MCEP Access Community Assistance and HMR Associates
Brian S. Ray/illegible name Amy Youk, DSP Crystal Reid Rita McLemore Hicks Ramona Kaye McDonald Kelley Heiston, DSP No name provided Illegible name	MCEP
Mike Mill, a board member Cathy Y. West Juainta West, community member Jennifer York, consumer Cathy Y. York, parent Lynda McWaters Karlie Stirm Kearston Breeden Melissa Sumner Linda Pogue Brad Waddell Kim Waddell Allen Waddell	

Brian Sams
Jack Ham
Jennifer Lane
Dustin Lane
Sharon Hamlet
Janice Pollard
Joe T. West
Rose Mary Gamble
Arlie Ross
Joetta Ross
Carla Griggs
Kelley Bennett
Larry Wright, consumer
No name
Joe. T. illegible last name, director

Marshall County
Exceptional School in
Benton, KY

Kelly Miller
Rebecca Stamm
Nora Bannesto
Mary McDaniel
Karen Brooks
Stephanie Gordon
Kelly Corlis
Kasey Corlis
Lena Fletcher
Tammy Dugan
Amy Henderson
Dudley Boling
Evelyn Atherton
Jackie Griffith
The guardian of Dorcas Kempf
Kathy Osborne
Michelle Moore
Michelle Riggs
Betty S. Meacham
Elora Hurt, Site Supervisor for a Comp Care Agency
Brooke Howswell/(not legible), direct support
professional DSP
Robie Carlos/(not legible) sister of an SCL participant
Penny Lou O'Neal, SCL participant
Diane Sue Adkins, SCL participant
Patty Adkins, SCL participant
Illegible name
Kenny Thomas
Illegible name

Hopkinsville, KY;

Nicholasville, KY
Lexington, KY
Grayson, KY

Lisa Bradley	Ashland, KY
Jeffery Fraley	Catlettsburg, KY
Phoebe Fitzgerald	Ashland, KY
Beth Adkins	Huntington, WV
Melanie R. Queen	Ashland, KY
No name provided	
No name provided	
John Willis, friend of SCL participants	Morehead, KY
Dee Dee Willis, friend of SCL participants	Morehead, KY
Illegible name	Worthington, KY
Tg. A. illegible last name	Huntington, WV
Kathy Roe	Greenup, KY
Matt illegible last name	Ashland, KY
Illegible first name A. Bradley, Jr.	Ashland, KY
Derek Sizemore	Ashland, KY
Bill illegible last name	
Stephanie Dewitt-Sizemore	Ashland, KY
Amanda S. Preston	Ashland, KY
Illegible name	Ashland, KY
Genetta McClove	Ashland, KY
Joseph D. Coleman	Ashland, KY
Beverly Coleman	Ashland, KY
Sydney Cullup	Ashland, KY
Janet Bradley	Ashland, KY
Rachel Rae Coleman	Ashland, KY
Amanda Leiber	Ashland, KY
Lainey Burgess	Ashland, KY
Amy Acord	Ashland, KY
Jeff Watters	Ashland, KY
Virginia Watters	Ashland, KY
Shannon illegible last name	Lexington, KY
Tim Huff	
Angel L. Silvey	Wheelersburg, OH
Casey Burke	Grayson, KY
Sonya Remy	Ashland, KY
Debbie Whitt	
Illegible name	Wheelersburg, OH
Misty Amytin	Grayson, KY
Illegible name	Ashland, KY
David P. illegible last name	Catlettsburg, KY
Jawana Binion	Grayson, KY
William July	
Lea Acord	Catlettsburg, KY
Myriah Weatherholt	Ashland, KY
H. M. illegible last name	Ashland, KY
Bill Bradley	Ashland, KY

Kyle illegible last name	Ashland, KY
Guy Brislin	Nicholasville, KY
Matthew Brislin	Nicholasville, KY
Becky Brislin	Covington, KY
Robyn A. Shaler	Nicholasville, KY
Ralph Brislin	Covington, KY
Jenny Meade	Flatwoods, KY
Jeff Hale	Flatwoods, KY
Cleta Thompson	Ashland, KY
Dawn Withrow	Ashland, KY
Jennifer and Joshua Roberts	Ashland, KY
Kathryn illegible last name	Ironton, OH
Shawna Dillon	Ashland, KY
Mr. and Mrs. Joseph A. Welch	Louisville, KY
Kevin Crisp	Grayson, KY
David Foster	Ashland, KY
Marvin Sizemore	Ashland, KY
Aaron Wallace	Grayson, KY
Jinny Adams	
Ally illegible last name	Ashland, KY
James Biggs, III	Ashland, KY
Ed Sizemore	Ashland, KY
Debbie Barnett	Catlettsburg, KY
No name	
Marshe Winemor	Ashland, KY
Michelle Tackett	Catlettsburg, KY
Lindsey illegible last name	Ashland, KY
Kimberly Owen	Ashland, KY
Michael Kaye	Ashland, KY
Alex Hamlin	Ashland, KY
Kaylin Gambill	Ashland, KY
Kelly D. Petrie	Ashland, KY
James Sterge	Catlettsburg, KY
Jason Love	Worthington, KY
Duane Hughes	Ashland, KY
Linda Vehela, MCCC and FP	Meade County constituent
Barbara Lewis	Meade County constituent
Betty M. Emberton	Meade County constituent
Bobbi Jo Dowell	Meade County constituent
Tammy Quire	Meade County constituent
Danny Carnady	Meade County constituent
Kelly Jones	Meade County constituent
Casey Hicks	Meade County constituent
Melissa Henning	Meade County constituent
Lisa McCubbin	Meade County constituent
Phoebe Wheetams	Meade County constituent

Billy (illegible) MALPA	Meade County constituent
Shelia L. Bennett	Meade County constituent
Phyllis Stinsm, LPPC	Meade County constituent
Pam Veach	Meade County constituent
Bonnie H	Meade County constituent
Illegible name	
Lisa McCubbin	Meade County constituent
Valerie J. Allen	Meade County constituent
Kristin Hibbard	Meade County constituent
Deborah King	Meade County constituent
Donna Short	Meade County constituent
Tammy McIntosh	Meade County constituent
Chris Bueyn	Meade County constituent
Tyler Schonbaechle	Meade County constituent
Amy A	Meade County constituent
Gaye J. Chapman	Meade County constituent
Clara L. McAdams	Meade County constituent
Michelle Thomas	Meade County constituent
Dulnh A M	Meade County constituent
Beth Risen	Meade County constituent
Tony Lewis	Meade County constituent
Illegible name	Meade County constituent
Illegible name	Meade County constituent
Illegible name	Meade County constituent
Kimberly Pence	Meade County constituent
Regina Marhis	Meade County constituent
Loretta Sharp	Meade County constituent
Sue Ellen Stuhl	Meade County constituent
Charles Goodwin	Meade County constituent
Tommy Stivom	Meade County constituent
Stu Dwilu	Meade County constituent
Bonnie Sue Hill	Meade County constituent
Bee Moore	Meade County constituent
Sue Neight	Meade County constituent
Debbie Davelin	Meade County constituent
Therese Self	Meade County constituent
Barbara Redman	Meade County constituent
Janet Kessinger	Meade County constituent
Ann Padgett	Meade County constituent
Larry M. Powell	Meade County constituent
Judy Harper	Meade County constituent
Shannon Bettencourt	Meade County constituent
Bonnie Tucker	Meade County constituent
Frank Lundy, Sr.	Meade County constituent
Phyllis Lundy	Meade County constituent
Elenea Smith	Meade County constituent

Illegible name	Meade County constituent
Ida Mae Singleton	Meade County constituent
Kimberly Gleason	Meade County constituent
Todd Piatt	Meade County constituent
Marcis Balley	Meade County constituent
Gerald L. Payton	Meade County constituent
Jay W. Powell	Meade County constituent
Suzy Jones	Meade County constituent
Mary Greenweld	Meade County constituent
Mary Bandy	Meade County constituent
Jessica S. Me	Meade County constituent
Hope Benham	Meade County constituent
Melody Lach	Meade County constituent
Mary Trentham	Meade County constituent
Gladys Daniels	Meade County constituent
Jeff Cook	Meade County constituent
Illegible	Meade County constituent
Illegible name	Meade County constituent
Nise Abeana	Meade County constituent
Geraldine Solomon	Meade County constituent
Stan (illegible)	Meade County constituent
Jack Bettencourt	Meade County constituent
Sande Brown	Meade County constituent
Janette Kerr	Meade County constituent
Timmy Boyle	Meade County constituent
Josh Jones	Meade County constituent
Gerald Lee Mobley	Meade County constituent
Mary Cnodd	Meade County constituent
Gary	Meade County constituent
Frank Lundy	Meade County constituent
Stephanie Dever	Meade County constituent
Patricia Brown	Meade County constituent
Deborah J. Horton	Meade County constituent
Linda Milam	Meade County constituent
Richard Redmon	Meade County constituent
Kevin Powell	Meade County constituent
Guy Lynn	Meade County constituent
Molly James	Meade County constituent
Amy M. Haynes	Meade County constituent
Shay Dankersley	Meade County constituent
Theresa Sinneth	Meade County constituent
John Shemwell	Meade County constituent
Connor Bruce	Meade County constituent
Pam Bash	Meade County constituent
Rechelle Johnson	Meade County constituent
Timmy Harper	Meade County constituent

Barry Ramsey	Meade County constituent
Joy Ramsey	Meade County constituent
Scott Harper	Meade County constituent
Tammy Juper	Meade County constituent
David W. Pace	Meade County constituent
Scott A	Meade County constituent
Robert E. Stith	Meade County constituent
D. Stith	Meade County constituent
Howard E. Kessinger, Sr.	Meade County constituent
Howard E. Kessinger, Jr.	Meade County constituent
Greg Stith	Meade County constituent
Megan Stith	Meade County constituent
Richard Stith	Meade County constituent
Tina G. Stith	Meade County constituent
Amber Kessinger	Meade County constituent
Eddie Greenwell	Meade County constituent
Doris S. Greenwell	Meade County constituent
Illegible name	Meade County constituent
Bonnie Wade	Meade County constituent
T. McMahan	Meade County constituent
Cole Mays	Meade County constituent
C. Wilson	Meade County constituent
Illegible name	Meade County constituent
Lorena Hardesty	Meade County constituent
Sharon Hardesty	Meade County constituent
Donna G. Sandberg	Meade County constituent
Illegible name	Meade County constituent
C. Wilson	Meade County constituent
Illegible name	Meade County constituent
Ida Singleton	Meade County constituent
Lana Smith	Meade County constituent
Kathy Stith	Meade County constituent
Franklin B. Stith	Meade County constituent
Phillys	Meade County constituent
Verna Allgeier	Meade County constituent
John Allgeier	Meade County constituent
Ben Kessinger	Meade County constituent
Mitzi Allgeier	Meade County constituent
Peggy G. Cox	Meade County constituent
Illegible name	Meade County constituent
Janet Powell	Meade County constituent
Illegible name	Meade County constituent
Illegible name	Meade County constituent
Reeci Hampton	Meade County constituent
Christine Zoeller	Meade County constituent
Michael Rihn	Meade County constituent

Christina Procter	Meade County constituent
Tabitha Clemens	Meade County constituent
Tina Heckman	Meade County constituent
Illegible name	Meade County constituent
David Sul	Meade County constituent
Jennifer Boothe	Meade County constituent
Illegible name	Meade County constituent
Kalishua Rowe	Meade County constituent
Marie Perry	Meade County constituent
William M	Meade County constituent
Illegible name	Meade County constituent
A. Hunt	Meade County constituent
Lois Mattingly	Meade County constituent
Betty Oder	Meade County constituent
Footh Ney	Meade County constituent
Cindie Dowell	Meade County constituent
Leslie Duke	Meade County constituent
Samantha C.	Meade County constituent
Terry Keown	Meade County constituent
Selena Trather	Meade County constituent
Martika Abell	Meade County constituent
Illegible name	Meade County constituent
Kelly Sihu	Meade County constituent
James	Meade County constituent
Teresa Ramey	Meade County constituent
Joe C. Benham	Meade County constituent
Stefanie Huddleston	Meade County constituent
Mario Monaco	Meade County constituent
Kim Barr	Meade County constituent
Donald P.	Meade County constituent
Melanie Rule	Meade County constituent
Andarr Bault	Meade County constituent
Lisa Skaggs	Meade County constituent
Vickie Grant	Meade County constituent
Terry Keown, Jr.	Meade County constituent
William Thorp	Meade County constituent
Amanda Guarnoos	Meade County constituent
Paul Nino	Meade County constituent
Pete Nino	Meade County constituent
Vickie Grant	Meade County constituent
Terry Keown, Jr.	Meade County constituent
LaDonna Rednour	Meade County constituent
Janet H. Spalding	Marion County constituent
Aaron Spalding	Marion County constituent
Jane Claire Spalding	Marion County constituent
Richard Anderson	Marion County constituent

Angela D. Nalley	Marion County constituent
Carla Waynes	Marion County constituent
Elaine Mull	Marion County constituent
Illegible name	Marion County constituent
Nicole Pinkston	Marion County constituent
Benard Abell .	Marion County constituent
Kathleen Pinkston	Marion County constituent
Virginia Mason	Marion County constituent
Janice P.	Marion County constituent
Phyllis Hardin	Marion County constituent
Illegible name	Marion County constituent
Debbie Higdon	Marion County constituent
Stephanie Pittman	Marion County constituent
Karen Spalding	Marion County constituent
Melissa Goff	Marion County constituent
Amy C. Sandusky	Marion County constituent
Illegible name	Marion County constituent
Sherri Hawkins	Marion County constituent
Flo Lowery	Marion County constituent
John D. Mattingly, C.J. Executive	Marion County constituent
Theresa Wilson	Marion County constituent
Agnes Dup .	Marion County constituent
Charles A. Jin	Marion County constituent
Karen Shewmaker	Marion County constituent
Carroll Kirkland	Marion County constituent
Stephanie Buckman	Marion County constituent
Marilyn Bowen	Marion County constituent
Linda Smith	Marion County constituent
Dana R. Pulliam	Marion County constituent
Linda Reynolds .	Marion County constituent
Julia Briarly	Marion County constituent
Lauren Williams	Marion County constituent
Tim Bundy	Marion County constituent
CamillaEwing	Marion County constituent
Alisha O' Daniel	Marion County constituent
Cathy O'Daniel	Marion County constituent
Dodie Polin	Marion County constituent
Elizabeth Wohner	Marion County constituent
Bonnie Wickes	Marion County constituent
Debbie Debarson	Marion County constituent
Vessia P. Smith	Marion County constituent
Gisele D. West, DVM	Marion County constituent
Dana R. Pulliam	Marion County constituent
Linda Reynolds .	Marion County constituent
Julia Briarly	Marion County constituent
Lauren Williams	Marion County constituent

Tim Bundy	Marion County constituent
CamillaEwing	Marion County constituent
Alisha O' Daniel	Marion County constituent
Cathy O'Daniel	Marion County constituent
Dodie Polin	Marion County constituent
Illegible name	Marion County constituent
Billy M. Osbourne	Marion County constituent
Lynette Osbourne	Marion County constituent
Anita M. Lanham	Marion County constituent
Burnani Lanham	Marion County constituent
Marguerite Clark	Marion County constituent
Mark Mattingly	Marion County constituent
Billy Mattingly	Marion County constituent
P. Mattingly	Marion County constituent
Malissa Garrett	Marion County constituent
Patti Beavers	Marion County constituent
Tresa Arnel	Marion County constituent
William Beaus	Marion County constituent
S. Broam	Marion County constituent
Mary Brownie	Marion County constituent
Amanda Ballard	Marion County constituent
Jenny Ritchie	Marion County constituent
Melinda Howard	Marion County constituent
C. Howard	Marion County constituent
Paul Mattingly	Marion County constituent
Barbara Lankin	Marion County constituent
Joe B. Lankin	Marion County constituent
Nick Lankin	Marion County constituent
Donna Keeling	Marion County constituent
Marjorie Bowman	Marion County constituent
Phyllis Helton	Marion County constituent
Lynn Davis	Marion County constituent
Babette B. Chesser	Marion County constituent
Vicki Goodroad	Marion County constituent
Jackie Votaw	Marion County constituent
Steven Votaw	Marion County constituent
Misty Brutto	Marion County constituent
Clement Brutto	Marion County constituent
Trena Baker	Marion County constituent
Justice Holder	Marion County constituent
Trey Holder	Marion County constituent
Timothy Davis	Marion County constituent
Tom Helton	Marion County constituent
EvanKeeling	Marion County constituent
David Goodroad	Marion County constituent
Dan Chesser	Marion County constituent

Fred Ryan	Marion County constituent
Chris Ryan	Marion County constituent
Frida Ryan	Marion County constituent
Moesli Wilson	Marion County constituent
Mary Grace Mattingly	Marion County constituent
Michelle Osbourne	Marion County constituent
Bud Abram	Marion County constituent
Barbara Rafferty	Marion County constituent
Cindy M. Kelty	Marion County constituent
Clarice Norris	Marion County constituent
Jeffrey T. Norris	Marion County constituent
Betty Murphy	Marion County constituent
Connie Adams	Marion County constituent
R. Murphy	Marion County constituent
Chad Spalding	Marion County constituent
Sandra Blanogard or Blandford	Marion County constituent
Larry Norris	Marion County constituent
Terri Norris	Marion County constituent
Jessie Norris	Marion County constituent
Sandra K. Shockney	Marion County constituent
Bettina Cambra	Marion County constituent
Martha Whitehouse	Marion County constituent
Debbie Reed	Marion County constituent
Illegible name	Marion County constituent
Rodney Lanham	Marion County constituent
Lisa Murphy	Marion County constituent
Joanna Johnson	Marion County constituent
Melissa Lee Knight	Marion County constituent
Catherine Mattingly	Marion County constituent
Illegible name	Marion County constituent
Sharon Smith	Marion County constituent
Betty Lou Mudd	Marion County constituent
Leslie P. Dulmage	Marion County constituent
Deirdre Bull	Marion County constituent
Lisa Ashowine	Marion County constituent
Dan Daderty	Marion County constituent
Bell Lauch	Marion County constituent
Connie Blandford	Marion County constituent
Brad Mattingly	Marion County constituent
Stephanie Lee	Marion County constituent
Illegible name	Marion County constituent
Margan Graves	Marion County constituent
Gloria Benningfield	Marion County constituent
Erin Tingle	Marion County constituent
Josh Osbourne	Marion County constituent
Latisha Dye	Marion County constituent

Pat Dye	Marion County constituent
Rickey Padgett	Marion County constituent
Greg Osbourne	Marion County constituent
Jennifer Osbourne	Marion County constituent
Lisa Sandusky	Marion County constituent
Daniel Mattingly	Marion County constituent
Donna Hutchins	Marion County constituent
Michael Cecil	Marion County constituent
Margaret Cessill	Marion County constituent
Libby Myers	Marion County constituent
Lalen Kirkland	Marion County constituent
Beverly Fenwick	Marion County constituent
Sharon Cecil	Marion County constituent
Stephanie Lee	Marion County constituent
Jessica Baker	Marion County constituent
Amanda Bowen	Marion County constituent
Mary Anne Blair	Marion County constituent
Mary May	Marion County constituent
Eva Jo Nugent	Marion County constituent
Betty Blair	Marion County constituent
Ashley Roberts	Marion County constituent
Joe V. Blair	Marion County constituent
Tracie Blair	Marion County constituent
Sarah Blair	Marion County constituent
Justin Price	Marion County constituent
Barbara Battcher	Marion County constituent
Benny Blair	Marion County constituent
Marion V. Blair, Jr.	Marion County constituent
Margaret Cessill	Marion County constituent
Patsy Blandford	Marion County constituent
Marty Blandford	Marion County constituent
Renee Benningfield	Marion County constituent
Stacey Benningfield	Marion County constituent
Beth Battcher	Marion County constituent
Phyllis Crane	Marion County constituent
Bob Crane	Marion County constituent
Margaret Crane	Marion County constituent
John Wiser	Marion County constituent
Nicole Robertson	Marion County constituent
Emily M. Zint	Marion County constituent
Sharon E.	Marion County constituent
Charles Ramey	Marion County constituent
Jessica L. Floyd	Marion County constituent
Krystal N. Leake	Marion County constituent
Mary Leo Wimsatt	Marion County constituent
Allyson Stine	Marion County constituent

Tammy May	Marion County constituent
Ann J. Cheaney	Marion County constituent
Davette Mays	Marion County constituent
McCall Thompson	Marion County constituent
Wendy Brady	Marion County constituent
Tracey Rinehart	Marion County constituent
Joan D. Wood	Marion County constituent
Beverly Thomas	Marion County constituent
Jill Guddie	Marion County constituent
Ashley Green	Marion County constituent
Ray Osbourne	Marion County constituent
Madeleine Farmer	Marion County constituent
Carrie Tuft	Marion County constituent
Diane Raley	Marion County constituent
Renee Spalding	Marion County constituent
Dorothy Wright	Marion County constituent
Holly Buckman	Marion County constituent
Tammy Mully	Marion County constituent
Jan Powers	Marion County constituent
Alex Poke	Marion County constituent
Jeremy Mc	Marion County constituent
Connie Doddie	Marion County constituent
Elizabeth Bright	Marion County constituent
Stacy May	Marion County constituent
Kim Bright	Marion County constituent
Deborah Wren	Marion County constituent
Raylyn Abell	Marion County constituent
Pete Farmer	Marion County constituent
Missy Spalding	Marion County constituent
Jenny Williams	Marion County constituent
Ila Hilts	Marion County constituent
Christina Holton	Marion County constituent
Krystal Douglas	Marion County constituent
Fred Browning	Marion County constituent
Donna Browning	Marion County constituent
Pat Browning	Marion County constituent
Wayne Browning	Marion County constituent
Melissa Browning	Marion County constituent
Judy Jackson	Marion County constituent
Jeff Jackson	Marion County constituent
Sara Beth Dolley	Marion County constituent
Sandra Nalley	Marion County constituent
Katherine Thompson	Marion County constituent
Peggy Browning	Marion County constituent
Mary Lou Mattingly	Marion County constituent
eraldine Spalding	Marion County constituent

Rita Hamilton	Marion County constituent
Joseph H. Mattingly, Jr.	Marion County constituent
Louise McCarley	Marion County constituent
Donna Smith	Marion County constituent
Gwen Mattingly	Marion County constituent
Andy Mattingly	Marion County constituent
Patty Brady	Marion County constituent
John L. Brady	Marion County constituent
Ashley S. Brady	Marion County constituent
Sheila Buckman Lanham	Marion County constituent
Neal Lanham	Marion County constituent
Wilma Buckman	Marion County constituent
Kenneth Buckman	Marion County constituent
Kathy Thompson	Marion County constituent
Mike Thompson	Marion County constituent
Joyce Spalding	Marion County constituent
Joe Paul Spalding	Marion County constituent
Chad Houd	Marion County constituent
Kim Houd	Marion County constituent
Tommy Mattingly	Marion County constituent
Linda Mattingly	Marion County constituent
Jerry Helm	Marion County constituent
Rita L. Spalding	Marion County constituent
Charles M. Spalding	Marion County constituent
Cecil Belcher	Marion County constituent
Alice Fungate	Marion County constituent
Donna G. Royse	Marion County constituent
Alice Young	Marion County constituent
Judy Tate Blackwell	Marion County constituent
Becky R. Clark	Marion County constituent
Robert Spalding	Marion County constituent
Sandy Drye	Marion County constituent
Patty O'Daniel	Marion County constituent
Crystal L. Edlin	Marion County constituent
Lisa Hall	Marion County constituent
Stacy Hall	Marion County constituent
Krystal Goster	Marion County constituent
Jessica Bagwell	Marion County constituent
Tammy Durham	Marion County constituent
Danny Marks	Marion County constituent
Wanda Walls	Marion County constituent
Kim Ford	Marion County constituent
Karen Brady	Marion County constituent
Sandi Smablis	Marion County constituent
Pence Schooling	Marion County constituent
D. Blandford	Marion County constituent

Betty Sullivan	Marion County constituent
Tina Bickett	Marion County constituent
Amanda Spalding	Marion County constituent
Janice Wheatley	Marion County constituent
Anne Caldwell	Marion County constituent
Lisa Lanham	Marion County constituent
Sherry Bell	Marion County constituent
Billy Caldwell	Marion County constituent
Illegible name	Marion County constituent
Beth Osborne	Marion County constituent
Melissa Russell	Marion County constituent
Erin illegible last name	Marion County constituent
Christie Bruce	Marion County constituent
Lori Whitlock	Marion County constituent
Lisa Alford	Marion County constituent
Margaret Blandford	Marion County constituent
Michelle Pierce	Marion County constituent
Ida L. Spalding	Marion County constituent
Pam Mattingly	Marion County constituent
Mimi Crum	Marion County constituent
Elizabeth Raley	Marion County constituent
Melissa Murphy	Marion County constituent
Semone Bradshaw	Marion County constituent
Kristen Brady	Marion County constituent
Illegible name	Marion County constituent
Illegible name	Marion County constituent
April Brown	Marion County constituent
Jimmie Brown	Marion County constituent
Christie Rakes	Marion County constituent
Doyle Downs	Marion County constituent
Doris Downs	Marion County constituent
Julian Thompson	Marion County constituent
Steve Downs	Marion County constituent
Juan Downs	Marion County constituent
Brenda Edelen	Marion County constituent
Karen Lake	Marion County constituent
Peggy Downs	Marion County constituent
Alex Thompson	Marion County constituent
Rick Downs	Marion County constituent
Sherry Thompson	Marion County constituent
Matthew Mattingly	Marion County constituent
Olivia Mattingly	Marion County constituent
Mark Downs	Marion County constituent
Samantha Downs	Marion County constituent
Amber Clark	Marion County constituent
Jason Clark	Marion County constituent

Jessica Hill	Marion County constituent
Matte Newton	Marion County constituent
Debbie Mattingly	Marion County constituent
Wanda Glasscock	Marion County constituent
Anita Elder	Marion County constituent
Pat Gaddie	Marion County constituent
Faye Browning	Marion County constituent
Mary Ann Blair	Marion County constituent
Estil Gaddie	Marion County constituent
Brian Gaddie	Marion County constituent
Frank Buckler	Marion County constituent
Jan Bradshaw	Marion County constituent
Justin Coyle	Marion County constituent
Misty Thurman	Marion County constituent
Bonnie Snochise	Marion County constituent
Dianna Bardin	Marion County constituent
Bobby Van Dyke	Marion County constituent
Cheryl Mays	Marion County constituent
Kay Coyle	Marion County constituent
Steve Coyle	Marion County constituent
Paige Gaddie	Marion County constituent
Judy Gaddie	Marion County constituent
Judy Lee	Marion County constituent
Donna Montgomery	Marion County constituent
Elaine Hoellemeer	Marion County constituent
Glenna Hunt	Marion County constituent
Terri Osbourne	Marion County constituent
Barbara Rapp	Marion County constituent
Amie Overstreet	Marion County constituent
Pam Vance	Marion County constituent
Cecilia Van Dyke	Marion County constituent
Joyce A. Caldwell	Marion County constituent
Amy Young	Marion County constituent
Leslie Van Why	Marion County constituent
Lindsey Muncie	Marion County constituent
Sara Brady	Marion County constituent
Nettie Brown	Marion County constituent
Joe Brown	Marion County constituent
Michael Gribbins	Marion County constituent
Shelly Gribbins	Marion County constituent
Matt illegible last name	Marion County constituent
Ricky Courtight	Marion County constituent
Ann Lee	Marion County constituent
Joe Buckler	Marion County constituent
Todd Simpson	Marion County constituent
Larry Mattingly	Marion County constituent

Illegible name	Marion County constituent
Carolyn Lynch	Marion County constituent
Michael Pnigh	Marion County constituent
Kenny Wright	Marion County constituent
Debbie Hall	Marion County constituent
Illegible name	Marion County constituent
Carol Thompson	Marion County constituent
Donna Turpin	Marion County constituent
Illegible name	Marion County constituent
Kay Mills	Marion County constituent
Charles Cambros	Marion County constituent
Gerald O'Daniel	Marion County constituent
Sheliah Buckman	Marion County constituent
Stephen Ballerd	Marion County constituent
James K. Hourigan	Marion County constituent
Tim Spalding	Marion County constituent
Richard Wilson	Marion County constituent
Dennis Whitehouse	Marion County constituent
Harry Thomas	Marion County constituent
Stephanie Brockman	Marion County constituent
Doug Brockman	Marion County constituent
Josh Brockman	Marion County constituent
Paul Brockman	Marion County constituent
Margaret Brockman	Marion County constituent
Steven Brockman	Marion County constituent
Jennifer Jarboe	Marion County constituent
Michael Jarboe	Marion County constituent
Laura Jarboe	Marion County constituent
Daniel Jarboe	Marion County constituent
Ruthie Jackson	Marion County constituent
Dana Jackson	Marion County constituent
Audrey Turner	Marion County constituent
Illegible name	Marion County constituent
Betty Bradshaw	Marion County constituent
Steve Baudistel	Marion County constituent
Dawn Leake	Marion County constituent
Gary Leake	Marion County constituent
Samantha Abell	Marion County constituent
Justine Abell	Marion County constituent
Tommy Lou Thomas	Marion County constituent
James S. Thompson	Marion County constituent
Anthony Mattingly	Marion County constituent
Jessica Mattingly	Marion County constituent

Joe Graves	Marion County constituent
Rita Graves	Marion County constituent
Tiffany Sapp	Marion County constituent
Savannah Graves	Marion County constituent
Angel Graves	Marion County constituent
Bradley Graves	Marion County constituent
Stephanie Graves	Marion County constituent
Mary E. O'Daniel	Marion County constituent
Susan Ballard	Marion County constituent
Eddie Ballard	Marion County constituent
Margaret Cissell	Marion County constituent
Janelle O'Daniel	Marion County constituent
Mike O'Daniel	Marion County constituent
Ann Bright	Marion County constituent
Dylan Bright	Marion County constituent
Elaine Helm	Marion County constituent
Johnny Helm	Marion County constituent
Kelly Pucker	Marion County constituent
Steve Pucker	Marion County constituent
Mary Lou McRay	Marion County constituent
Cyril S. McCauley	Marion County constituent
Loren McRay	Marion County constituent
Illegible name	Grayson County constituent
Bobby Lyons	Grayson County constituent
Randy Weedman	Grayson County constituent
Elizabeth Clemons	Grayson County constituent
Shirlene Fentress	Grayson County constituent
Tina Riggs	Grayson County constituent
Darene	Grayson County constituent
Jennifer Mudd	Grayson County constituent
Stephen Mudd	Grayson County constituent
Lana Lackfield	Grayson County constituent
Darrin Embry	Grayson County constituent
Joyce Pierce	Grayson County constituent
Lillian White	Grayson County constituent
Charles H. White	Grayson County constituent
Veronica Gibson	Grayson County constituent
Henry Basham	Grayson County constituent
Doug Weedman	Grayson County constituent
Andrew Haven	Grayson County constituent
J. Cole	Grayson County constituent
Gerald L. Payton	Grayson County constituent
Michelle Francis	Grayson County constituent
Brenda Palmer	Grayson County constituent
Illegible name	Grayson County constituent
Chris Palmer	Grayson County constituent

Kari Haven	Grayson County constituent
Illegible name	Grayson County constituent
Janice Harrel	Grayson County constituent
Sara Lindsey	Grayson County constituent
Regina Huff	Grayson County constituent
Rickey Stephen	Grayson County constituent
Cathy Nelson	Grayson County constituent
Shannon Ward	Grayson County constituent
Sandra Ward	Grayson County constituent
Samantha Ward	Grayson County constituent
Shawna Ward	Grayson County constituent
Mary Mercer	Grayson County constituent
Charles Mercer	Grayson County constituent
Deborah Bush	Grayson County constituent
Bufford Stafford	Grayson County constituent
Kim Stafford	Grayson County constituent
Philip Probus	Grayson County constituent
Larry Miller	Grayson County constituent
Brianna Cary	Grayson County constituent
Buddy Shorter	Grayson County constituent
Ashley Franklin	Grayson County constituent
Pamela Franklin	Grayson County constituent
Scottie Franklin	Grayson County constituent
Marshall Moutardier	Grayson County constituent
Angel Moutardier	Grayson County constituent
Junior Moutardier	Grayson County constituent
Sherry Moutardier	Grayson County constituent
Rose Lucas	Grayson County constituent
Danny Lucas	Grayson County constituent
Darrell Lucas	Grayson County constituent
LaDawn Lucas	Grayson County constituent
Ruth Ann Young	Grayson County constituent
Howard Young	Grayson County constituent
Robert Moutardier	Grayson County constituent
Cathy Moutardier	Grayson County constituent
Larry Moutardier	Grayson County constituent
Donna Probus	Grayson County constituent
Tina Vanderman	Grayson County constituent
Kim Dowell	Grayson County constituent
Casey Jones	Grayson County constituent
Kristina Puckett	Grayson County constituent
Cheryl Higdon	Grayson County constituent
Daniel Sherodean	Grayson County constituent
Joann Kerr	Grayson County constituent
Lanny Kerr	Grayson County constituent
Devin Kerr	Grayson County constituent

Ed Burchett	Grayson County constituent
Mildred Burchett	Grayson County constituent
Illegible name	Grayson County constituent
Jess illegible last name	Grayson County constituent
Orita illegible last name	Grayson County constituent
Cammy Cordus	Grayson County constituent
Illegible name	Grayson County constituent
Illegible name	Grayson County constituent
Sarah illegible last name	Grayson County constituent
Illegible name	Grayson County constituent
Illegible name	Grayson County constituent
William illegible last name	Grayson County constituent
Veronica Sanders	Grayson County constituent
Illegible name	Grayson County constituent
Sally Bogdarn	Grayson County constituent
Sandra illegible last name Jones	Grayson County constituent
Illegible name	Grayson County constituent
Patti Parriga	Grayson County constituent
Phyllis Coole	Grayson County constituent
Wanda Van Meter	Grayson County constituent
Amanda Williams	Grayson County constituent
Larry illegible last name	Grayson County constituent
Josh Decker	Grayson County constituent
Robbie illegible last name	Grayson County constituent
Carrie Elder	Grayson County constituent
Thomas Roof	Grayson County constituent
Tim Suttern	Grayson County constituent
Illegible name	Grayson County constituent
Mark Stanton	Grayson County constituent
Pamela Sue Willis	Grayson County constituent
Illegible name	Grayson County constituent
Jeff Clemons	Grayson County constituent
Illegible name	Grayson County constituent
Will illegible last name	Grayson County constituent
Tammy Barton	Grayson County constituent
Samantha Martinez	Grayson County constituent
Jennifer Barton	Grayson County constituent
Alice Simmons	Grayson County constituent
Lorie Williams	Grayson County constituent
Jim Swafford	Grayson County constituent
Scott Raffet	Grayson County constituent
Illegible name	Grayson County constituent
Mark A. Gary	Grayson County constituent
Ilise Johnson	Grayson County constituent
Randall Alvey	Grayson County constituent
Dr, Ar or An Reul	Grayson County constituent

Brendan Rafferty	Grayson County constituent
Barry illegible last name	Grayson County constituent
Amy Hart	Grayson County constituent
Carrie Maye	Grayson County constituent
Alfred Potts	Grayson County constituent
Sabrina Snartzen	Grayson County constituent
Terry Paul	Grayson County constituent
Jeff illegible last name	Grayson County constituent
Larry illegible last name	Grayson County constituent
Paulett Searun	Grayson County constituent
Loretta Moreno	Grayson County constituent
Brendan Rafferty	Grayson County constituent
Barry illegible last name	Grayson County constituent
Amy Hart	Grayson County constituent
Carrie Maye	Grayson County constituent
Alfred Potts	Grayson County constituent
Sabrina Snartzen	Grayson County constituent
Terry Paul	Grayson County constituent
Jeff illegible last name	Grayson County constituent
Larry illegible last name	Grayson County constituent
Paulett Searun	Grayson County constituent
Loretta Moreno	Grayson County constituent
Sunny Fegett	Grayson County constituent
Illegible name	Grayson County constituent
George House, Jr.	Grayson County constituent
Mike Frost	Grayson County constituent
Illegible first name Maltz	Grayson County constituent
Melissa R. Carrell.	Grayson County constituent
Johnny Carrell	Grayson County constituent
Illegible name	Grayson County constituent
Travis Dunn	Grayson County constituent
Melissa Dunn	Grayson County constituent
Danny Dunn	Grayson County constituent
Holly Dunn	Grayson County constituent
Kayla Putton	Grayson County constituent
Tiffany illegible last name	Grayson County constituent
Patricia Kendall.	Grayson County constituent
Ricky Kendall	Grayson County constituent
Patrick Burton	Grayson County constituent
Illegible name	Grayson County constituent
Rachel Hall	Grayson County constituent
Elaine Houchin	Grayson County constituent
Mike Houchin	Grayson County constituent
Christy McMillen	Grayson County constituent
Julie Colmin	Grayson County constituent
Cathy Darst	Grayson County constituent

Valeria Hayes-Hicks	Grayson County constituent
Larry Raley	Grayson County constituent
Lisa Payton	Grayson County constituent
Kelli White	Grayson County constituent
Gayle Parker	Grayson County constituent
Kathleen V. illegible last name	Grayson County constituent
LaNean Davis	Grayson County constituent
Donna White	Grayson County constituent
Angel Collins	Grayson County constituent
Jeanell Bradley	Grayson County constituent
Susan Foote	Grayson County constituent
Tammy Saltsmein.	Grayson County constituent
Diania Decker	Grayson County constituent
Virginia Schultz	Grayson County constituent
Jennifer illegible last name	Grayson County constituent
Sandy Langh	Grayson County constituent
Tammy Bratcher	Grayson County constituent
Illegible name	Grayson County constituent
Kim Curt	Grayson County constituent
Brenda Parks	Grayson County constituent
Debbie Thornton	Grayson County constituent
Illegible name	Grayson County constituent
Hollye R. Bina	Grayson County constituent
Illegible name	Grayson County constituent
Franklin K. Higdon	Grayson County constituent
Debbie Nevitt	Grayson County constituent
Elisha Decker	Grayson County constituent
J. J. Decker	Grayson County constituent
Alicia Hayes	Grayson County constituent
Lisa Roark	Grayson County constituent
Carol Hall	Grayson County constituent
Carroll Aubrey	Grayson County constituent
Bonnie Dodson	Grayson County constituent
Lilian Brashars	Grayson County constituent
Brenda J. Miller	Grayson County constituent
Sallie Dodson	Grayson County constituent
Lois F. Buntain	Grayson County constituent
Bill Buntain	Grayson County constituent
Brandy Sebastian	Grayson County constituent
Todd Bruyer	Grayson County constituent
David Buntain	Grayson County constituent
Charles Willis	Grayson County constituent
Hope Willis	Grayson County constituent
Jessie Blair	Grayson County constituent
Terry Blair	Grayson County constituent
Shirley McNutt	Grayson County constituent

Charly Blair	Grayson County constituent
Linda Wood	Grayson County constituent
Bonnie Dodson	Grayson County constituent
Audrey illegible last name	Grayson County constituent
Adam Sealy	Grayson County constituent
Josh illegible last name	Grayson County constituent
Adam Davenport	Grayson County constituent
Mike Readdy	Grayson County constituent
Illegible first name Goosetree	Grayson County constituent
Samantha Truman	Grayson County constituent
Josh Truman	Grayson County constituent
Keith Lucas	Grayson County constituent
Tracy Miller	Grayson County constituent
Charles illegible last name	Grayson County constituent
Clayton Miller	Grayson County constituent
Joyce Miller	Grayson County constituent
Stacy Miller	Grayson County constituent
Larry Parker	Grayson County constituent
Marlina Parker	Grayson County constituent
Martha Dodson	Grayson County constituent
Illegible first name Sue Van Beeskirk	Grayson County constituent
David L. Saho	Grayson County constituent
Danny Saho	Grayson County constituent
Ronnie L. Aubrey	Grayson County constituent
Lastasha Aubrey	Grayson County constituent
Tonya Kersey Aubrey	Grayson County constituent
Billy Joe Aubrey	Grayson County constituent
Brenda Campbell	Grayson County constituent
Ronnie Willis	Grayson County constituent
Jesse Willis	Grayson County constituent
Gail Butler	Grayson County constituent
Ronnie Dodson	Grayson County constituent
Barbara Higdon	Grayson County constituent
Donnie Higdon	Grayson County constituent
Maggie Decker	Grayson County constituent
Heather Higdon	Grayson County constituent
Monica Houtchens	Grayson County constituent
Vickie Beville	Grayson County constituent
Tim Beville	Grayson County constituent
Andrya Carnes	Grayson County constituent
Andy Carnes	Grayson County constituent
James Houtchens	Grayson County constituent
Megan E. Quackenbush	Grayson County constituent
Luke Smith	Grayson County constituent
Karen Williams	Grayson County constituent
Donna Harrel	Grayson County constituent

Evelyn Decker	Grayson County constituent
Travis Decker	Grayson County constituent
Michael Decker	Grayson County constituent
Linda Wilson	Grayson County constituent
Stacy Beltz	Grayson County constituent
Albert Wilson	Grayson County constituent
Sandie Wilson	Grayson County constituent
Jackie Begley	Grayson County constituent
Alex Begley	Grayson County constituent
Bethany Horning	Grayson County constituent
Janet Brown	Grayson County constituent
Mary Alice Meredith	Grayson County constituent
Tonya Neff Decker	Grayson County constituent
Tamara Mudd	Grayson County constituent
Shannon Ward	Grayson County constituent
Mary Morgan	Grayson County constituent
Illegible name	Grayson County constituent
Deb Bush	Grayson County constituent
Chuck Mercer	Grayson County constituent
Bie Marr	Grayson County constituent
Tammy Anne	Grayson County constituent
Sandra Ward	Grayson County constituent
Torra illegible last name	Grayson County constituent
Deb Marr	Grayson County constituent
Karen Marr	Grayson County constituent
Chrisy Marr	Grayson County constituent
Andie Carol	Grayson County constituent
Shawna Ward	Grayson County constituent
Betty Cary	Grayson County constituent
Ashley Franklin	Grayson County constituent
Pam Franklin	Grayson County constituent
Billie Willis	Grayson County constituent
Scott Franklin	Grayson County constituent
Marsha Moutardier	Grayson County constituent
Angel Moutardier	Grayson County constituent
Junior Moutardier	Grayson County constituent
Nancy Ryan	Grayson County constituent
Tommy Ryan	Grayson County constituent
Marty Ryan, Jr.	Grayson County constituent
Ken Rafferty	Grayson County constituent
Patrick Ryan	Grayson County constituent
Gary Good	Grayson County constituent
Dorothy Good	Grayson County constituent
D. Good	Grayson County constituent
Tony Mudd	Grayson County constituent
Bradley Mudd	Grayson County constituent

William Jutz	Grayson County constituent
Jeremy Holb	Grayson County constituent
Ronnie Baxter	Grayson County constituent
R. illegible last name	Grayson County constituent
Lois Baxter	Grayson County constituent
Sharon Tuckett	Grayson County constituent
Rickie L. Early	Grayson County constituent
Kay P.	Grayson County constituent
Lane Critchelaw	Grayson County constituent
Regina White	Grayson County constituent
Verda V. Paucar	Grayson County constituent
Wanda Terry	Grayson County constituent
Illegible name	Grayson County constituent
Betty Roberts	Grayson County constituent
Bobby Clemons	Grayson County constituent
Brenda Shoptan	Grayson County constituent
Bobbie Jo Butter	Grayson County constituent
Illegible name	Grayson County constituent
Amanda Joyce	Grayson County constituent
Ann Clemsus	Grayson County constituent
Brandie Emmerting	Grayson County constituent
Martha Logsdon	Grayson County constituent
Barbara Slocum	Grayson County constituent
Rose Gibbs	Grayson County constituent
Ola Porter	Grayson County constituent
Patricia Ward	Grayson County constituent
David Logsdon	Grayson County constituent
Jane Tripp	Grayson County constituent
Paul Shoptan	Grayson County constituent
Brittany Huett	Grayson County constituent
Ashley Pryor	Grayson County constituent
Trent Huett	Grayson County constituent
Aaron Miller	Grayson County constituent
Tonya Lutz	Grayson County constituent
Jeff Lutz	Grayson County constituent
Evelyn Mayes	Grayson County constituent
Jimmy Mayes	Grayson County constituent
Darrell Mayes	Grayson County constituent
Martha Mayes	Grayson County constituent
Paul Shoptan, Jr.	Grayson County constituent
Steve Shoptan	Grayson County constituent
Margie Wooten	Grayson County constituent
Sarah Wooten	Grayson County constituent
Joseph Shoptan	Grayson County constituent
Illegible name	Grayson County constituent
Illegible name	Grayson County constituent

Wayne Clemons	Grayson County constituent
Kevin Encore	Grayson County constituent
Keith Rafferty	Grayson County constituent
Linda Alley	Grayson County constituent
Martha Duvall	Grayson County constituent
Illegible name	Grayson County constituent
Illegible name	Grayson County constituent
Jason illegible last name	Grayson County constituent
K. Brown	Grayson County constituent
Sarah Castleman	Grayson County constituent
Deloris Miller	Grayson County constituent
Todd Bullock	Grayson County constituent
Eddie Bullock	Grayson County constituent
Jill illegible last name	Grayson County constituent
Kathy Bullock	Grayson County constituent
Michelle Shoemaker	Grayson County constituent
Kelly Harris	Grayson County constituent
Julia Foreman	Grayson County constituent
Leslie Shantzer	Grayson County constituent
Angie Esau	Grayson County constituent
Bryan illegible last name	Grayson County constituent
Mary Sims	Grayson County constituent
Joe illegible last name	Grayson County constituent
Brett Harris	Grayson County constituent
Kathy Harris	Grayson County constituent
Sherry Singleton	Grayson County constituent
Brittney Harris	Grayson County constituent
David Starcher	Grayson County constituent
Josie Starcher	Grayson County constituent
Tori Starcher	Grayson County constituent
Joshua Harris	Grayson County constituent
Davey Starcher	Grayson County constituent
Kelli Harris	Grayson County constituent
Illegible name	Grayson County constituent
Hollie Parelle	Grayson County constituent
Karen Smith	Grayson County constituent
Cindy Eades	Grayson County constituent
Terry Decker	Grayson County constituent
Cindy Decker	Grayson County constituent
Paula Kinney	Grayson County constituent
Alden Alley	Grayson County constituent
Brandon Rafferty	Grayson County constituent
Donald Ward	Grayson County constituent
Freda Ward	Grayson County constituent
Jean Ward	Grayson County constituent
Mike Ward	Grayson County constituent

Renee Ward	Grayson County constituent
Lynne Taul, Breckinridge County constituent	Breckinridge County, KY
John Taul, Breckinridge County constituent	Breckinridge County, KY
Johnny Compton, Breckinridge County constituent	Breckinridge County, KY
Tonia illegible last name, VSA	Breckinridge County constituent
Lois Broadbent	Breckinridge County constituent
Valine K. Hughes, MSW/Case Mgr.	Breckinridge County constituent
Shannen Frank, VSA	Breckinridge County constituent
Lisa A. Richardson	Breckinridge County constituent
Jewel Burch	Breckinridge County constituent
Robert Armes	Breckinridge County constituent
Henry Burch	Breckinridge County constituent
Jean Greenwell, VSA	Breckinridge County constituent
Joan Robbins, VSA	Breckinridge County constituent
William B. Sims	Breckinridge County constituent
Sandra Mayer	Breckinridge County constituent
David W. Morgan	Breckinridge County constituent
Connie L. Gillette	Breckinridge County constituent
Jill Green	Breckinridge County constituent
Suzanne L. Tate	Breckinridge County constituent
Anita May	Breckinridge County constituent
Katrina Bell	Breckinridge County constituent
Marshall PVa	Breckinridge County constituent
Maurice illegible last name	Breckinridge County constituent
Sue Midkiff	Breckinridge County constituent
Illegible name	Breckinridge County constituent
Sherry D. Stith	Breckinridge County constituent
Jonathan Boyd	Breckinridge County constituent
Robin Alexander	Breckinridge County constituent
Michelle Carlin	Breckinridge County constituent
Elaine B. Lucas	Breckinridge County constituent
Jeanne Lee	Breckinridge County constituent
David Lec	Breckinridge County constituent
Christy Smith	Breckinridge County constituent
Stephanie Grieser	Breckinridge County constituent
Joyce Woods	Breckinridge County constituent
Sara Lindsey	Breckinridge County constituent
Sandra Weis	Breckinridge County constituent
Harold Ray	Breckinridge County constituent
Mark illegible last name	Breckinridge County constituent
Barney MIngus	Breckinridge County constituent
Mark illegible last name	Breckinridge County constituent
Illegible name	Breckinridge County constituent
Stan Wandip	Breckinridge County constituent
Gail Ryan	Breckinridge County constituent
Edward L. Wright	Breckinridge County constituent

Charlene Wright	Breckinridge County constituent
William S. illegible last name	Breckinridge County constituent
Laura illegible last name	Breckinridge County constituent
Dyt Butler	Breckinridge County constituent
Sarah King	Breckinridge County constituent
Jill Clinton	Breckinridge County constituent
Tracie Helen	Breckinridge County constituent
Latish Asllaugh	Breckinridge County constituent
Victoria Mexchan	Breckinridge County constituent
Illegible name	Breckinridge County constituent
Illegible name	Breckinridge County constituent
Illegible name	Breckinridge County constituent
Rachel Semmons	Breckinridge County constituent
Monica Ball	Breckinridge County constituent
Brenda Wright	Breckinridge County constituent
Lynne E. Taul	Breckinridge County constituent
John E. Taul	Breckinridge County constituent
Mary Lois Irwin	Breckinridge County constituent
Marilou Claycomb	Breckinridge County constituent
Donald Claycomb	Breckinridge County constituent
Carlos Irwin	Breckinridge County constituent
Marilyn Traxle	Breckinridge County constituent
Sue Puirt	Breckinridge County constituent
Linda Elliott	Breckinridge County constituent
Jean Osborne	Breckinridge County constituent
Paul Osborne	Breckinridge County constituent
Frank Dowell	Breckinridge County constituent
Theresa Dowell	Breckinridge County constituent
Barbara K. Richards	Breckinridge County constituent
Lois L. Morgan	Breckinridge County constituent
Paul Morgan	Breckinridge County constituent
Karen Adkins	Breckinridge County constituent
Darrell Adkins	Breckinridge County constituent
Emily Moornan	Breckinridge County constituent
Ashley Ashcraft	Breckinridge County constituent
Patricia Dyer	Breckinridge County constituent
Jackie Jolly	Breckinridge County constituent
Sandra Tabor	Breckinridge County constituent
Elaine Hinton	Breckinridge County constituent
Lindy Nix	Breckinridge County constituent
Tara Greenwell	Breckinridge County constituent
Randy Greenwell	Breckinridge County constituent
Breanna Arnold	Breckinridge County constituent
Amy Bradley	Breckinridge County constituent
Scott Bradley	Breckinridge County constituent
Tonya Roach	Breckinridge County constituent

Barbara Stevenson	Breckinridge County constituent
Sue Lucas	Breckinridge County constituent
Angela Conner	Breckinridge County constituent
Frances Hardin	Breckinridge County constituent
Sasha Critchelow	Breckinridge County constituent
Angela D. Truitt	Breckinridge County constituent
Shannon Greenwell	Breckinridge County constituent
Robert Kent Greenwell	Breckinridge County constituent
Bonnie Henderson	Breckinridge County constituent
Niccole Ulewitt	Breckinridge County constituent
Melonie Dugan	Breckinridge County constituent
Earl Anthony	Breckinridge County constituent
Shay Medly	Breckinridge County constituent
Shelly Jeffries	Breckinridge County constituent
Illegible first name Jeffries	Breckinridge County constituent
Jennifer Jeffries	Breckinridge County constituent
Jeanette Jeffries	Breckinridge County constituent
Jarrold Brackman	Breckinridge County constituent
Will. T. Illegible last name	Breckinridge County constituent
Elaine Adkins	Breckinridge County constituent
David Adkins	Breckinridge County constituent
Ruth Brown	Breckinridge County constituent
Gary Brown	Breckinridge County constituent
Ashley Brown	Breckinridge County constituent
Linda Haynes	Breckinridge County constituent
Nettie Parker	Breckinridge County constituent
Bert Parker	Breckinridge County constituent
Lesha Embrey	Breckinridge County constituent
William H. Embrey	Breckinridge County constituent
Sandy Carden	Breckinridge County constituent
Riso Carter	Breckinridge County constituent
Joan R. Brown	Breckinridge County constituent
Susan Jo Basham	Breckinridge County constituent
Breanna Arnold	Breckinridge County constituent
M. Arnold	Breckinridge County constituent
Ollie Armes	Breckinridge County constituent
Cate M. Heindar	Breckinridge County constituent
Kimberly Hunt	Breckinridge County constituent
Susan Robinson	Breckinridge County constituent
Loretta French	Breckinridge County constituent
Angela Mingus	Breckinridge County constituent
Leslie Macey	Breckinridge County constituent
Mike Brizius	Breckinridge County constituent
Kacy Eldridge	Breckinridge County constituent
Kari L. Critchelow	Breckinridge County constituent
Dana Carman	Breckinridge County constituent

Dylan Fowler	Breckinridge County constituent
Mont Straight	Breckinridge County constituent
David G. England	Breckinridge County constituent
Linda England	Breckinridge County constituent
Melissa Stevens	Breckinridge County constituent
Tracey Dowell	Breckinridge County constituent
Destiney Dowell	Breckinridge County constituent
Hannah Ball	Breckinridge County constituent
Tammy Milburn	Breckinridge County constituent
Margaret Frymire	Breckinridge County constituent
Tom Frymire	Breckinridge County constituent
Jenny West	Breckinridge County constituent
Brenda Hildenbrandt	Breckinridge County constituent
Joe Terry	Breckinridge County constituent
Latonia Hargrove	Breckinridge County constituent
Dennis Hintch	Breckinridge County constituent
Illegible name	Breckinridge County constituent
Sherrie Sonksen	Breckinridge County constituent
Randall Suchu	Breckinridge County constituent
Renae Allgood	Breckinridge County constituent
Sondra Shrewsbury	Breckinridge County constituent
Denita Wood	Breckinridge County constituent
Illegible name	Breckinridge County constituent
Illegible name	Breckinridge County constituent
Jaymer Knochel	Breckinridge County constituent
Kim Crist	Breckinridge County constituent
Jay Crist	Breckinridge County constituent
Donna Pruit	Breckinridge County constituent
Melissa Cannon	Breckinridge County constituent
Hannah J. Dowell	Breckinridge County constituent
Stacy T. Bennett	Breckinridge County constituent
Taylor Henning	Breckinridge County constituent
Racheal Bennett	Breckinridge County constituent
Anita F. Moore	Breckinridge County constituent
Jennie Maiden	Breckinridge County constituent
Pam Puton	Breckinridge County constituent
Emma Mede	Breckinridge County constituent
Debbie Graham	Breckinridge County constituent
Missy Critchelow	Breckinridge County constituent
Lisa Smallwood	Breckinridge County constituent
Sue McCarmise	Breckinridge County constituent
Tabby De Haven	Breckinridge County constituent
Jane Upmeyer	Breckinridge County constituent
Barbara Critchelow	Breckinridge County constituent
Jenny Armes	Breckinridge County constituent
Donna Shartzter	Breckinridge County constituent

Calletta H. Dowell	Breckinridge County constituent
Illegible name	Breckinridge County constituent
Illegible name	Breckinridge County constituent
Cathy Syn	Breckinridge County constituent
Danielle Segura	Breckinridge County constituent
Jackie Pito	Breckinridge County constituent
Jane Upmeyer	Breckinridge County constituent
Barbara Critchelow	Breckinridge County constituent
Inna G. Snyder	Breckinridge County constituent
Paul D. Tabor	Breckinridge County constituent
Libby Tabor	Breckinridge County constituent
Tomi Sue Smith	Breckinridge County constituent
Mindy Smith	Breckinridge County constituent
Byron Miley	Breckinridge County constituent
John Miley	Breckinridge County constituent
Vickie Whorley	Breckinridge County constituent
Rebecca S. King	Breckinridge County constituent
Stacy King	Breckinridge County constituent
Claudia Maysly	Breckinridge County constituent
Mary Nojoro	Breckinridge County constituent
Pat illegible last name	Breckinridge County constituent
Joe Poe	Breckinridge County constituent
Clara E. Boling	Breckinridge County constituent
Nikki Wooch	Breckinridge County constituent
Loretta Embry	Breckinridge County constituent
Keith Beckett	Breckinridge County constituent
Daffanye McFall	Breckinridge County constituent
Lynda Lamar	Breckinridge County constituent
Illegible name	Breckinridge County constituent
Danny Mitz	Breckinridge County constituent
Lori Mitz	Breckinridge County constituent
Clara E. Boling	Breckinridge County constituent
Jean Curtsinger	Washington County constituent
Thelma Lampkin	Washington County constituent
Cleo Lewis	Washington County constituent
B. Moore	Washington County constituent
Leon Young	Washington County constituent
Jami Adam (illegible name)	Washington County constituent
Carissa Karley	Washington County constituent
L. Goodlett	Washington County constituent
DeAnna Washer (illegible name)	Washington County constituent
Eddie (illegible name)	Washington County constituent
(illegible name)	Washington County constituent
Clinton Thompson	Washington County constituent
Kenny Smith	Washington County constituent
Illegible name	Washington County constituent

Illegible name	Washington County constituent
Illegible name	Washington County constituent
Illegible name	Washington County constituent
Laetitia A. Campbell	Washington County constituent
Ronnie Hooper	Washington County constituent
Nicole Cochran	Washington County constituent
Amber Sagracy	Washington County constituent
Sheila Hourigan	Washington County constituent
Margaret S. (illegible name)	Washington County constituent
Laura Smith	Washington County constituent
Robin Schradel	Washington County constituent
Tressia D. Wright	Washington County constituent
Sue Tyler	Washington County constituent
Carolyn Hardin	Washington County constituent
(Illegible name) Lewis	Washington County constituent
Illegible name	Washington County constituent
Connie Fowler	Washington County constituent
Cheryl H. Yates	Washington County constituent
Lisa Richardson	Washington County constituent
Gloria Graves	Washington County constituent
Darrell (illegible name)	Washington County constituent
Tim Goodwin	Washington County constituent
Rev. Tina Mae Standiford	Washington County constituent
Illegible name	Washington County constituent
Karen Boblitt	Washington County constituent
Tana (illegible name)	Washington County constituent
Billie (illegible name)	Washington County constituent
Nicole Ballard	Washington County constituent
Charles Hayes	Washington County constituent
(Illegible name) Elliott	Washington County constituent
Kathlyn H. Hare	Washington County constituent
Clara Carrico	Washington County constituent
Rachel Klopfenstein	Washington County constituent
Mattingly	Washington County constituent
Illegible name	Washington County constituent
Julie (illegible name)	Washington County constituent
(illegible name)	Washington County constituent
Judy Jewell	Washington County constituent
Pat Grisley	Washington County constituent
Mary K. Hamilton	Washington County constituent
Illegible name	Washington County constituent
Cathy Smith	Washington County constituent
George (illegible name)	Washington County constituent
(illegible) Young	Washington County constituent
Janet Trent	Washington County constituent
Marvin E. Trent	Washington County constituent

Paul & Hazel Howard	Washington County constituent
G. Mattingly	Washington County constituent
Patti Davis	Washington County constituent
Joel Allen	Washington County constituent
Julia Allen	Washington County constituent
Julia Spalding	Washington County constituent
Illegible name	Washington County constituent
Jerry (illegible name)	Washington County constituent
Illegible name	Washington County constituent
Ruby Breeding	Washington County constituent
Gene Breeding	Washington County constituent
Jamie (illegible name)	Washington County constituent
Judy Montgomery	Washington County constituent
Betty Bishop	Washington County constituent
Danny Montgomery	Washington County constituent
John Willie Ellery	Washington County constituent
Sheila D. Smith	Washington County constituent
Jackie Frederick	Washington County constituent
Missy McCarthy	Washington County constituent
April Withron (illegible name)	Washington County constituent
Helen Rigdon	Washington County constituent
Margaret Greenwell (illegible name)	Washington County constituent
Jim Coomes	Washington County constituent
Joey Rigdon	Washington County constituent
Hazel Rigdon	Washington County constituent
Rosemary Goff	Washington County constituent
Krystal Clements	Washington County constituent
Katie Goff	Washington County constituent
Steven (illegible name)	Washington County constituent
Ben Osborne	Washington County constituent
Sarah Jo Riley	Washington County constituent
Holli Camon	Washington County constituent
Derinda Osborne	Washington County constituent
Betty Medley	Washington County constituent
John Morris	Washington County constituent
Joyce Morris	Washington County constituent
Karen Sagracy	Washington County constituent
Nancy Vigil (illegible name)	Washington County constituent
(illegible name) Lewis	Washington County constituent
Rose Coleman	Washington County constituent
Vicky Cheeser	Washington County constituent
Illegible name	Washington County constituent
Illegible name	Washington County constituent
Joe Young Jr	Washington County constituent
Sam (illegible name)	Washington County constituent
Jim Medley	Washington County constituent

Nancy O. Bryan	Washington County constituent
John A Settle	Washington County constituent
Glem Black	Washington County constituent
Brett Barry	Washington County constituent
Teresa C. Morrison	Washington County constituent
Mary Bryan Smith	Washington County constituent
Dewayne Tapscott	Washington County constituent
Katherine H. Smith	Washington County constituent
Jennifer Drury	Washington County constituent
Jeanette Edelen	Washington County constituent
Illegible name	Washington County constituent
Halli Jewell III	Washington County constituent
Candace Jewell	Washington County constituent
Amy Gomer	Washington County constituent
Auquintis Litsey	Washington County constituent
D. Chesser	Washington County constituent
Teresa Chesser	Washington County constituent
David Montgomery	Washington County constituent
Debra Montgomery	Washington County constituent
Kevin Montgomery	Washington County constituent
Judy Garland Montgomery	Washington County constituent
Mike Montgomery	Washington County constituent
Tabitha Montgomery	Washington County constituent
Christy Waldrige	Washington County constituent
Anthony Waldrige	Washington County constituent
Emma Hellard	Washington County constituent
Rick Hellard	Washington County constituent
Judy Curtsinger	Washington County constituent
Dennis Curtsinger	Washington County constituent
Troy Curtsinger	Washington County constituent
Linda Scott	Washington County constituent
Linda Montgomery	Washington County constituent
907 KAR Lisa Chesser	Washington County constituent
Illegible name	Washington County constituent
Melissa Coleman	Washington County constituent
Janet Osborne	Washington County constituent
Sue A. Hill	Washington County constituent
Ana Mudd	Washington County constituent
Wanda Goff	Washington County constituent
Joyce Spalding	Washington County constituent
Melissa Blanford	Washington County constituent
Leigh Winsott	Washington County constituent
Illegible name	Washington County constituent
Nicole Miller (illegible name)	Washington County constituent
Carol Morgeson	Washington County constituent
Betty Royalty	Washington County constituent

Karen Montgomery	Washington County constituent
Ashley Montgomery	Washington County constituent
(illegible name) Montgomery	Washington County constituent
Christine Carrier	Washington County constituent
Illegible name	Washington County constituent
Charles R Carrier	Washington County constituent
Rhonda Singer (illegible name)	Washington County constituent
Terry Tingle	Washington County constituent
Eva Tingle	Washington County constituent
June Spaulding	Washington County constituent
Taylor Spaulding	Washington County constituent
Billy Thompson	Washington County constituent
Myrna Thompson	Washington County constituent
Illegible name	Washington County constituent
Illegible name	Washington County constituent
Teresa Rogers	Washington County constituent
M. Chesser	Washington County constituent
Ray Chesser	Washington County constituent
Ray Chesser	Washington County constituent
Jeremy Chesser	Washington County constituent
Chasity Bell	Washington County constituent
Jerry Abell JR	Washington County constituent
Doris Bell	Washington County constituent
Samantha Bell	Washington County constituent
Laura (illegible name)	Washington County constituent
Kim Humes	Washington County constituent
Jessica Abell	Washington County constituent
Connie Nally	Washington County constituent
Donald R. Bell	Washington County constituent
Joyce Drury	Washington County constituent
Helen Russell	Washington County constituent
Eunice Ballard	Washington County constituent
H. Grigsby	Washington County constituent
Earl Grigsby	Washington County constituent
Joyce Settles	Washington County constituent
Tammy M. Hamilton	Washington County constituent
Kenny Yates	Washington County constituent
Ricky Hamilton	Washington County constituent
Kathy Burton	Washington County constituent
(illegible name) Wells	Washington County constituent
Billy Wells	Washington County constituent
Brittany Wells	Washington County constituent
Brandon Wellls	Washington County constituent
Debbie Barnes	Washington County constituent
Stevie Barnes	Washington County constituent
J.J. Burton	Washington County constituent

Jennifer Smith	Washington County constituent
Casey Smith	Washington County constituent
Todd (illegible name)	Washington County constituent
Kelly Christerson by D. Osborne	Washington County constituent
Illegible name	Washington County constituent
Robert D. Campbell	Washington County constituent
(illegible name) Foster	Washington County constituent
Eunice Nally	Washington County constituent
Mary Jane Burns	Washington County constituent
Debbie Caldwell	Washington County constituent
Illegible name	Washington County constituent
(illegible name) Hahn	Washington County constituent
Debbie Russell	Washington County constituent
Mary (illegible name)	Washington County constituent
Stacey Spaulding	Washington County constituent
B. Riley	Washington County constituent
Jenny Devine	Washington County constituent
Connie Terrell	Washington County constituent
J. Spaulding	Washington County constituent
Illegible name	Washington County constituent
Timothy Smith	Washington County constituent
Issac Sutton	Washington County constituent
Dora Bickett	Washington County constituent
Joshua Walher	Washington County constituent
Dana Carrico	Washington County constituent
Payton (illegible name)	Washington County constituent
Blake Smith	Washington County constituent
(illegible name)Settles	Washington County constituent
Illegible name	Nelson County constituent
Illegible name	Nelson County constituent
Illegible name	Nelson County constituent
Chris Smith	Nelson County constituent
Ronald R. McCullin	Nelson County constituent
Patrick Medley	Nelson County constituent
Illegible name	Nelson County constituent
Darrel Cole	Nelson County constituent
Chris T Ayers	Nelson County constituent
Illegible name	Nelson County constituent
Michael Turner	Nelson County constituent
Rachel Turner	Nelson County constituent
Pam (illegible name)	Nelson County constituent
Nick (illegible name)	Nelson County constituent
Pat Douglas	Nelson County constituent
Cash Sweany	Nelson County constituent
Sherry Reid	Nelson County constituent
(Illegible name) Ayers	Nelson County constituent

D. Ayers	Nelson County constituent
Scott Turner	Nelson County constituent
Wanda Turner	Nelson County constituent
Illegible name	Nelson County constituent
Brenda Brown	Nelson County constituent
Darlene Langley	Nelson County constituent
Adam Wethington	Nelson County constituent
John McDonald	Nelson County constituent
Rick Smith	Nelson County constituent
Bridget Ralston	Nelson County constituent
Wayne Price	Nelson County constituent
Mark Mattingly	Nelson County constituent
Shane Phillips	Nelson County constituent
Gary Wethington	Nelson County constituent
Tom Martin	Nelson County constituent
V. Thompson	Nelson County constituent
Brad Leake	Nelson County constituent
Robert Newton	Nelson County constituent
Cliff Miracle	Nelson County constituent
Josh (illegible name)	Nelson County constituent
Tim (illegible name)	Nelson County constituent
Shawn Newton	Nelson County constituent
Randy Kidwell	Nelson County constituent
Matt Linsley	Nelson County constituent
Bruce Lucas	Nelson County constituent
Illegible name	Nelson County constituent
Dustin Keaton	Nelson County constituent
John Hurst	Nelson County constituent
Marty Lee	Nelson County constituent
Brian Hurst	Nelson County constituent
Matt Ellis	Nelson County constituent
Bryan Humes	Nelson County constituent
Archie Ballash (illegible name)	Nelson County constituent
Tim Barnes	Nelson County constituent
Zeo Hughes	Nelson County constituent
Jeremy (illegible name)	Nelson County constituent
Kurt Ballard	Nelson County constituent
Daniel Clark	Nelson County constituent
John (illegible name)	Nelson County constituent
Illegible name	Nelson County constituent
Chris Hodge	Nelson County constituent
Drew (illegible name)	Nelson County constituent
Steve (illegible name)	Nelson County constituent
Danny Davis	Nelson County constituent
Jerry Burgin	Nelson County constituent
Jamie Blandford	Nelson County constituent

Garry Wethergton	Nelson County constituent
Michael (illegible name)	Nelson County constituent
Ann Rosalie Ballard	Nelson County constituent
Scarlett Hibbs	Nelson County constituent
Illegible name	Nelson County constituent
Cassie Downs	Nelson County constituent
Katie Thompson	Nelson County constituent
Stanley Brady	Nelson County constituent
Tasha Rose	Nelson County constituent
Larry Green	Nelson County constituent
Rosemary Brauch	Nelson County constituent
Charlie Brauch	Nelson County constituent
J.W. Osborne	Nelson County constituent
Illegible name	Nelson County constituent
Jerry (illegible name)	Nelson County constituent
K. (illegible name)	Nelson County constituent
Laura Mudd	Nelson County constituent
Illegible name	Nelson County constituent
M. Mattingly	Nelson County constituent
Illegible name	Nelson County constituent
Gary Ethington	Nelson County constituent
David Murphy	Nelson County constituent
Ronald Osborne	Nelson County constituent
Richard Boone	Nelson County constituent
Illegible name	Nelson County constituent
Illegible name	Nelson County constituent
Timothy (illegible name)	Nelson County constituent
Mayor Bill Sheckles	Nelson County constituent
Jan Megyese	Nelson County constituent
Mildred (illegible name)	Nelson County constituent
Greg (illegible name)	Nelson County constituent
Illegible name	Nelson County constituent
(illegible name) Heaton	Nelson County constituent
Dick Heaton	Nelson County constituent
Illegible name	Nelson County constituent
Michael Boone	Nelson County constituent
LeRay (illegible name)	Nelson County constituent
Illegible name	Nelson County constituent
Illegible name	Nelson County constituent
Kim Rogers	Nelson County constituent
Jan White	Nelson County constituent
Debbie (illegible name)	Nelson County constituent
Illegible name	Nelson County constituent
Peggy Johnson	Nelson County constituent
Karen Ballard	Nelson County constituent
Illegible name	Nelson County constituent

Janet (illegible name)	Nelson County constituent
Vickie Atcher	Nelson County constituent
Shannon Hanson	Nelson County constituent
Chrystal Head	Nelson County constituent
Theresa Hampton	Nelson County constituent
Eddie Greenwell	Nelson County constituent
Margaret Cissell	Nelson County constituent
Carole Raymond	Nelson County constituent
Susie Wheatly	Nelson County constituent
Mary Hellard	Nelson County constituent
Donna Jones	Nelson County constituent
Betty Norris	Nelson County constituent
Shannon (illegible name)	Nelson County constituent
Robyn (illegible name)	Nelson County constituent
Illegible name	Nelson County constituent
Dorene Thomas	Nelson County constituent
Melinda Noris	Nelson County constituent
Jennifer (illegible name)	Nelson County constituent
S. Rogers	Nelson County constituent
(illegible name) Smith	Nelson County constituent
Illegible name	Nelson County constituent
Illegible name	Nelson County constituent
(illegible name) Keerie	Nelson County constituent
Illegible name	Nelson County constituent
Bonnie Lewis	Nelson County constituent
Felicia Litsey	Nelson County constituent
Illegible name	Nelson County constituent
Illegible name	Nelson County constituent
Sherry (illegible name)	Nelson County constituent
Angel Muller	Nelson County constituent
Martin Tingle	Nelson County constituent
Illegible name	Nelson County constituent
Lois Drymun	Nelson County constituent
Sarah (illegible name)	Nelson County constituent
Illegible name	Nelson County constituent
Dorothy Johnson	Nelson County constituent
Barbara Cissell	Nelson County constituent
Linda Spalding	Nelson County constituent
Thomas Linton	Nelson County constituent
William Linton	Nelson County constituent
Tommy Linton	Nelson County constituent
F. Linton	Nelson County constituent
Lora Beth Bland	Nelson County constituent
Dale Belden	Nelson County constituent
George (illegible name)	Nelson County constituent
Aldene (illegible name)	Nelson County constituent

(illegible name) Brady	Nelson County constituent
Felisha Brady	Nelson County constituent
Judy Brady	Nelson County constituent
Sherri Brady	Nelson County constituent
Kristy McCullins	Nelson County constituent
(illegible name) McCoy	Nelson County constituent
Ron (illegible name)	Elizabethtown/Hardin County constituent
Sherry (illegible name)	Elizabethtown/Hardin County constituent
M. Brown	Elizabethtown/Hardin County constituent
Pamela Sullivan	Elizabethtown/Hardin County constituent
Marie Anderson	Elizabethtown/Hardin County constituent
Rhonda Crutcher	Elizabethtown/Hardin County constituent
Kathy Riggs	Elizabethtown/Hardin County constituent
Amy Rattiff	Elizabethtown/Hardin County constituent
Chastity Wise	Elizabethtown/Hardin County constituent
Illegible name	Elizabethtown/Hardin County constituent
Shannon Riggs	Elizabethtown/Hardin County constituent
Beverly (illegible name)	Elizabethtown/Hardin County constituent
Pamela Williams	Elizabethtown/Hardin County constituent
Cynthia Carter	Elizabethtown/Hardin County constituent
Linda Light	Elizabethtown/Hardin County constituent
Jody Milly	Elizabethtown/Hardin County constituent
William Elliott	Elizabethtown/Hardin County constituent
Posey Sue Wise	Elizabethtown/Hardin County constituent
Megan Criss Branham	Elizabethtown/Hardin County constituent
Cecilia Cave	Elizabethtown/Hardin County constituent
Robin Bush	Elizabethtown/Hardin County constituent
Leigh (illegible name)	Elizabethtown/Hardin County constituent
Caroline (illegible name)	Elizabethtown/Hardin County constituent
Karen Stephens	Elizabethtown/Hardin County constituent
Beverly Owen	Elizabethtown/Hardin County constituent
Robert S. Owen	Elizabethtown/Hardin County constituent
Karen Fentress	Elizabethtown/Hardin County constituent
Eddie Sandfer	Elizabethtown/Hardin County constituent
Angela Peters	Elizabethtown/Hardin County constituent
Illegible name	Elizabethtown/Hardin County constituent
Karen (illegible name)	Elizabethtown/Hardin County constituent
Deborah Stallins	Elizabethtown/Hardin County constituent
Pam Ogden Crum	Elizabethtown/Hardin County constituent
Lisa Lathams	Elizabethtown/Hardin County constituent
Joyce Smith	Elizabethtown/Hardin County constituent
Brent Pohlman	Elizabethtown/Hardin County constituent
Lean Priddy	Elizabethtown/Hardin County constituent

Melissa Bolmas	Elizabethtown/Hardin County constituent
Illegible name	Elizabethtown/Hardin County constituent
R. Lopey	Elizabethtown/Hardin County constituent
Connie Evans	Elizabethtown/Hardin County constituent
Cathy (illegible name)	Elizabethtown/Hardin County constituent
Sandra Stubb	Elizabethtown/Hardin County constituent
Illegible name	Elizabethtown/Hardin County constituent
David (illegible name)	Elizabethtown/Hardin County constituent
Illegible name	Elizabethtown/Hardin County constituent
Donald (illegible name)	Elizabethtown/Hardin County constituent
Jennifer (illegible name)	Elizabethtown/Hardin County constituent
Illegible name	Elizabethtown/Hardin County constituent
Melissa Wilkins	Elizabethtown/Hardin County constituent
Debbie Mucker	Elizabethtown/Hardin County constituent
K. Crow	Elizabethtown/Hardin County constituent
Illegible name	Elizabethtown/Hardin County constituent
Pam Lippe	Elizabethtown/Hardin County constituent
Dakota Edwards	Elizabethtown/Hardin County constituent
Earl (illegible name)	Elizabethtown/Hardin County constituent
Jessica (illegible name)	Elizabethtown/Hardin County constituent
Carrie Elliott	Elizabethtown/Hardin County constituent
Thomas (illegible name)	Elizabethtown/Hardin County constituent
Wanda Bryant	Elizabethtown/Hardin County constituent
Katherine Hudspeth	Elizabethtown/Hardin County constituent
Darrel (illegible name)	Elizabethtown/Hardin County constituent
Illegible name	Elizabethtown/Hardin County constituent
Illegible name	Elizabethtown/Hardin County constituent
Theresa Cook	Elizabethtown/Hardin County constituent
Illegible name	Elizabethtown/Hardin County constituent
(Illegible name) Coates	Elizabethtown/Hardin County constituent
Tony Smith	Elizabethtown/Hardin County constituent
Ricky (illegible name)	Elizabethtown/Hardin County constituent
Tanya Samtiago	Elizabethtown/Hardin County constituent
Tasha Hallin	Elizabethtown/Hardin County constituent
Connie Jackson	Elizabethtown/Hardin County constituent
Eleanor Jones	Elizabethtown/Hardin County constituent
Illegible name	Elizabethtown/Hardin County constituent
Kayla (illegible name)	Elizabethtown/Hardin County constituent
Brandy (illegible name)	Elizabethtown/Hardin County constituent
Shandy Seymore	Elizabethtown/Hardin County constituent
Ashley Sweet	Elizabethtown/Hardin County constituent
Mark (illegible name)	Elizabethtown/Hardin County constituent
Meagan Bell	Elizabethtown/Hardin County constituent

Morgan Bell	Elizabethtown/Hardin County constituent
Charlene (illegible name)	Elizabethtown/Hardin County constituent
Tracy (illegible name)	Elizabethtown/Hardin County constituent
(Illegible name) Holmes	Elizabethtown/Hardin County constituent
Chris (illegible name)	Elizabethtown/Hardin County constituent
Ryan Wilkenson	Elizabethtown/Hardin County constituent
Illegible name	Elizabethtown/Hardin County constituent
Illegible name	Elizabethtown/Hardin County constituent
Illegible name	Elizabethtown/Hardin County constituent
Rosella Lightfoot	Elizabethtown/Hardin County constituent
James Lightfoot	Elizabethtown/Hardin County constituent
Leslie Lightfoot	Elizabethtown/Hardin County constituent
Gladys Purnell	Elizabethtown/Hardin County constituent
Joyce Chase	Elizabethtown/Hardin County constituent
Illegible name	Elizabethtown/Hardin County constituent
Rhonda Randall	Elizabethtown/Hardin County constituent
Nancy (illegible name) Cox	Elizabethtown/Hardin County constituent
Alex Cox	Elizabethtown/Hardin County constituent
Robert (illegible name)	Elizabethtown/Hardin County constituent
Illegible name	Elizabethtown/Hardin County constituent
Tom Dennis	Elizabethtown/Hardin County constituent
Illegible name	Elizabethtown/Hardin County constituent
(Illegible name) Edmonds	Elizabethtown/Hardin County constituent
Illegible name	Elizabethtown/Hardin County constituent
George Lang	Elizabethtown/Hardin County constituent
K. Walker	Elizabethtown/Hardin County constituent
Illegible name	Elizabethtown/Hardin County constituent
Illegible name	Elizabethtown/Hardin County constituent
Stacy Rogers	Elizabethtown/Hardin County constituent
Ruby (illegible name)	Elizabethtown/Hardin County constituent
Illegible name)	Elizabethtown/Hardin County constituent
Illegible name	Elizabethtown/Hardin County constituent
Pat (illegible name)	Elizabethtown/Hardin County constituent
Illegible name	Elizabethtown/Hardin County constituent
Illegible name	Elizabethtown/Hardin County constituent
(Illegible name) Watts	Elizabethtown/Hardin County constituent
Vickie Caldwell	Elizabethtown/Hardin County constituent
Illegible name	Elizabethtown/Hardin County constituent
Linda Moors	Elizabethtown/Hardin County constituent
Allen Moors Jr	Elizabethtown/Hardin County constituent
David (illegible name)	Elizabethtown/Hardin County constituent
Victoria (illegible name)	Elizabethtown/Hardin County constituent
Rosemary Rice	Elizabethtown/Hardin County constituent

Illegible name	Elizabethtown/Hardin County constituent
Jerry (illegible name)	Elizabethtown/Hardin County constituent
Illegible name	Elizabethtown/Hardin County constituent
Troy (illegible name)	Elizabethtown/Hardin County constituent
Angela (illegible name)	Elizabethtown/Hardin County constituent
Robert (illegible name)	Elizabethtown/Hardin County constituent
Illegible name	Elizabethtown/Hardin County constituent
John (illegible name)	Elizabethtown/Hardin County constituent
Beth Mattien	Elizabethtown/Hardin County constituent
Tana (illegible name)	Elizabethtown/Hardin County constituent
Gary Hardin	Elizabethtown/Hardin County constituent
Lee Watson	Elizabethtown/Hardin County constituent
(Illegible name) Corhran	Elizabethtown/Hardin County constituent
Sharon McDowell	Elizabethtown/Hardin County constituent
(Illegible name) McDowell	Elizabethtown/Hardin County constituent
Latoya McDowell	Elizabethtown/Hardin County constituent
Lakisa Greatheart	Elizabethtown/Hardin County constituent
Arie Greatheart	Elizabethtown/Hardin County constituent
Brenda Chandler	Elizabethtown/Hardin County constituent
Natalie Chandler	Elizabethtown/Hardin County constituent
Clifford McDowell	Elizabethtown/Hardin County constituent
(Illegible name)	Elizabethtown/Hardin County constituent
Vickie Bell	Elizabethtown/Hardin County constituent
Sis Clark	Elizabethtown/Hardin County constituent
Bro Clark	Elizabethtown/Hardin County constituent
Mrs. Rains	Elizabethtown/Hardin County constituent
Gary Glenn	Elizabethtown/Hardin County constituent
Illegible name	Elizabethtown/Hardin County constituent
Becky (illegible name)	Elizabethtown/Hardin County constituent
Denna Plouch	Elizabethtown/Hardin County constituent
Peter Boughton	Elizabethtown/Hardin County constituent
Illegible name	Elizabethtown/Hardin County constituent
Renee Damos	Elizabethtown/Hardin County constituent
Illegible name	Elizabethtown/Hardin County constituent
Melanie (illegible name)	Elizabethtown/Hardin County constituent
Ronald Basham	Elizabethtown/Hardin County constituent
Tina (illegible name)	Elizabethtown/Hardin County constituent
Lisa Gunning Padgett	Elizabethtown/Hardin County constituent

Quinn (illegible name)	Elizabethtown/Hardin County constituent
Cassandra Davis	Elizabethtown/Hardin County constituent
Earl John	Elizabethtown/Hardin County constituent
Shaun Barker	Elizabethtown/Hardin County constituent
Illegible name	Elizabethtown/Hardin County constituent
Janet (illegible name)	Elizabethtown/Hardin County constituent
Dr. Laura Young, licensed clinical Psychologist	Apple Patch; Crestwood, KY
Steve Zaricki, president and executive director	Kentucky Association of Private Providers (KAPP) Community Living; Louisville, KY
Dr. Stanley Bittman, a licensed psychologist and president	Behavior Associates, LLC; Owensboro, KY
Dr. Sheila Cooley-Parker, licensed counseling Psychologist	Hopkinsville, KY
William S. Dolan, staff attorney supervisor	P & A
Carla Talley, mother of an SCL participant	Almo, KY
Ross Talley, father of an SCL participant	Almo, KY
Shanolette Pierce	
W. Edward Barker	
Sheila Barrett	
David Back, EdS., LPCA	Homeplace Support Services
Lili Lutgens, licensed attorney, licensed clinical social worker and behavior support specialist stated	
Barbara Howard, executive director and CEO	Redwood; Ft. Mitchell, KY
Dr. Sheila Schuster	Kentucky Psychological Association; Louisville, KY
Tara Sorgi Pelfrey, board certified behavior analyst	Louisville, KY
Wade T. Mullins, father of a daughter with autism	Lexington, KY
Wendy Wheeler-Mullins, mother of a daughter With autism	Lexington, KY
Patti Parsons, mother of a son with autism spectrum disorder	Lexington, KY
Vicky Roark grandmother of an individual with autism spectrum disorder	Lexington, KY
Brian Veach, father and legal guardian of	

an SCL participant	
Regina Veach, mother and legal guardian of an SCL participant	
Eddie Mane	Paducah, KY
Phyllis Anderson	
Jennifer Dillworth	West Paducah, KY
Illegible name	
Lisa Hall	Benton, KY
Thomas Apple	
Chuck Smith	
Rick White	
Cory McMeus	
Illegible name	
Tim White	
D. Hold or Hall	
Lrabeola Walker	
Beverly McKinley	
Keith Petssities	
Leann Schnamke	Paducah, KY
Tammy Hunt	Ledbetter, KY
Marcie Moore, guardian of an SCL participant	West Paducah, KY
Rhonda Beach	
Illegible name	
Richard Hundley	Paducah, KY
David Sinkfeld, SCL participant	
Larry Colwell, SCL participant	
Anita Townsend, family home care provider	Ashland, KY
Sharon Allsup, family home care provider	Ashland, KY
Carolyn J. Thorpe, primary caregiver of an SCL participant	
Steve Stratford, SCL provider	REACH of Louisville, KY
Tammy Endicott, direct support professional	
Kathryn Nicole Cook, direct support professional	
Jennifer Perry, director support professional	
Jamie Hardy, direct support professional	
Beverly Mills, director support professional	
Steve Shannon, executive director	The Kentucky Association of Regional Mental Health/Mental Retardation Programs, Inc. (KARP)
Shannon Ware, president and CEO	Bluegrass Regional Mental Health-Mental Retardation Board, Inc.; Lexington, KY
Thomas P. Laurino, provider	Choices Unlimited, Inc.; Paducah, KY
Erin Lowell	Ashland, KY
Laura Nue	Ashland, KY

Misty Patton	Coal Grove, OH
Illegible name	Ashland, KY
Reety Rumh/illegible	
Patricia Mills, SCL participant	
Katharine A. Gum, SCL participant	
Cassidy Marie Hall, SCL participant	
Susan Moon, SCL participant	
Amelia Lee Gamble, SCL participant	
Susan Lens, GDN	
D/illegible Easterling, GDN	
Louisa Hughes, SCL participant	
Joe Tingler, SCL participant	
Elmer Mills, SCL participant	
Darrell Wayne Tipton, SCL participant	
Illegible name	Paducah, KY
Betty Powell, direct support professional	
Natasha L. Widd/illegible, direct support professional	
Shannon Nichols	Olive Hill, KY
Mark Cottrell, SCL participant	
Bell Gash, mother of an SCL participant	
Randall Bohmfalk, SCL participant	Mayfield, KY
Karen Puckett	
Luke Puckett	
Gregory Spees, father of an SCL participant	Salem, KY
Robbie Spees, mother of an SCL participant	Salem, KY
Terry Ellis	Smithland, KY
Amie Lyons, RP	
Charlene Phillips, SCL participant	
Joe Bayer, SCL participant	
George Marshall/illegible, Jr., SCL participant	
David Wheeler, SCL participant	
Kenneth, SCL participant	
Corey, SCL participant	
Illegible name, SCL participant	
Harvey Puckett	
Teresa McDowell, DSC	
Debbie Ahart, foster care provider	
Beau Holmes, SCL participant	
Sandy Barnes, parent of a child with disabilities and president	Cumberland River Homes, Inc., Salem, KY
Marie Burkhart, executive director	Cumberland River Homes, Inc.; Salem, KY
Dennis illegible last name, board member	MCEP
Neka Whitley, SCL participant	
Norma Treon	

Kandy Smith, mother of an SCL participant
 Amber Baker, SCL participant
 Mary B. Smith, sister of an SCL participant
 Christopher George, board certified behavior analyst and licensed behavior analyst
 Amber Durham, a licensed behavior analyst

Amanda Rupert, behavior analyst and concerned citizen
 Jean Russell, vice president of developmental Services

Janice Elder, sister of an SCL participant and MSN/RN/CNOR, director of surgery

Dan Simpson, chief executive officer

Joe Brothers, chairman

Glenn Black, board member

Arthur Young, board member

Charles J. Branch, board member

Chuck R. Cox/illegible name, board member

John. A. Elan/illegible, board member

P.O./illegible name, board member

Donna illegible last name, board member

Mark Grimes, board member

Joy Weeslmen, board member

Roz Hill, board member

Peggy Snow, board member

John L. Rogers, board member

T.L.Mabrey, board member

Taylor Mill, KY

Applied Behavior Advancements
 Applied Behavioral Advancements

Seven Counties Services, Inc.;
 Louisville, KY

Twin Lakes Regional
 Medical Center

Communicare;
 Elizabethtown, KY
 Communicare Board of Directors; Elizabethtown, KY

Koinu Nealey, board member	Communicare Board of Directors; Elizabethtown, KY
Lloyd E. Henderson, board member	Communicare Board of Directors; Elizabethtown, KY
Fred V. Smith, board member	Communicare Board of Directors; Elizabethtown, KY
Kelley Miller, board member	Communicare Board of Directors; Elizabethtown, KY
Stephanie Sharp, chairperson	The Commonwealth Council on Developmental Disabilities
Oyo Fummilayo, member	The Commonwealth Council on Developmental Disabilities
Jerry McDonald, program director	Links of Kentucky; Somerset, KY
Johnny Callebs, executive director	Independent Opportunities; Richmond, KY
Wayne Harvey, vice president and CEO	Independent Opportunities; Richmond, KY
Shirley Patterson, a family home provider	
Daniel Dodd, father of a daughter with disability	
Judy Erwin, director of compliance	Zoom Group; Louisville, KY

(4) The following individuals from the promulgating agency responded to comments received regarding 907 KAR 12:020:

<u>Name and Title</u>	<u>Organization/Agency/Other Entity</u>
Dr. Stephen Hall, Commissioner	Department for Behavioral Health, Developmental and Intellectual Disabilities
Claudia Johnson, Assistant Director	Department for Behavioral Health, Developmental and Intellectual Disabilities, Office of Intellectual Disabilities
Stuart Owen, Regulation Coordinator	Department for Medicaid Services

(1) Subject: Adult Day Training Rate Reduction/Supported Employment Rate Increase

(a) Comment: Annelle S. Fulmer, sister of an SCL participant stated, "In addition to these changes you are also proposing a reduction to the reimbursement the ADT receives for day training. The reimbursement rate for supported employment increases significantly, however, many of the individuals currently at the ADT are not candidates for supported employment. Many of the ADTs are barely surviving with the current reimbursement. With a decrease in reimbursement for day training, they will have to cut staff and reduce their services, if not discontinue them entirely. Since many of the individuals are not eligible for employment in the community and therefore cannot earn a 'customary wage and level of benefits', it appears you will not reimburse the ADT anything for working with these individuals, leaving no option other than for the ADT to remove the non-performing individuals."

(b) Response: There is not, nor has there ever been any plan or procedure which forces participants to engage in integrated community employment when they do not wish to do so. If participants are satisfied with the type of services that they currently receive they will be required to change nothing. At the same time, there is the expectation that all participants indicating they do desire integrated employment receive appropriate training and be given every opportunity to pursue that goal.

For those who choose to seek integrated community employment there is also no requirement that participant pursue employment at any specific level. The participant could work full-time or part-time depending upon the choices they make. As a matter of fact, after transitioning to integrated community employment, the participant may choose to return to the sheltered program on a part time basis to refine their community employment skills or to a traditional day program to maintain friendships, for the difference between the amount of time they work in integrated employment and forty (40) hours per week.

The median salary for full-time day training workers in Kentucky found on the internet after adding contributions for FICA, Medicare, Unemployment, twelve days of sick leave, ten holidays with pay, seven days of vacation, and a \$3,951 per year contribution to health insurance (health insurance source: The Kaiser Foundation) is \$2.68 per unit (quarter-hour). At the proposed rate, our analysis shows that providers will begin generating a contribution to their fixed cost at the one staff member to two participant level. Although we have witnessed staff to participant ratios at levels much greater than 1:5 we have limited our analysis to this range as a maximum. Depending upon the number of participants supervised, using this data a provider would generate a per unit contribution margin of \$1.72 to \$8.32.

Using fiscal year 2011 day training billing data from a large day training provider (417,493 units) and using the proposed rate, a contribution to fixed costs between \$359,043.98 with an average of two participants supervised per staff member; and, \$694,708.35 with an average of five participants supervised per staff member would be generated.

In addition, when compared to the day training rates paid to providers in contiguous states, after adjusting to account for coverage limits and local variations, Kentucky's proposed day training rate is exceeded by only one state. The total difference between the maximum income generated between the state with the largest return and Kentucky is \$120 per participant per year.

DMS is postponing the reduction in day training rate [to \$2.20 per fifteen (15) minutes] until January 1, 2014 and will preserve the \$2.50 per fifteen (15) minute rate through December 31, 2013.

(c) Comment: Robert C. Reifsnyder, President of the United Way of Greater Cincinnati and Leshia Lyman, Director of the Northern Kentucky Area Center of the United Way of Greater Cincinnati expressed opposition to the new adult day training

policies in concert with others comments and stated, "Making sheltered work environments ineligible for Medicaid reimbursement will ultimately mean the end of work for SCL consumers in Adult Day Training programs. We agree that individuals with disabilities should attain community-based employment in an integrated setting whenever feasible. But we also know that making such a widespread and complete change, particularly in this economy, would be extremely detrimental to our citizens with developmental and/or intellectual disabilities who require the level of support that is provided at Adult Day Training programs." They expressed why their organization funds adult day training providers and also added "in our present job market, it has become increasingly difficult for individuals with developmental and/or intellectual disabilities to compete against those without disabilities for our community's available jobs. We ask that no change be made to the current Medicaid reimbursement agreement and that our opposition to the proposed change be included in the public hearing report."

Janice Elder, sister of an SCL participant and MSN/RN/CNOR, director of surgery at Twin Lakes Regional Medical Center, opposed any cuts and stated, "As it is, there is not enough funding for this program now, so I am asking you with all my sincerity to please not let what little funding there is now be cut. If this happens, then there is nothing for our special needs population in our county."

(d) Response: There is not, nor has there ever been any plan or procedure which forces participants to engage in integrated community employment when they do not wish to do so. If participants are satisfied with the type of services that they currently receive they will be required to change nothing. At the same time, there is the expectation that all participants indicating they do desire integrated employment receive appropriate training and be given every opportunity to pursue that goal.

For those who choose to seek integrated community employment there is also no requirement that participant pursue employment at any specific level. The participant could work full-time or part-time depending upon the choices they make. As a matter of fact, after transitioning to integrated community employment, the participant may choose to return to the sheltered program on a part time basis to refine their community employment skills or to a traditional day program to maintain friendships, for the difference between the amount of time they work in integrated employment and forty (40) hours per week.

It is quite true that many waiver participants have a great deal of difficulty meeting all of the elements in the typical job description. That is why our supported employment services are built upon discovering individual strengths and individual employer opportunities discovered by customized employment. With a customized employment approach, work opportunities which match the interests or skills of the participant are negotiated with the employer in order to free up existing staff to focus on the other tasks that need to be accomplished. This creates greater efficiency. In essence, the goal is to find a win/win situation for both the participant and the employer.

As an example, a waiver participant who works for a truss manufacturer ensures that

the drill bits used in the process are sharpened and are the correct length. Prior to this participant taking over the task, all of the experienced truss builders had to stop what they were doing as their stock of drill bits wore out and use a machine called “the grinder” to prepare more bits. As these employees worked at roughly the same pace, they tended to run out of bits at the same time. Since there was only one “grinder,” this task created a significant bottleneck in the operation. The hiring of the waiver participant for this specific task, even though the participant was slower than any of the experienced truss makers at this task, removed the responsibility from everyone else and enabled the operation to generate a greater profit.

Sometimes the “tools” that the participant uses for mobility can enhance a participant’s employability. A Kentucky hospital discovered it had a serious problem when their accrediting body found that over 80% of the hand sanitizer units in the hospital were either empty or broken. They hired a waiver participant who used a motorized wheelchair to travel a route around the campus testing the units, filling those that were empty, and turning in a maintenance request for those that were broken. During the follow-up accreditation visit they were found to be 100% in compliance. Since that time, the participant has expanded his hours and responsibilities by maintaining a continuous inventory of cleaning materials in each unit. This allows housekeeping staff to spend their time keeping the premises clean instead of traveling back and forth to central stores to obtain materials.

In order for supported employment to work effectively, the employment specialist must function as both an advocate for the participant and a consultant for the business.

DMS is postponing the reduction in day training rate [to \$2.20 per fifteen (15) minutes] until January 1, 2014 and will preserve the \$2.50 per fifteen (15) minute rate through December 31, 2013.

(e) Comment: Shelly Buntain, President of Independent Industries, Inc. asked

Shelly Buntain, President of Independent Industries, Inc., asked “Will the Department of Behavioral Health/Developmental and Intellectual Disabilities reimburse Day Training programs at the rate of \$8.80 per hour for persons with developmental and intellectual disabilities they employ in segregated work settings and that are paid Prevailing Wage Rate wages based upon their productivity?”

(f) Response: There is not, nor has there ever been any plan or procedure which forces participants to engage in integrated community employment when they do not wish to do so. If participants are satisfied with the type of services that they currently receive they will be required to change nothing and the provider will be reimbursed at the day training rate.

At the same time, there is the expectation that all participants indicating they do desire integrated employment receive appropriate training and be given every opportunity to pursue that goal.

For those who choose to seek integrated community employment there is also no requirement that participant pursue employment at any specific level. The participant could work full-time or part-time depending upon the choices they make. As a matter of fact, after transitioning to integrated community employment, the participant may choose to return to the sheltered program on a part time basis to refine their community employment skills or to a traditional day program to maintain friendships, for the difference between the amount of time they work in integrated employment and forty (40) hours per week.

DMS is postponing the reduction in day training rate [to \$2.20 per fifteen (15) minutes] until January 1, 2014 and will preserve the \$2.50 per fifteen (15) minute rate through December 31, 2013.

(g) Comment: Steve Zaricki, president of the Kentucky Association of Private Providers and executive director of Community Living, stated, "Our request or recommendation, one, retain the day services model and rates until supported employment programs have been--have begun to develop and thrive. Keep this alternative intact for many participants who utilize it as a primary activity in their daily lives."

Steve Zaricki also stated, "Issues to be considered and addressed in implementation. The negative effective rate reductions. The reduction of day training rates from \$3 off site, 2.50 on site to a flat rate of 220 per unit, may be intended to discourage this service option, but it could have unintended effects. Providers could--could resort to higher participants to staff ratio in order to manage labor costs and other expenses. This would likely result in less intensive supervision and a decrease in quality of supports. In addition, the quality and quantity of community based services will be diminished.

It's clear to everyone in this field that when you impact one area of service, such as adult day training, you impact the other areas as well in the person's life, whether it's residential, therapies, other services."

Mr. Zaricki also requested that the adult day training reimbursement rate be increased to \$2.75 per unit.

Jenifer Frommeyer, executive director of Dreams With Wings and mother of a child with Down syndrome, stated, "Negative Effect of Rate Reduction: The reduction of the Day Training rate from \$3.00 (off-site) and \$2.50 (on-site) to a flat rate of \$2.20 per unit may be intended to discourage this service option, but it could have an unintended effect. Providers could resort to higher participant to staff ratios in order to manage labor costs and other expenses. This would likely result in less intensive supervision and a decrease in quality of supports. In addition, the quality and quantity of community-based services will be diminished."

Jenifer Frommeyer also recommended that the adult day training rate be increased to the “median rate of \$2.75 per unit.”

(h) Response: The median salary for full-time day training workers in Kentucky after adding contributions for FICA, Medicare, Unemployment, twelve days of sick leave, ten holidays with pay, seven days of vacation, and a \$3,951 per year contribution to health insurance (health insurance source: The Kaiser Foundation) is \$2.68 per unit (quarter-hour). At the proposed rate, our analysis shows that providers will begin generating above their fixed cost at the one staff member to two participant level. Although we have witnessed staff to participant ratios at levels much greater than 1:5 we have limited our analysis to this range as a maximum. Depending upon the number of participants supervised, using this data a provider would generate a per unit contribution margin of \$1.72 to \$8.32. Using fiscal year 2011 day training billing data from a large day training provider (417,493 units) and using the proposed rate, a contribution to fixed costs between \$359,043.98 with an average of two participants supervised per staff member; and, \$694,708.35 with an average of five participants supervised per staff member would be generated.

In addition, when compared to the day training rates paid to providers in contiguous states, after adjusting to account for coverage limits and local variations, Kentucky’s proposed day training rate is exceeded by only one state and by only \$120 per participant per year.

The reduction in the day training rate will reduce the potential income from day services by \$2,476.80 per participant per year for day service providers with a service mix that is 100% day training. However, under the new rate structure, developing a service mix that is 80% day training, 15% community access, and 5% supported employment would generate \$8,028.96 more per participant accessing the new services than would have been generated at the previous rate.

DMS is postponing the reduction in day training rate [to \$2.20 per fifteen (15) minutes] until January 1, 2014 and will preserve the \$2.50 per fifteen (15) minute rate through December 31, 2013.

(i) Comment: Wayne Harvey, vice president and CEO of Independent Opportunities indicated that the adult day training ADT rate hasn’t been adjusted since 2004 to offset rising admin costs and that new requirements add to the admin costs; that ADT services are the most utilized and under the newly drafted regulation that will endanger the health, safety and welfare of the people receiving this service. He stated, “I urge the Cabinet for Health and Family Services to reconsider the proposed rate for ADT services within the new SCL regulation as service providers will not be able to provide staff to participant ratios under the new rate to ensure the health, safety and welfare of program participants wanting this invaluable service. The economics of not having any rate adjustments since 2004 had providers already providing this service with minimal ratios due to the rising cost of operations related to inflation and cost of living. I sincerely hope the Cabinet for Health and Family Services will do the right thing in relation to the

rate for the most utilized service within the SCL waiver program.”

Johnny Callebs, executive director of Independent Opportunities, stated the following: “My name is Johnny Callebs and I'm the executive director for Independent Opportunities in Richmond, Kentucky. And, I'm here today to give comment on behalf of Wayne Harvey, our chief operations officer. And, so I just have one page of brief comments on day training.

I'm submitting the following comments for consideration by--for--for consideration by the Cabinet for Health and Family Services in relation to the recently filed regulations for the SCL waiver program.

I want to first acknowledge that our organizations within Kentucky are proud members of the Kentucky Association of Private Providers, also known as KAPP and fully support the comments and recommendations that the Association has presented on the new regulations at the public hearing today.

I would like to further expand on one issue that I find critical to providers of adult day training services listed in the new SCL regulation as it is currently drafted.

Day training services are the most utilized service within the 1915C waiver program that is not mandatory for program recipients.

The new regulations propose cutting the rate for this invaluable service for families and participants to \$2.20 per unit. This proposal made it in to the regulation despite providers being at the same reimbursement rate for ADT services since 2004 without any cost of living adjustments or adjustments to offset rising costs to administer the services.

There are also new requirements for--listed within the regulation for this service that will require providers of the service to spend more money to administer that service to program participants.

The Cabinet will place SCL program participants receiving ADT Services under this newly drafted regulation in environments that will endanger the health, safety and welfare of people receiving this service as it cannot be delivered safely at the rate that is proposed within the new regulation.

I urge the Cabinet to reconsider the proposed rate for ADT services within the new regulation as service providers will not be able to provide staff to participant ratios under the new rate to ensure health, safety and welfare.

The economics of not having any rate adjustments since 2004, had providers already providing this service with minimal ratios due to the rising cost of operations related to inflation and cost of living.

I sincerely hope the Cabinet for Health and Family services will do the right thing in relations to the rate for the most utilized services within the waiver program.”

Judy Erwin, director of compliance with the Zoom Group, stated, “Please revise 907 LAR 12:020 to change the rate of Day Training services to \$2.75 per unit. Reducing the Day Training rate from \$3.00 (off-site) and \$2.50 (on-site) to a flat rate of \$2.20 could have a negative impact on recipients who chose to retain their choice to receive Day Training services. Some providers could use higher participant to staff ratios in order to manage their costs and other expenses. This could result in less intensive supports and a decrease in quality of supports.

The Day Training rate (previously called the Adult Day Training rate) has not been increased in at least 8 years, and it is unfair to reduce the rate for the Day Training service in order to pay for Supported Employment or Community Access rate increases since many participants may choose to not access those services, There are many unfunded mandates in the regulation, including drug testing, additional educational requirements and training for staff, medication training by an RN, daily contact notes, etc. that will cost the Day Training providers more money, while their rate is being decreased, This rate reduction could also ultimately negatively impact Direct Support Professionals (DSP's) who are very dedicated and passionate about the work they do in the Day Training programs. Many providers and other organizations are attempting to make progress towards increasing wages for DSP's, however this rate reduction is counter to that cause by reducing the rates to those who pay the wages. Please reconsider changing the Day Training rate to at least \$2.75 per unit.”

Ms. Erwin also stated the following:

“My name is Judy Erwin, I work for a non-profit organization in Louisville that serves people with developmental disabilities. And, I just had to say something. I actually wasn't planning to say anything.

But, our organization depends on DSPs, they are our life blood. They truly care about the people they serve. And, these are not your people with doctor degrees, but they-- they are valuable in so many other ways.

And, by cutting the ADT rate or the DT rate to \$2.20 a unit is truly a disservice.

We're a non-profit company, we're not about money, we're about mission. But, unfortunately, we have to pay the bills and we have to pay the people who work for us.

And, to decrease the day training rate, whether philosophically you believe day training is necessary or not, is really devaluing these people who are so dedicated and work for such a low wage.

I request that the Department reconsider the day training rate. Michelle P waiver is \$2.75 a unit. And, you know, we've not looking to make a lot of money, but we have to exist. We have to sustain ourselves to help people in the future. So, we do request that

the day training rate be increased to, at least, \$2.75 a unit.”

Jerry McDonald, program director of Links of Kentucky, stated the following:
“Day Training: Reimbursement rate is too low to cover the cost of adequate supervision and training. Supports are person centered and are directly related to personally chosen outcomes. The lowered reimbursement rate does not allow for such individualized support. Day Training is to include teaching workplace skills, workplace conduct, problem solving, workplace safety, and communication, and should be based upon needs outlined in the Person- Centered Employment Plan, or POC. The reimbursement rate for day training is too low to cover costs of such individualized supports. Supported Employment staff are better trained to provide these supports, but they have been delegated to Day Training. The Day Training is to take place in a variety of settings, but the lower reimbursement rate will not cover any transportation costs. It also does not factor in the amount and cost of staff documenting supports, attending meetings, and additional training cost. A rate of \$2.75 per unit would allow for person-centered supports and access to a variety of settings.”

(j) Response: The median salary for full-time day training workers in Kentucky after adding contributions for FICA, Medicare, Unemployment, twelve days of sick leave, ten holidays with pay, seven days of vacation, and a \$3,951 per year contribution to health insurance (health insurance source: The Kaiser Foundation) is \$2.68 per unit (quarter-hour). At the proposed rate, our analysis shows that providers will begin generating above their fixed cost at the one staff member to two participant level. Although we have witnessed staff to participant ratios at levels much greater than 1:5 we have limited our analysis to this range as a maximum. Depending upon the number of participants supervised, using this data a provider would generate a per unit contribution margin of \$1.72 to \$8.32. Using fiscal year 2011 day training billing data from a large day training provider (417,493 units) and using the proposed rate, a contribution to fixed costs between \$359,043.98 with an average of two participants supervised per staff member; and, \$694,708.35 with an average of five participants supervised per staff member would be generated.

In addition, when compared to the Day Training rates paid to providers in contiguous states, after adjusting to account for coverage limits and local variations, Kentucky’s proposed day training rate is exceeded by only one state and by only \$120 per participant per year.

The reduction in the Day Training rate will reduce the potential income from day services by \$2,476.80 per participant per year for day service providers with a service mix that is 100% Day Training. However, under the new rate structure, developing a service mix that is 80% Day Training, 15% Community Access, and 5% Supported Employment would generate \$8,028.96 more per participant accessing the new services than would have been generated at the previous rate.

DMS is postponing the reduction in day training rate [to \$2.20 per fifteen (15) minutes] until January 1, 2014 and will preserve the \$2.50 per fifteen (15) minute rate through

December 31, 2013.

(k) Comment: Steve and Melanie Tyner-Wilson expressed support for the increased rate for supported employment and decreased rate for adult day training and described them as reasonable changes that will assist providers to increase services.

(l) Response: Thank you.

(m) Comment: Barbara Howard, executive director and CEO of Redwood in Ft. Mitchell, KY stated, "This letter is to share my concern about the KY Medicaid's proposed amendments to the regulations in the Supports for Community Living (SCL) Medicaid Waiver (907 KAR 12:010).

Many of the proposed changes in the regulation were shared with providers in mid spring 2011. The changes that impact Adult Day Training and Sheltered Employment were not shared until summer 2012. At that time, the Northern Kentucky organizations collaborated to hold a town meeting to inform consumers and families. The proposed changes were a complete surprise to these individuals, as well as to service providers. As you are aware, many of them have written letters to express their concern.

The proposed changes include higher rates for supported employment and lower rates for Day Training (sheltered employment). One individual at CHFS recently told a legislator that this change was to serve as an incentive for service providers to move people from the workshops to community employment. Please know, though, that it is not the "money" that is driving whether people participate in sheltered or supported employment; it is their needs and preferences. The population of adults with intellectual/developmental disabilities is not a homogenous group. There is a wide range of types and levels of disabling conditions, with many people experiencing multiple disabilities, medical fragility, and mental health disorders. One size program or service does not fit all. Additionally, it is important to consider individual choice. Some people wish to work in the community. Others do not for a variety of reasons. There is need for both types of programs—supported employment in community jobs and sheltered employment in Adult Day Training Programs.

Supported Employment

Redwood, BAWAC, New Perceptions, and North Key are fully committed to community employment for people who choose to work, as well as to providing opportunities for them to receive support to attain and maintain a community job. Each organization offers "supported employment" services for that purpose. Everyone appreciates Commissioner Hall's attempts to increase funding for supported employment. It is important to note, however, that the plan requires individuals seeking community employment to first exhaust funding through the Office of Vocational Rehabilitation (OVR). OVR Funding, though, is tied to the outcome of a person finding and maintaining employment for 90 days. If that doesn't happen—which is likely in the current economy of high unemployment—there is no funding to cover the cost of the

services provided. Unemployment rates are a huge barrier to placing individuals with severe disabilities when people without disabilities can't find jobs.”

(n) Response: The intent of the waiver is to update the services for participants from the practice of the 1970's to current best practices. The above interpretation means that what we have communicated has been largely misunderstood or significantly misrepresented.

There is not, nor has there ever been, any plan or procedure which forces participants to engage in integrated community employment when they do not wish to do so. If participants are satisfied with the type of services that they currently receive they will be required to change nothing. At the same time, there is the expectation that all participants indicating they do desire integrated employment receive appropriate training and be given every opportunity to pursue that goal.

For those who choose to seek integrated community employment there is also no requirement that participant pursue employment at any specific level. The participant could work full-time or part-time depending upon the choices they make. As a matter of fact, after transitioning to integrated community employment, the participant may choose to return to the sheltered program on a part time basis to refine their community employment skills or to a traditional day program to maintain friendships, for the difference between the amount of time they work in integrated employment and forty (40) hours per week.

Career planning activities are not the only activities that can make up an adult day training program. In general, any activities that are designed to foster the acquisition of skills, build positive social behavior and interpersonal competence, and foster greater independence and personal choice meet the regulatory definition. Other specific activities that would meet these requirements other than employment or career planning and development include: supported retirement, health and wellness activities to slow the progress of medical conditions, and activities to build networks of non-program friends (community integration).

Traditionally, many people with disabilities had no expectation of ever having a job. Today, there is a new generation of young people with disabilities who grew up in accessible communities and integrated classrooms who not only expect jobs, but are demanding them. Add to that the numbers of soldiers with disabilities returning with the strong desire to work and support their families and we see a prepared and motivated workforce ready to make their mark on the world.

What we did not realize until recently is that people with disabilities and their families represent a very significant segment of any potential customer base. Globally there are 1.1 billion people with disabilities controlling more than \$4 trillion annually. This makes people with disabilities a market roughly the size of China. One in five Americans has a disability making people with disabilities the largest single minority group in the country. Of all families, 29% have at least one member with a disability, and marketing research

shows that families with one or more persons with disabilities and consumers in general are significantly more likely to do business with a disability-friendly company.

President Obama said the federal government will hire an additional 100,000 persons with disabilities by 2015 and the U. S. Chamber of Commerce challenged private employers to hire an additional one million persons with disabilities also by 2015. Proposed rules from the U.S. Department of Labor require all federal contractors to work toward a goal of having at least seven percent of their workforce, at all levels, be persons with disabilities. No one claims that providing supported employment is easy; but we do not believe that the fact it is difficult to provide should eliminate it from the participant's menu of choices.

While we certainly must follow the law, the 1973 Rehabilitation Act, its subsequent amendments and the Americans With Disabilities Act (ADA), BHDID and Kentucky's Office of Vocational Rehabilitation worked together to negotiate and sign a memorandum of understanding regarding our roles in providing employment opportunities to participants. We are full partners in this effort and preparation is in progress to accommodate increased participation.

DMS is postponing the reduction in day training rate [to \$2.20 per fifteen (15) minutes] until January 1, 2014 and will preserve the \$2.50 per fifteen (15) minute rate through December 31, 2013.

(o) Comment: Steve Stratford, an SCL provider with REACH, stated, "With a reduction in the AADT rate our agency will likely be forced to quit providing free community outings and activities including : movies, bowling, the Y, and other such activities. We are also likely to have to stop providing free meals to individuals. These changes will cause a cost shift to the individuals we serve or a discontinuation of these services all together.

(p) Response: The median salary for full-time day training workers in Kentucky after adding contributions for FICA, Medicare, Unemployment, twelve days of sick leave, ten holidays with pay, seven days of vacation, and a \$3,951 per year contribution to health insurance (health insurance source: The Kaiser Foundation) is \$2.68 per unit (quarter-hour). At the proposed rate, our analysis shows that providers will begin generating above their fixed cost at the one staff member to two participant level. Although we have witnessed staff to participant ratios at levels much greater than 1:5 we have limited our analysis to this range as a maximum. Depending upon the number of participants supervised, using this data a provider would generate a per unit contribution margin of \$1.72 to \$8.32. Using fiscal year 2011 day training billing data from a large day training provider (417,493 units) and using the proposed rate, a contribution to fixed costs between \$359,043.98 with an average of two participants supervised per staff member; and, \$694,708.35 with an average of five participants supervised per staff member would be generated.

In addition, when compared to the Day Training rates paid to providers in contiguous

states, after adjusting to account for coverage limits and local variations, Kentucky's proposed day training rate is exceeded by only one state and by only \$120 per participant per year.

The reduction in the Day Training rate will reduce the potential income from day services by \$2,476.80 per participant per year for day service providers with a service mix that is 100% Day Training. However, under the new rate structure, developing a service mix that is 80% Day Training, 15% Community Access, and 5% Supported Employment would generate \$8,028.96 more per participant accessing the new services than would have been generated at the previous rate.

DMS is postponing the reduction in day training rate [to \$2.20 per fifteen (15) minutes] until January 1, 2014 and will preserve the \$2.50 per fifteen (15) minute rate through December 31, 2013.

(q) Comment: Amanda Rupert, behavior analyst and concerned citizen, stated, "How will a decrease in funding to ADT (Adult Day Training) centers result in a positive outcome for clients? \$8 per hour will not support clients. Where will they go during the day? I have clients that see ADTs as their jobs. You are cutting a valuable resource."

(r) Response: There is not, nor has there ever been, any plan or procedure which forces participants to engage in integrated community employment when they do not wish to do so. If participants are satisfied with the type of services that they currently receive they will be required to change nothing. At the same time, there is the expectation that all participants indicating they do desire integrated employment receive appropriate training and be given every opportunity to pursue that goal.

For those who choose to seek integrated community employment there is also no requirement that participant pursue employment at any specific level. The participant could work full-time or part-time depending upon the choices they make. As a matter of fact, after transitioning to integrated community employment, the participant may choose to return to the sheltered program on a part time basis to refine their community employment skills or to a traditional day program to maintain friendships, for the difference between the amount of time they work in integrated employment and forty (40) hours per week.

The median salary for full-time day training workers in Kentucky after adding contributions for FICA, Medicare, Unemployment, twelve days of sick leave, ten holidays with pay, seven days of vacation, and a \$3,951 per year contribution to health insurance (health insurance source: The Kaiser Foundation) is \$2.68 per unit (quarter-hour). At the proposed rate, our analysis shows that providers will begin generating above their fixed cost at the one staff member to two participant level. Although we have witnessed staff to participant ratios at levels much greater than 1:5 we have limited our analysis to this range as a maximum. Depending upon the number of participants supervised, using this data a provider would generate a per unit contribution margin of \$1.72 to \$8.32. Using fiscal year 2011 day training billing data from a large day training

provider (417,493 units) and using the proposed rate, a contribution to fixed costs between \$359,043.98 with an average of two participants supervised per staff member; and, \$694,708.35 with an average of five participants supervised per staff member would be generated.

In addition, when compared to the Day Training rates paid to providers in contiguous states, after adjusting to account for coverage limits and local variations, Kentucky's proposed day training rate is exceeded by only one state and by only \$120 per participant per year.

The reduction in the Day Training rate will reduce the potential income from day services by \$2,476.80 per participant per year for day service providers with a service mix that is 100% Day Training. However, under the new rate structure, developing a service mix that is 80% Day Training, 15% Community Access, and 5% Supported Employment would generate \$8,028.96 more per participant accessing the new services than would have been generated at the previous rate.

DMS is postponing the reduction in day training rate [to \$2.20 per fifteen (15) minutes] until January 1, 2014 and will preserve the \$2.50 per fifteen (15) minute rate through December 31, 2013.

(s) Comment: Stephanie Sharp, chairperson of the Commonwealth Council on Developmental Disabilities on behalf of the council, stated the following:

“Supported employment and day training.

We believe the increased rate for supported employment and decreased rate for day training are reasonable changes that will incentivize providers to increase supported employment services. Our Council's experiences, as well as the data show that individuals with disabilities in Kentucky want more supported employment opportunities.

According to the 2010/2011 national core indicator survey of adults with disabilities only nine percent of Kentuckians surveyed had jobs in the community. But, forty-six of those Kentuckians surveyed wanted a job in the community. This indicates that the demand for supported employment far outstems the current provisions. Not only is there a demanding Kentucky first supported employment, but the research indicates that supported employment improves the lives of individuals with disabilities.

In a review of fifteen quantitative peer grouping studies of supported employment, a 2007 survey of the Journal of Applied Research and Intellectual Disabilities concluded the review--the review to positive outcomes for people with intellectual disabilities entering employment, particularly in terms of quality of life, well-being and autonomy.

Finally, the data suggests that supported employment is not just beneficial for individuals served, it is cost effective for society and public budgets as a whole.

A study of all individuals who received supported employment services from the Kentucky's Department of Vocational Rehabilitation from 2002 to 2007 shows that every dollar put in to the program \$1.35 is resulting. Giving what seems to be a great impact potential of supported employment in Kentucky, we feel that's in sensitizing the provision of supported needs make logical sense and we have--and we will have positive outcomes.”

(t) Response: Thank you for your positive comments.

(u) Comment: Jerry McDonald, program director of Links of Kentucky, stated the following:

“Another area is, in the supported employment I was very glad to see that rates for people who were trained to be support employment specialists was going to be increased. I assume the intent of that was to encourage us to provide more support employment opportunities and find jobs for our individuals who wanted jobs in the community.

I think most of that critical time spent in assessing the person, developing that person's plan, actually finding jobs and placing that person is reimbursed through voc rehab and would not be reimbursed at the rates of the SCL waiver.

I wish the voc rehab rates for reimbursement, you know, would have gone up a little bit for that. SCL doesn't, you know, begin until all those other resources have been exhausted.”

(v) Response: The rates through vocational rehabilitation did increase and the terms for payment changed for job development from an outcome fee to an hourly rate. When participants have exhausted their access to services through vocational rehabilitation, funding for any applicable segment of supported employment as defined by the SCL regulation may be accessed through the SCL waiver to support the participant's employment outcomes.

(2) Subject: Case Management Reimbursement Reduction

(a) Comment: Annelle S. Fulmer, sister of an SCL participant stated, “Currently you are proposing the pay for the case manager be lowered from \$376.06 per month to \$320.00 per month. I know DeeDee puts in a lot of time for Martha [Ms. Fulmer's sister] and is her advocate. I don't think the current rate of pay is sufficient to cover all of DeeDee's time. By lowering the payment by \$56.06 per month, agencies will not be able to pay their case managers as much money, so they will terminate some case managers and the rest will each have to be responsible for more individuals. The only way the case managers will get their added work done is to do their jobs halfway. No more personal interest in the individual – just get the paperwork done as fast as possible. So now I've got a case manager that doesn't know anything about Martha and really doesn't care because they don't have the time to care. Is this progress?”

(b) Response: Case management services are the cornerstone for excellence in providing assurances that people in SCL services are safe, have choices, are respected, and enjoy living and working in their communities. In order to promote best practice in Kentucky, case managers are being provided enhanced training that includes more tools and assessments to enable the case manager to better identify and implement support strategies. Through ongoing continuing education, case managers are empowered to facilitate and guide the person centered team towards designing person focused plans that reflects choice, opportunity, and what is important to and for the person. The adjustment of the rates is to better align Kentucky's rates with the national median payment ranges of \$100-250.00 per month as reported by the National Association of State Directors of Developmental Disability Services (NASDDDS).

(c) Comment: Regarding the following change regarding case management responsibilities in 907 KAR 12:010, Susan Stokes, owner of Access Community Assistance and HMR Associates, stated, The 351 assessment is not mentioned in the-- in the regulation. It places a--it is replaced by multiple other assessment tools, including the SIS, the HRST, the focus tool, Page 26, Line 1 and 2. This is creating a much more--and maybe those tools--we're using the focus tool now and I have no problem with it, but you have just added more and more time and expertise and implication to the process and yet, you are paying the case manager less."

(d) Response: The use of more sophisticated assessment tools may well require an increase of initial effort but it is our contention that the availability of more accurate and more meaningful information will inform the planning process in a manner that greatly reduces many of the costly difficulties that are commonly experienced in our existing system. As to the payment for services, while it is true that the reimbursement for SCL waiver case management is being reduced by \$56.06 per participant per month, the Michelle P. waiver case management rate is increasing by \$120 per participant per month. Since there are nearly twice as many participants in the Michelle P. waiver as there are in the SCL waiver, it should be clear that case management providers are likely to see a significant increase in revenue.

Case management services are the cornerstone for excellence in providing assurances that people in SCL services are safe, have choices, are respected, and enjoy living and working in their communities. In order to promote best practice in Kentucky, case managers are being provided enhanced training that includes more tools and assessments to enable the case manager to better identify and implement support strategies. Through ongoing continuing education, case managers are empowered to facilitate and guide the person centered team towards designing person focused plans that reflects choice, opportunity, and what is important to and for the person. The adjustment of the rates is to better align Kentucky's rates with the national median payment ranges of \$100-250.00 per month as reported by the National Association of State Directors of Developmental Disability Services (NASDDDS).

(e) Comment: Steve Zaricki, president of the Kentucky Association of Private Providers

and executive director of Community Living, stated, “The description of additional responsibilities in anticipated authoritative role of case managers, not to mention increased training requirements, detailed in the personnel section, seem to constitute a rate increase or, at least, a maintenance of the rate. Instead the rate for case management is decreasing from \$376 per month to \$320 per month, despite the increase in responsibility. This will likely result in higher case loads, reduce--and reduced contact for many case managers. So, while they've increased the responsibilities of the case manager, giving them, quote, authority, they've decreased the rate of reimbursement. So, those provider--case manager provider agencies or case management agencies will have more to do with less money to fund them.

The one request we have in this area is to retain case management reimbursement rates at the \$376.06, considering the increase in training requirements and responsibilities.”

(f) Response: The adjustment of the rates is to better align Kentucky’s rates with the national median payment ranges of \$100-250.00 per month as reported by the National Association of State Directors of Developmental Disability Services (NASDDDS). While the SCL Case Management rate declines by 56.06 per month, the proposed Michelle P. waiver case management rate increases by \$120 per month. As there are at least twice as many people with intellectual and developmental disabilities receiving services through the Michelle P. waiver, it is safe to assume that the total income for case management providers is likely to significantly increase.

(g) Comment: Steve Shannon, executive director of The Kentucky Association of Regional Mental Health/Mental Retardation Programs, Inc, (KARP), stated (and Shannon Ware, president and CEO of Bluegrass Regional Mental Health-Mental Retardation Board, Inc., supported Mr. Shanon’s comments), commented that “The role, responsibility and accountability of case management have greatly increased in the proposed regulation” (referring to 907 KAR 12:010 “while the reimbursement rate included in the payment regulation has decreased to \$320 from \$376. We are concerned about the decreased rate not being commensurate with the increased responsibility and the impact it may have on quality.”

(h) Response: Case management services are the cornerstone for excellence in providing assurances that people in SCL services are safe, have choices, are respected, and enjoy living and working in their communities. In order to promote best practice in Kentucky, case managers are being provided enhanced training that includes more tools and assessments to enable the case manager to better identify and implement support strategies. Through ongoing continuing education, case managers are empowered to facilitate and guide the person centered team towards designing person focused plans that reflects choice, opportunity, and what is important to and for the person. The adjustment of the rates is to better align Kentucky’s rates with the national median payment ranges of \$100-250.00 per month as reported by the National Association of State Directors of Developmental Disability Services (NASDDDS).

While the SCL waiver case management rate declines by 56.06 per month, the proposed Michelle P. waiver case management rate increases by \$120 per month. As there are at least twice as many people with intellectual and developmental disabilities receiving services through the Michelle P. waiver, it is safe to assume that the total income for case management providers is likely to significantly increase.

(i) Comment: Steve Stratford, SCL provider with REACH stated, "The concept of independent case management is a good idea and should create better services for those served, but the reimbursement rate cut will put those individuals at jeopardy by causing case managers to have to increase the number of clients they serve to make this a financially viable services, this will be especially an issue in times of crisis and case managers are most needed."

(j) Response: While the SCL waiver case management rate declines by 56.06 per month, the proposed Michelle P. waiver case management rate increases by \$120 per month. As there are at least twice as many people with intellectual and developmental disabilities receiving services through the Michelle P. waiver, it is safe to assume that the total income for case management providers is likely to significantly increase.

(3) Subject: Respite Reimbursement Reduction or Limit

(a) Comment: Diana Wall, executive director of the Marshall County Exceptional Center (MCEP); Shirley Don Haws, an MCEP board member; Brian S. Ray/illegible last name (MCEP); Amy You, DSP; Crystal Reid, Rita McLemore Hicks, Ramona Kaye McDonald, Kelley Heiston, DSP; no name provided; illegible name; Mike Mill, an MCEP board member; Cathy Y. West; Juainta West, community member; Jennifer York, consumer; Cathy Y. York, parent; Lynda McWaters; Karlie Stirm; Kearston Breeden; Melissa Sumner; Linda Pogue; Brad Waddell; Kim Waddell; Allen Waddell; Brian Sams; Jack Ham; Jennifer Lane; Dustin Lane; Sharon Hamlet; Janice Pollard; Joe T. West; Rose Mary Gamble; Arlie Ross; Joetta Ross; Carla Griggs; Kelley Bennett; Larry Wright, consumer; no name; and Joe. T. illegible last name, director of the Marshall County Exceptional School in Benton, KY stated, ". . . by cutting the rates that are allowed for respite services, for those who would still qualify, is again limiting the resources of our individuals. Respite service providers work hard to insure that individuals are safe, happy, and enjoy their time away from their normal residences. By offering less reimbursement for such services, several respite providers may stop offering their services, again limiting the availability of services."

Kelly Miller, Rebecca Stamm, Nora Bannesto, Mary McDaniel, Karen Brooks, Stephanie Gordon, Kelly Corlis, Kasey Corlis, Lena Fletcher, Tammy Dugan, Amy Henderson, Dudley Boling, Evelyn Atherton, Jackie Griffith, the guardian of Dorcas Kempf, Kathy Osborne, Michelle Moore, Bryan Veach (father and legal guardian of an SCL participant), Michelle Riggs Betty S. Meacham, Shanolette Pierce, W. Edward Barker, Sheila Barrett, John Willis (friend of SCL participants), Dee Dee Willis (friend of SCL participants), Bryan Dudding (Pathways Respite Center), David Sinkfeld, SCL participant; Larry Colwell, SCL participant; Anita Townsend, family home care provider;

Sharon Allsup, family home care provider; Brian Veach, father and legal guardian of an SCL participant; Regina Veach, mother and legal guardian of an SCL participant; Carolyn J. Thorpe, primary caregiver of an SCL participant; Kim Hayes, mother of an SCL participant; Carol Repovick; Jessica Repovick; Marle Repovick; Myra Fassell; Edna James; Jerry Jones; Margo Tullos; Randall (illegible name); Gene Tully; Karin Kent; Leo (illegible name); Paula (illegible name); Mary Alice Kowalkyk(illegible name); Rose Logsdon; R. Douglas Logsdon; Diane (illegible name); R J Witowski; Marilyn Brooks; John Brooks; Jeanette Hayes; (illegible name) Hayes; Shanna Garrett, works with SCL participants; M H Lewellyn; Roberta Lewellyn; Leslie H. Carroll, consumer/parent/guardian; Chesley Dunn, Jr. parent/guardian of an SCL participant; Debbie S. Dunn, parent/guardian of an SCL participant; Andrea Hulett; Jacqueline Arnette, SCL participant; Jason, SCL participant; Missy Gamble, SCL participant; Elora Hurt, Site Supervisor for a Comp Care Agency; Brooke Howswell/(not legible), direct support professional; Anthony Bracke, parent of an SCL participant; Colleen Bracke, parent of an SCL participant; Jessica Wilson, direct support professional Betty West, direct support professional; Helen Bodkin, parent of an SCL participant; Glenda Saxon, friend of/concerned for an SCL participant; Frances Owens, friend of/concerned for an SCL participant; Michelle Morgan, sister of an SCL participant; Christy Tomes, parent of an SCL participant; Joseph F. Hayden, brother of an SCL participant; Lorine Mays, works at J.U. Kevil Center; Cheryl Dunn, parent of an SCL participant; Rachel, SCL participant; Dallas N. Horn, certified financial planner; Charity Walters, SCL participant; Chris Carman, SCL participant; Patrick Lueken, SCL participant; Brent Lueken, SCL participant; Mary Anne Lueken, mother of an SCL participant; Patty McGlone, SCL participant; Eric Ston, friend of an SCL participant on behalf of an SCL participant; Jackie Arnett, SCL participant; Heran Fugitt, SCL participant; Jason Gillum, SCL participant; Diane Sue Adkins, SCL participant Patty Adkins, SCL participant; Whitney Chibres, SCL participant; Robie Carlos/(not legible) sister of an SCL participant; Penny Lou O'Neal, SCL participant; Diane Sue Adkins, SCL participant; Patty Adkins, SCL participant; Tammy Endicott, direct support professional; Kathryn Nicole Cook, direct support professional; Jennifer Perry, director support professional; Jamie Hardy, direct support professional; Beverly Mills, director support professional; Erin Lowell; Laura Nue; Misty Patton; Illegible name;Reety Rumh/illegible; Patricia Mills, SCL participant; Katharine A. Gum, SCL participant; Cassidy Marie Hall, SCL participant; Susan Moon, SCL participant; Amelia Lee Gamble, SCL participant; Susan Lens, GDN; D/illegible Easterling, GDN; Louisa Hughes, SCL participant; Joe Tingler, SCL participant; Elmer Mills, SCL participant; Darrell Wayne Tipton, SCL participant; Illegible name; Betty Powell, direct support professional; Natasha L. Widd/illegible, direct support professional; Shannon Nichols; Mark Cottrell, SCL participant; Bell Gash, mother of an SCL participant; Randall Bohmfalk, SCL participant ; Karen Puckett; Luke Puckett; Gregory Spees, father of an SCL participant; Robbie Spees, mother of an SCL participant; Terry Ellis;Amie Lyons, RP; Charlene Phillips, SCL participant; Joe Bayer, SCL participant; George Marshall/illegible, Jr., SCL participant; David Wheeler, SCL participant; Kenneth, SCL participant; Corey, SCL participant; Illegible name, SCL participant; Harvey Puckett; Teresa McDowell, DSC; Debbie Ahart, foster care provider; Beau Holmes, SCL participant; Sandy Barnes, parent of a child with disabilities and president of Cumberland River Homes,Inc.; Neka

Whitley, SCL participant; Norma Treon; Marie Burkhart, executive director of Cumberland River Homes, Inc.; Lynne Taul, Breckinridge County constituent; John Taul, Breckinridge County constituent; Johnny Compton, Breckinridge County constituent; Dan Simpson, chief executive officer, Communicare; Joe Brothers, chairman Communicare Board of Directors; Glenn Black, board member, Communicare Board of Directors; Arthur Young, board member, Communicare Board of Directors; Charles J. Branch, board member, Communicare Board of Directors; Chuck R. Cox/illegible name, board member, Communicare Board of Directors; John. A. Elan/illegible, board member, Communicare Board of Directors; P.O./illegible name, board member, Communicare Board of Directors; Donna illegible last name, board member, Communicare Board of Directors; Mark Grimes, board member, Communicare Board of Directors; Joy Weeslmen, board member, Communicare Board of Directors; Roz Hill, board member, Communicare Board of Directors; Peggy Snow, board member, Communicare Board of Directors; John L. Rogers, board member, Communicare Board of Directors; T.L.Mabrey, board member, Communicare Board of Directors; Koinu Nealey, board member, Communicare Board of Directors; Lloyd E. Henderson, board member, Communicare Board of Directors; Fred V. Smith, board member, Communicare Board of Directors; Kelley Miller, board member, Communicare Board of Directors; Dennis illegible last name, board member MCEP; Kandy Smith, mother of an SCL participant; Mary B. Smith, sister of an SCL participant; Amber Baker, SCL participant; and the Meade County, Marion County, Grayson County, Nelson County, Washington County, Elizabethtown/Hardin County, and Breckinridge County constituents listed in the first part of the statement of consideration as individuals providing written comments opposed the reduction in the respite service limit and expressed that respite is very valuable consumers and providers. They requested that the current regulations not be changed regarding respite.

Kenny Thomas, illegible name, Lisa Bradley, Jeffery Fraley, Phoebe Fitzgerald, Beth Adkins, Melanie R. Queen, no name provided, no name provided, illegible name, Tg. A. illegible last name, Kathy Roe, Matt illegible last name, illegible first name A. Bradley, Jr., Derek Sizemore, Bill illegible last name, Stephanie Dewitt-Sizemore, Amanda S. Preston, illegible name, Genetta McClove, Joseph D. Coleman, Beverly Coleman, Sydney Cullup, Janet Bradley, Rachel Rae Coleman, Amanda Leiber, Lainey Burgess, Amy Acord, Jeff Watters, Virginia Watters, Shannon illegible last name, Tim Huff, Angel L. Silvey, Casey Burke, Sonya Remy, Eddie Mane, Phyllis Anderson, Jennifer Dillworth, Illegible name, Lisa Hall, Thomas Apple, Chuck Smith, Rick White, Cory McMeus, Illegible name, Tim White, D. Hold or Hall, Lrabeola Walker, Beverly McKinley, Keith Petssities, Leann Schnamke, Tammy Hunt, Marcie Moore, guardian of an SCL participant, Rhonda Beach, Illegible name, Richard Hundley, Debbie Whitt, illegible name, Misty Amytin, illegible name, David P. illegible last name, Jawana Binion, William July, Lea Acord, Myriah Weatherholt, H. M. illegible last name, Bill Bradley, Kyle illegible last name, Guy Brislin, Matthew Brislin, Becky Brislin, Robyn A. Shaler, Ralph Brislin, Jenny Meade, Jeff Hale, Cleeta Thompson, Dawn Withrow, Jennifer and Joshua Roberts, Kathryn illegible last name, Shawna Dillon, Mr. and Mrs. Joseph A. Welch, Kevin Crisp, David Foster, Marvin Sizemore, Aaron Wallace, Jinny Adams, Ally illegible last name, James Biggs, III, Ed Sizemore, Debbie Barnett, No name, Marshe Winemor,

Michelle Tackett, Lindsey illegible last name, Kimberly Owen, Michael Kaye, Alex Hamlin, Kaylin Gambill, Kelly D. Petrie, James Sterge, Jason Love and Duane Hughes expressed similar comments as stated above and also stated, "Reducing hours for relief services may eventually force families or caregivers to seek other permanent residential services at state institutions or health care facilities because they are unable to provide 100% care without adequate relief."

Carla Talley, mother of an SCL participant and Ross Talley, father of an SCL participant also expressed opposition to the reduction in respite hours and expressed the need for and benefits of respite.

Dr. and Mrs. Jeffrey Lederer, parents of an SCL participant utilizing the consumer directed option, stated, "We have concern that the amounts for both respite and supplies have been reduced. If services are to be truly person centered people need the option to choose services that will promote what they need."

Steve Shannon, executive director of The Kentucky Association of Regional Mental Health/Mental Retardation Programs, Inc, (KARP), stated the following:
"Reducing respite hours, we heard earlier, if it's the average, why worry about it? People need to have access to respite they say in their home, much better affordable choice.

So, CMHCs are going to put it in much more detailed writing."

(b) Response: Units or cost above the limits may be requested through the exceptional supports protocol and will be reviewed based on justified need.

(c) Comment: Anita Townsend and Sharon Allsup, family home care provides stated, "Why would a child living at home with their family receive these services and not my individuals? They are considered our family. There biological families in one case hasn't seen him in 25 years, the other has only seen his family 2 times in 8 years. This is absolutely ridiculous. Lastly, if you figure it out I would make approximately \$1.65 cents per hour, plus have to pay someone to watch them if I have a sickness, or the state would just take them away. How concerned are all of you? This is an absolute outrage and I want their voice to be heard through me. Does this mean my pay would increase to minimum wage, which would cost the state much more money? By the way, I have to also pay income taxes and state taxes at the end of the year on the \$1100.00 dollars per month per person, and I also have to spend \$75.00 a month on each individual. You tell me is this fair?

(d) Response: Respite for residential providers – There is a change in the way that Family Home (FHP) and Adult Foster Care (AFC) providers will receive time off for relief of the caregiver. Respite is not a paid service for residential providers, but time off from the job is expected for the Level II residential provider. Level II residential providers (Adult Foster Care and Family Home Providers) are paid a flat rate for residential services by the certified SCL provider agency.

Contractual agreements between the SCL provider agency and the contracted Level II residential provider should include Level II residential provider time off from the job. Arrangements for the ongoing care of the person receiving residential services should be identified by the team and planning should occur for ongoing residential service during these times. As long as residential services are provided, the SCL provider agency will continue to receive Medicaid waiver residential reimbursement for the care of the person receiving residential services.

The rate for FHP and AFC services has been increased to offset this change in respite. We did this in collaboration with providers to ensure that this would not disrupt this important residential option for people.

(e) Comment: Thomas P. Laurino with Choices Unlimited, Inc., stated, “1. I am very concerned about the cutback on respite to those individuals that live at home with their parents. To cut back almost in half is far too much for the group of individuals that costs Medicaid the least. I would think that they would want to encourage families to continue to have their children reside in their home. This cutback will encourage families to look towards residential programs for their individuals. I am sure this will have a major impact on those parents that have chosen the PDS (old CDO) approach because it will reduce their budgets considerably. I take issue with the method used to determine the new amount. An average of all of those individuals eligible for respite services sounds like a good approach, but to include all of those individuals that never use their respite allotments even though they are entitled to them resulted in an askew number.

Recommendation: Not to cut back on the amount of respite, but in the alternative to step it down slowly over a few years by reducing a little bit each year if it must be cut back. The final amount should be determined by numbers actually used instead of an average of all entitled.”

(f) Response: The amount of respite requested and approved must be based on assessed need for the service. Units or cost above the limits may be requested through the exceptional supports protocol and will be reviewed based on justified need.

(g) Comment: Jerry McDonald, program director of Links of Kentucky, stated the following:

“The other thing that is important to some of our individuals is respite and I know that people who live at home with family members, other people caring for them, as well as people who live in family home provider situations or adult foster care situations, the people providing those care and service, at times it's a twenty-four/seven job, month after month after month. They cannot, you know, close down because it's a holiday or a weekend. And, now that respite care is being severely limited for family members cut from, I think 1,440 hours per year down to 830. And, what I was told was that that was the average that was being provided before, so now they just took the average and put that as the cap for families and other people that are taking care of those individuals.

That option has also been totally taken away from people who are in family home provider situations and adult foster care. And, now those people are going to be working with those individuals, trying to provide supervision and care without any covered service to give that person a break, if there's a--a family emergency in their family or if there's some things that they have to take care of that their individual might not be able to participate in or might not really want to participate in, there's no covered service to give that person any relief whatsoever.”

Mr. McDonald also stated the following:

“Respite: This support was completely eliminated for participants who receive Adult Foster Care, or Family Home Provider Supports. These providers work 7 days per week and need to have respite services available. Staff burn-out is more likely to occur if there is no provision for time off. Providers may also need respite to take care of family issues, illness, or other personal issues. Why would this support be eliminated? Reducing the available Respite for persons living with natural family from 1440 hours per year to 830 hours per year is a drastic cut for families who have respite as their only relief. Respite should be available as a covered service for participants in FHP or Adult Foster Care up to at least 864 hrs per year, and allow exceptional support provision to increase amounts for families and providers if necessary.”

(h) Response: Regarding respite for residential providers – there is a change in the way that Family Home (FHP) and Adult Foster Care (AFC) providers will receive time off for relief of the caregiver. Respite is not a paid service for residential providers, but time off from the job is expected for the Level II residential provider. Level II residential providers (Adult Foster Care and Family Home Providers) are paid a flat rate for residential services by the certified SCL provider agency.

Contractual agreements between the SCL provider agency and the contracted Level II residential provider should include Level II residential provider time off from the job. Arrangements for the ongoing care of the person receiving residential services should be identified by the team and planning should occur for continued residential treatment services during these times. We did this in collaboration with FHP and AFC providers to ensure that this would not disrupt this important residential option for people.

(i) Comment: Shirley Patterson, a family home provider, stated the following: “Hi, my name is Shirley Patterson. I am a family home provider. I'm very concerned with the changes that you all are purposing in respite care.

We work for \$4.06 an hour. If you take and consider our people are gone to day programs, with transportation and everything, they're gone nine hours a day, that's if they attend that day program.

Medicaid workers don't work as many hours as we work.

The only thing that we have is our respite care to get away for family emergencies,

because we all have families too.

The people that we serve are very much a part of our family.

I have the father of the consumer that I serve here. He wanted to appointment me as his standby guardian. But, the company that I work for says, oh, no, if you do that, when you become guardian, we're going to take her away. I've had her for two and a half years. I've stayed with her in the hospital, when Medicaid wouldn't pay me. And, I love this person.

And, you all are not considering the person themselves here. You're only considering the dollar amount.

You're saying that you give us too much power, if we become guardians. What power are we going to have? Power to access \$200 that we don't already get out of their check. What's \$200 going to do me, you know?

It's only going to give me the power to get her medical help and to assure that she stays where she's happy, because personally, if you walk in and you're guardian and you say, hey, I don't like this FHP, I like this one over here better, you have the power to jerk that person from my home against her father's wishes, if he should--something should have happened to him by then.

I'm not trying to take advantage of my individual.

The respite hours, like I say, we need those or, at least, half as much as what you were giving us before. I don't use but maybe half of them in here anyway. I don't care if you take half of them away. But, we still need a break.

I have took care of her, when she should have been in rehab.

I switched agencies because the agency I was working with could provide me with six hours of respite a week. You know, you can't go do the grocery shopping and all the other business that you need to take care of. You can't--a lot of meds, we can't say, oh, well, she's going to be out of it Tuesday, but I can't get respite until Friday and I can't leave to get that med because I can't--she's incapacitated, she can't bend her leg, can't transport her.

You know, you all need to stop and think about all the aspects of what we do before you go making a lot of drastic changes.

And, I'm--I've listened to a lot of stuff and learned a lot of stuff from listening to all of you all.

I agree we--we're not college educated, but a lot of times we know these individuals better than the college educated people do. We know--I'm not going to tell the behavior

specialist how to do his job. But, this individual's behavior specialist, I told him, I said, if you watched us in the morning go through our little routine, you'd think she needs a lot more behavior programs, but she's laughing, she's happy. She's not hurting anybody. This is her way of showing affection, you know. And, he said, oh, I've never seen her laugh, she's always serious. She's not. And, I had a person from another agency watch us talk and interact and they said, huh, I've never seen her interact with anybody like that before and I worked with her for quite a while.

You know, but if you stress out the people who are doing this by taking all their respite away, then you're going to get one of two things. You're going to get people saying, huh, I don't want this person anymore, let's throw them back into the agencies. Let's throw them back into the staff residence. Let's throw them back in to the ICFMRs. Or you're going to see abuse cases skyrocket.

I Louisville, 'cause Seven Counties, if you're in crises. Well, guess who Seven Counties calls when they get that person in crises? It's us to say, hey, can you help? This person needs some place to stay on an emergency basis. We need somebody that can care for them.

But, basically--and we're doing it for very little. If we take away some of the red tape, then maybe we can make a decent living and provide our people with what they need.

My person goes out in public. I bought a handicap van just so I could take her out, because where I live, they don't have services on weekends, you know. I can't call and say, hey, TARC 3, I need to take this person out to a movie, 'cause they're going to say, oh, we don't provide service for your area.

So, I just would like for you all to take these things into consideration before you make you decisions. And, her father wants to say—“

Daniel Dodd, father of a daughter with disability stated the following:

“My name is Daniel Dodd. I live in Louisville, Kentucky. I have a physical and mentally handicap daughter. And, I was wanting to try to make the FHP her conservatorship. I'm the guardianship. And, they're saying that that's giving conservatorship too much power.

So, I--I need somebody to be her conservatorship, 'cause I'm getting up in age. I'm more than three scores and ten.

I've been having sickness myself. So, I don't have a wife. I used to have. I've had four wives, I don't have one now. So, I'm not looking for nobody.

But, she is good to her. And, she's good to the FHP. So, I can see it in them how she acts and everything. And, I guess, if I told everything, the state would be ready to put some more--they probably would be changing the rules. That's how good they are to each other.

She's in a wheelchairs, she's been in there about six years. And, I have to slip around and push her wheelchair, 'cause if she knows I'm pushing the wheelchair, she'd reach back and push my hand back there. And, she would say, mamma, and she would push her. She wouldn't let me push her. And, so she--she--I really need that conservatorship so that, if I'm not there, you know, she could take over and do the job just like I would do it.

I'm going to the doctor every time she goes. And, she goes to the doctor a lot.

And, so I just hope that more come out of the state than they're offering. They're just not offering enough.”

(j) Response: There is a change in the way that Family Home (FHP) and Adult Foster Care (AFC) providers will receive time off for relief of the caregiver. Respite is not a paid service for residential providers, but time off from the job is expected for the Level II residential provider. Level II residential providers (Adult Foster Care and Family Home Providers) are paid a flat rate for residential services by the certified SCL provider agency.

Contractual agreements between the SCL provider agency and the contracted Level II residential provider should include Level II residential provider time off from the job. Arrangements for the ongoing care of the person receiving residential services should be identified by the team and planning should occur for continued residential treatment services during these times. As long as residential services are provided, the SCL provider agency will continue to receive Medicaid waiver residential reimbursement for the care of the person receiving residential services.

The rate for FHP and AFC services has been increased to offset the change in respite. We did this in collaboration with FHP and AFC providers to ensure that this would not disrupt this important residential option for people.

(4) Subject: Reimbursement for Psychologists

(a) Comment: Dr. Laura Young, a licensed clinical psychologist with Apple Patch in Crestwood, KY stated, I'm a doctor level psychologist. I completed a four year undergraduate program. I completed a two years master program. I completed a five year doctoral program. And, I completed a one year full-time post doctoral internship in order to call myself Doctor Laura Young. The SCL waiver amendment is proposing a rate reimbursement cut of forty-two percent for psychologists.”

Dr. Young also stated the following:

“The SCL waiver amendment is proposing a rate reimbursement cut of forty-two percent for psychologists. So, this is going to cut my rate from \$155 an hour to \$90 an hour. It should be noted that psychologists at the doctoral level made \$90 an hour in 1990, in 1990. So, we had a rate increase and now we are going to have a rate decrease that is

going to take us back to 1990.

It should be noted that this rate is the rate paid to the agencies with SCL contracts, not to the providers themselves. After the agency takes out its administrative costs, the rate of reimbursement to me, as a doctoral level psychologist will be insufficient for me to support myself and my own family.

I have already informed the agency through which I provide psychological services that I can no longer provide SCL services for the proposed reduced rate. My colleagues providing SCL psychological services have shared with me that this rate decrease will result in their inability to provide SCL services as well.

The factors involved in this decision include the agency's administrative fee. The cost of office supplies and positive reinforcers and rewards, which we provide for our clients. and the automobile maintenance and gasoline expenses, which are significant, especially when providing services in rural areas. I traveled 26,500 miles last year and I was not reimbursed for any of that.

In addition, the reduction in available--billable time - as a result of the travel time needed to work with our clients, this is going to decrease my ability to bill because I spend so much time driving back and forth between my clients.

The sad conclusion is that we cannot afford to provide home and community based psychotherapy services at this reduced rate. It will become much more financially attractive for providers such as myself to work in other areas of psychology if this reimbursement rate is not adjusted.

In order to help you understand what doctoral level psychologists are billing, I researched billing in the practices in my area and I started with Seven Counties. And, I like Seven Counties and I don't want to bash them today, so I hope this does not come across that way. Doctoral level psychologists are billed at significantly higher rates than the SCL waiver amendment offers. For example, when I contacted Seven Counties their full fee rate for assessment and therapy services by a doctoral level psychologist in Jefferson County was \$160 an hour. In Oldham County the Seven County full fee rate for assessment and therapy services by a doctoral level psychologist is \$180 an hour. Please note that these services are provided in an in office setting. There's no travel time, no gasoline expense, no rural service provision in people's homes.

And, then here's the real kicker, I also learned that master's level psychotherapist at Seven Counties that are billed through the State Medicaid system, they're billed at \$116.80 per hour for office based services. This is Medicaid. This is what's funding my services through SCL. They're getting \$26.80 more per hour than what the proposed regulation is going to pay me, when I have more education. I'm working in the community with the clients and offering a service that is going to be more effective to meet their needs. Where's the parody?

If SCL clients aren't seen for therapy by psychologists, where are they going to go? Well, they're going to go to Seven Counties for office based therapy, which is significantly more costly and less effective for this population. In an office based setting the psychologist must rely on client self report as well as discussion of events in the abstract. Our clients don't do well with abstract conversation. The psychologist is unable to observe the client interacting with their peers in their natural environment, let alone assist and coach the client through difficult situations while they are occurring. Instead, the psychologist is limited to talking hypothetically about conflicts and problems and intervention that has limited impact and success, especially with clients who have difficulty generalizing new learning between settings.

The office based psychologist never meets day program or residential staff, rarely consults with family and administrators and, typically fails to know any of the client's natural supports. It is absolutely imperative to include these individuals in the treatment of SCL clients, if their treatment is to be successful.”

(b) Response: According to the United States Department of Labor Bureau of Labor Statistics Occupational Outlook Handbook, the median salary for practicing Psychologists in May 2010 was \$68,640 per year (\$33.00 per hour). This figure seems to be confirmed by various other sources putting the salary range of clinical psychologists between \$45,475 (approximately \$22.00 per hour) and \$104,397 (approximately \$50.00 per hour). For comparison's sake, the proposed Kentucky rate of \$90 per hour equates to \$187,200 per year and the quoted existing rate of \$155 per hour equates to \$322,400 per year.

The hourly rates for counseling through the Medicaid waivers in states contiguous to Kentucky are as follows:

Ohio	Indiana	Illinois	West Virginia	Virginia
\$54.74	\$71.48	\$37.00	\$40.08	\$57.20

It should be noted that Virginia does offer a payment of \$92.65 per hour for crisis stabilization with significant limitations to the quantity of services which can be delivered.

The current approved hourly rate for psychological services through Impact Plus services for children with significant mental health needs in Kentucky is \$78.40 for services from a Psychologist and \$147.00 for services from a psychiatrist.

The proposed rate for psychological services in the SCL waiver is still significantly higher than the reimbursement rates in contiguous states. The rate should allow providers to easily cover reasonable wages for psychologists, reimburse travel expenses, and generate a significant contribution toward their fixed costs.

(c) Comment: Dr. Sheila Schuster, on behalf of the Kentucky Psychological Association

and over 670 psychologists which it represents, stated, “The changes in reimbursement for psychological services proposed in 907 KAR 12:020 would cut the reimbursement rate for all classifications of psychological providers by approximately 42%. This is an unprecedented and dramatic decrease in payment for psychological services – and one that is not reflected in the proposed reimbursement levels for any other SCL professional.

Value of Psychological Services:

The psychological providers in the SCL program make significant contributions to the assessment of the individual, formulation of treatment strategies and appropriate interventions and consultations with behavioral support professionals and others. For those SCL participants who are dually-diagnosed with a psychological condition, access to psychological services will likely save the SCL program money by providing the needed treatment interventions (with coordination of Positive Behavioral Support services where indicated) to prevent expensive psychiatric hospitalizations or return to an institutional placement.

Access to Psychological Services:

The great concern is that if the recommended changes in reimbursement are finalized as proposed, then psychological providers – particularly those who are at the doctoral level – will likely cease to be providers of services in the SCL program. We would also point out that the psychological services offered to SCL participants are typically provided in the individual’s home or community placement, thus negating the need for transportation and increasing the effectiveness of treatment over that done in a traditional therapy office.

We strongly urge that the reimbursement rate for Psychological Services be restored to a level of reimbursement commensurate with current rates, with no greater decrease or cut than that proposed for similarly-educated and trained providers in the SCL program.”

Dr. Schuster summarized the concern by stating, “Proposing an unprecedented cut of 42% in reimbursement for Psychological Services – a cut unmatched in proposed reimbursement rates for any other providers of SCL services – will significantly reduce or eliminate the number of psychologists who are willing to provide services in the SCL program.” Dr. Schuster requested that the “The reimbursement rate for psychological services in 907KAR12:020 should be restored to a level commensurate with the education and training of the providers.”

(d) Response: According to the United States Department of Labor Bureau of Labor Statistics Occupational Outlook Handbook, the median salary for practicing Psychologists in May 2010 was \$68,640 per year (\$33.00 per hour). This figure seems to be confirmed by various other sources putting the salary range of Clinical Psychologists between \$45,475 (approximately \$22.00 per hour) and \$104,397 (approximately \$50.00 per hour). For comparison’s sake, the proposed Kentucky rate of \$90 per hour equates to \$187,200 per year and the quoted existing rate of \$155 per

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The proposed rate for psychological services in the SCL waiver is still significantly higher than the reimbursement rates in contiguous states. The rate should allow providers to easily cover reasonable wages for psychologists, reimburse travel expenses, and generate a significant contribution toward their fixed costs.

(e) Comment: Christopher George, a board certified behavior analyst, a licensed behavior analyst in Kentucky, and executive director of Applied Behavioral Advancements, stated the following:

One of the biggest concerns that I see in this reimbursement rate, we've talked about the reduction in rate for ADTs and for other services.

For behavioral and psychological services, behavior support professionals are taking a thirty-eight percent reduction in their reimbursement rate. The reimbursement rate for psychologists, including doctorate level psychologists is a reduction of forty-four percent of their current reimbursement rate.

Kind of a rhetorical question, I'm really not meaning it to be inflammatory, but is anyone in the Cabinet taking a forty-four percent reduction in their pay in order to implement this regulation?

As we look around, I don't think that there's any one of us here in the room that, as we sit down with our families at night, we talk about the things that we're going to do and our plans for the future and those things, say, hey, mom and dad--or, you know, dad comes home and says, hey, I just--I just took a forty-four percent cut in my salary, devastating. Absolutely devastating.

I understand the state of our economy. I understand the place where we are with taxation and those things and I recognize that. However, the rate has been reduced

down from the rates to those that are commensurate with bachelor's level degrees for occupational therapists, physical therapists and speech pathologist. So, we have taken folks--I had two additional years in school to get my master's degree, I had another additional eighteen months of training that I did to become a board certified behavior analyst, that was with additional cost. For our fine doctor standing up here and others of you that may be in the room and going through doctoral level programs and the added expense that is there, the reimbursement that the rate feels is appropriate for you is that of a bachelor's level clinician.

The problem with that is not just the money that comes in and those things and trying to pay off our student loans and doing those things. When you look--and I spoke earlier about the expectations that the Cabinet has for us, to oversee the plans of care, to make recommendations about the overall service delivery, to do things there and have given a great responsibility on us, not only as clinicians in our field and our discipline as behavior support professionals, dietitians too, or psychologists, but also for team management.

The folks with the highest level--the highest requirement of education, are behavior analysts, are psychologists are given some of the most responsibility, but then are given a cut in that rate. Those folks have expertise, additional years of training. Additional years of education. And, they are there on those teams for a purpose, to drive and insure that we are following person centered plans, that the quality of life continues to go up and that we're able to meet the overall goals and expectations of this new regulation. For people--and again, for people to be fully employed in the community, to have full community access and to be involved and have a greater quality of life.

By reducing the rate down to that of a bachelor's level folks, your most qualified individuals to lead that process, your doctoral level folks, your master's level folks, are going to look for employment that is more competitive with where they are.

There's not been an--well, to my knowledge, there's not been a reduction for doctors at ICFMRs. Reduction in psychologists at ICFMRs. For behavior folks at ICFMRs. So, they are going to pay a greater salary.

One thing to remember is that as clinicians we are all--work on billable hours. I don't get a salary. We call--you know, we eat what we kill. You know, when we go out there, and as far as the things that we get. If I get laid up, I don't have money. I average 35,000 miles a year on my car, no one reimburses me for gas. I pay for every single reinforcer that I put into a plan for our individuals, no one reimburses me for that, it comes out of my pocket. I pay for my own health insurance. I don't have a state plan. And, all those things come in, as far as making the decision about whether or not--especially for new--for our existing clinicians that have been doing this for many, many years and have--have extensive more experience. Forty-four percent cut is devastating to them. Actually, it's quite an insult, if you ask me, given the responsibilities that the Cabinet has placed on our shoulders, as we go through and we begin to look at that for new individuals coming in to provide services.

I listened to Commissioner Hall when he spoke before the Kentucky Association of Behavior Specialists where he completely--where he again and again reiterated his commitment to quality behavior services, to increasing the quality of the behavior support providers within this state. Cutting the reimbursement rate almost in half does not put an incentive for the best and highly qualified folks to come in.

That means that folks that may be less qualified that are not as good clinicians will be filling those roles, therefore, lower a standard of quality for our folks.

My recommendation--I realize where we are. We're actually--and I take that back. When I say that we're on par that brought us down to--with bachelor's level folks, we actually do get \$1.38 more an hour than a bachelor's level person.

My recommendation for this is that the upper limit on that be increased to twenty-six fifty a unit, that's \$4 additional a unit. That's a reduction in twenty percent of what we currently are reimbursing at. Again, I understand the state of the economy and those things and understand that, you know, there's only limited dollars. And, I think that's reasonable and I think that that's fair. I think that also gives some incentive for not just bachelor's level folks, but for our masters and our doctoral level folks, the ones, again, with some of the--with the most expensive and the most time consuming education to come in to increase the overall quality of services for the individuals we serve."

(f) Response: According to the United States Department of Labor Bureau of Labor Statistics Occupational Outlook Handbook, the median salary for practicing Psychologists in May 2010 was \$68,640 per year (\$33.00 per hour). This figure seems to be confirmed by various other sources putting the salary range of Clinical Psychologists between \$45,475 (approximately \$22.00 per hour) and \$104,397 (approximately \$50.00 per hour). For comparison's sake, the proposed Kentucky rate of \$90 per hour equates to \$187,200 per year and the quoted existing rate of \$155 per hour equates to \$322,400 per year.

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The proposed rate for psychological services in the SCL waiver is still significantly higher than the reimbursement rates in contiguous states. The rate should allow providers to easily cover reasonable wages for psychologists, reimburse travel expenses, and generate a significant contribution toward their fixed costs.

(5) Subject: Consultative Clinical and Therapeutic Service Limit and Reimbursement

(a) Comment: Steve Zaricki, president of the Kentucky Association of Private Providers and executive director of Community Living, and Jenifer Frommeyer, executive director of Dreams With Wings and mother of a child with Down syndrome, requested that the rate for one unit of CCT services to be increased to “\$26.50 so that there is only a twenty percent reduction in the reimbursement rate for behavioral specialists.”

Jenifer Frommeyer, executive director of Dreams With Wings and mother of a child with Down syndrome, and Steve Zaricki, president of the Kentucky Association of Private Providers and executive director of Community Living, stated, “Retaining qualified clinicians: Payment for CCT has been reduced to \$22.50 a unit from \$33.25 and \$38.79 unit for behavioral support and psychological services, respectively. This is a 33% and 42% reduction for behavior services and psychological services, respectively. This will make hiring well-educated Master's and Doctoral clinicians very difficult and reduce the overall quality of these services for participants with the highest risks for health, safety, and welfare.”

(b) Response: According to the United States Department of Labor Bureau of Labor Statistics Occupational Outlook Handbook, the median salary for practicing Psychologists in May 2010 was \$68,640 per year (\$33.00 per hour). This figure seems to be confirmed by various other sources putting the salary range of Clinical Psychologists between \$45,475 (approximately \$22.00 per hour) and \$104,397 (approximately \$50.00 per hour). For comparison’s sake, the proposed Kentucky rate of \$90 per hour equates to \$187,200 per year and the quoted existing rate of \$155 per hour equates to \$322,400 per year.

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The proposed rate for psychological services in the SCL waiver is still significantly higher than the reimbursement rates in contiguous states. The rate should allow providers to easily cover reasonable wages for psychologists, reimburse travel expenses, and generate a significant contribution toward their fixed costs.

(c) Comment: David Back, EdS. LPCA expressed that the rate reduction for clinical services “is significant and will negatively impact clinicians.” He recommended that the rate “should be raised to at least \$29 per unit in order to compensate professionals in a manner fairly and in line with other insurance coverages.”

(d) Response: Please see the above response - (b).

(e) Comment: Christopher George, a board certified behavior analyst, a licensed behavior analyst in Kentucky, and executive director of Applied Behavioral Advancements stated the following:

“REIMBURSEMENT

1) This regulation reduces the reimbursement rate for Behavior support professionals by 38% and psychologists by 42% This is a huge reduction in reimbursement rate that places behavioral and psychological services on the same rate as other therapies that only require a bachelor’s degree. Positive behavior support specialists and psychologists have additional education requirements for advanced graduate degrees. This is a discrepancy that provides no incentive for clinicians to seek advanced degrees (i.e. additional time in school and increased student loan debt for the same reimbursement rate for someone with a bachelor’s degree).

2) Most psychologists and positive behavior support specialists are contractors and only receive payment for billable services. In my agency most clinicians average just at 20 hours a week of billable services, due to travel between locations and non-billable requirements (i.e. progress notes, etc). All of their expenses are paid out of pocket and relative to the other therapies do not see clients in a clinical setting where they are able to bill back to back for appointments. This severely limits a clinician’s ability to provide a reasonable income for their families. I have already lost two of my best clinicians who have decided to move out of state due to the upcoming cuts (both in reimbursement rate and available units). I have spoken to several other providers who have clearly expressed that they will stop providing behavioral and psychological services if the regulations are approved without change.

a. QUESTION: Will DDID please provide in writing the rate analysis that was used to justify a 40% (on average) decrease in reimbursement rate for the most highly qualified clinicians?

b. RECOMMENDATION: Please increase the reimbursement rate by \$4/unit from \$22.50 to \$26.50 a unit. This would be only a 20% decrease from current rates which would help the Cabinet to control costs while retaining clinicians with the most advanced educational degrees.”

(f) Response: According to the United States Department of Labor Bureau of Labor Statistics Occupational Outlook Handbook, the median salary for practicing Psychologists in May 2010 was \$68,640 per year (\$33.00 per hour). This figure seems to be confirmed by various other sources putting the salary range of Clinical Psychologists between \$45,475 (approximately \$22.00 per hour) and \$104,397 (approximately \$50.00 per hour). For comparison's sake, the proposed Kentucky rate of \$90 per hour equates to \$187,200 per year and the quoted existing rate of \$155 per hour equates to \$322,400 per year.

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(g) Comment: Jean Russell, vice president of developmental services with Seven Counties Services, Inc., stated, "SCS is very concerned about the limitation of 160 fifteen minute units or 40 hours of service available per year. SCS would recommend 'carving out' the Functional Analysis required to develop a Behavior Support Plan from this limit and reimbursing that activity as a one unit service at the rate of \$900.00 SCS would also recommend that the Behavior Intervention Committee (BIC) have authority to recommend exceptions to this limitation based on consumer needs."

(h) Response: A recommendation from the Behavior Intervention Committee should be a part of the documentation submitted with a request for exceptional supports in the area of consultative clinical and therapeutic supports. Any additional units required for a functional assessment should be determined through the person centered team process and submitted as well.

(i) Comment: Christopher George, a board certified behavior analyst, a licensed behavior analyst in Kentucky, and executive director of Applied Behavioral

Advancements, stated the following:

One of the biggest concerns that I see in this reimbursement rate, we've talked about the reduction in rate for ADTs and for other services.

For behavioral and psychological services, behavior support professionals are taking a thirty-eight percent reduction in their reimbursement rate. The reimbursement rate for psychologists, including doctorate level psychologists is a reduction of forty-four percent of their current reimbursement rate.

Kind of a rhetorical question, I'm really not meaning it to be inflammatory, but is anyone in the Cabinet taking a forty-four percent reduction in their pay in order to implement this regulation?

As we look around, I don't think that there's any one of us here in the room that, as we sit down with our families at night, we talk about the things that we're going to do and our plans for the future and those things, say, hey, mom and dad--or, you know, dad comes home and says, hey, I just--I just took a forty-four percent cut in my salary, devastating. Absolutely devastating.

I understand the state of our economy. I understand the place where we are with taxation and those things and I recognize that. However, the rate has been reduced down from the rates to those that are commensurate with bachelor's level degrees for occupational therapists, physical therapists and speech pathologist. So, we have taken folks--I had two additional years in school to get my master's degree, I had another additional eighteen months of training that I did to become a board certified behavior analyst, that was with additional cost. For our fine doctor standing up here and others of you that may be in the room and going through doctoral level programs and the added expense that is there, the reimbursement that the rate feels is appropriate for you is that of a bachelor's level clinician.

The problem with that is not just the money that comes in and those things and trying to pay off our student loans and doing those things. When you look--and I spoke earlier about the expectations that the Cabinet has for us, to oversee the plans of care, to make recommendations about the overall service delivery, to do things there and have given a great responsibility on us, not only as clinicians in our field and our discipline as behavior support professionals, dietitians too, or psychologists, but also for team management.

The folks with the highest level--the highest requirement of education, are behavior analysts, are psychologists are given some of the most responsibility, but then are given a cut in that rate. Those folks have expertise, additional years of training. Additional years of education. And, they are there on those teams for a purpose, to drive and insure that we are following person centered plans, that the quality of life continues to go up and that we're able to meet the overall goals and expectations of this new regulation. For people--and again, for people to be fully employed in the community, to

have full community access and to be involved and have a greater quality of life.

By reducing the rate down to that of a bachelor's level folks, your most qualified individuals to lead that process, your doctoral level folks, your master's level folks, are going to look for employment that is more competitive with where they are.

There's not been an--well, to my knowledge, there's not been a reduction for doctors at ICFMRs. Reduction in psychologists at ICFMRs. For behavior folks at ICFMRs. So, they are going to pay a greater salary.

One thing to remember is that as clinicians we are all--work on billable hours. I don't get a salary. We call--you know, we eat what we kill. You know, when we go out there, and as far as the things that we get. If I get laid up, I don't have money. I average 35,000 miles a year on my car, no one reimburses me for gas. I pay for every single reinforcer that I put into a plan for our individuals, no one reimburses me for that, it comes out of my pocket. I pay for my own health insurance. I don't have a state plan. And, all those things come in, as far as making the decision about whether or not--especially for new--for our existing clinicians that have been doing this for many, many years and have--have extensive more experience. Forty-four percent cut is devastating to them. Actually, it's quite an insult, if you ask me, given the responsibilities that the Cabinet has placed on our shoulders, as we go through and we begin to look at that for new individuals coming in to provide services.

I listened to Commissioner Hall when he spoke before the Kentucky Association of Behavior Specialists where he completely--where he again and again reiterated his commitment to quality behavior services, to increasing the quality of the behavior support providers within this state. Cutting the reimbursement rate almost in half does not put an incentive for the best and highly qualified folks to come in.

That means that folks that may be less qualified that are not as good clinicians will be filling those roles, therefore, lower a standard of quality for our folks.

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(j) Response: According to the United States Department of Labor Bureau of Labor

Statistics Occupational Outlook Handbook, the median salary for practicing Psychologists in May 2010 was \$68,640 per year (\$33.00 per hour). This figure seems to be confirmed by various other sources putting the salary range of Clinical Psychologists between \$45,475 (approximately \$22.00 per hour) and \$104,397 (approximately \$50.00 per hour). For comparison's sake, the proposed Kentucky rate of \$90 per hour equates to \$187,200 per year and the quoted existing rate of \$155 per hour equates to \$322,400 per year.

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\$54.74	\$71.48	\$37.00	\$40.08	\$57.20

It should be noted that Virginia does offer a payment of \$92.65 per hour for crisis stabilization with significant limitations to the quantity of services which can be delivered.

The current approved hourly rate for psychological services through Impact Plus services for children with significant mental health needs in Kentucky is \$78.40 for services from a psychologist and \$147.00 for services from a psychiatrist.

The proposed rate for psychological services in the SCL waiver is still significantly higher than the reimbursement rates in contiguous states. The rate should allow providers to easily cover reasonable wages for psychologists, reimburse travel expenses, and generate a significant contribution toward their fixed costs.

(6) Subject: Psychological Services/Consultative Clinical and Therapeutic Services

(a) Comment: Dr. Laura Young, a licensed clinical psychologist with Apple Patch in Crestwood, KY stated, "In this amendment, psychological services have been inappropriately combined with those of nutrition and behavior support, under the category of consultative clinical and therapeutic service.

These three very separate disciplines have been given a combined total, a combined total of 3.3 hours per month to serve an SCL client. This 3.3 hour limitation on psychological, nutritional and behavior support services does not allow for the sufficient provision of psychological services for the sub population of SCL clients who are dually diagnosed and in need of those interventions.

In the past year, my case load had included individuals with histories of sexual and physical abuse, suicidal and homicidal ideation, severe depression, grief and loss issues, rape and assault issues, severe anxiety, physical aggression issues, alcohol and drug abuse, system negligence, exploitation and involvement with the court system. Many of these clients must be seen one to two times per week just to remain stable in

the community and to avoid psychiatric hospitalization or ICF/MR placement.

As you know, such placements are far more expensive than community based services. One overnight trip to University of Louisville ER for a psychiatric emergency costs the state \$1,102, this would cover my services for a month.

I work with most of my clients one to two hours a week, three to four hours per week, if the need is severe.

On eleven of my fifteen current cases, I work closely with behavior specialists who initially require one to three hours per week for behavioral monitoring, training of residential and day program staff, direct communication with the client and consultation with other members of the team.

We cannot coexist effectively with 3.3 hours of combined service per month. Neither of us will be able to get our job done and the client will suffer, increasing the risk of hospitalization.

For example, I currently work with one severe client four hours per week in order to help her maintain her community placement. I share this client with a behavior support specialist who works with her team two additional hours per week, for a total of twenty-four hours of service provision per month just to keep her stable. Without this intense level of services, she would quickly end up in an ICF/MR.

Our psychological and behavior support services costs a maximum of \$3,536 per month under the current regulation. It is worthy to note that one month, one month of room and board at the Bingham Gardens ICF/MR, costs the state \$35,550, this includes no mental health services. Weekly individual therapy in the ICF/MR adds another \$1,148 to the bill, that is, if you can find someone who actually has the time to provide the service in the ICF/MR. Now, we're billing the state \$36,698 per month.

Funding all of the client's psychological and behavioral services through the SCL waiver program saves the state a minimum of \$33,162 a month while giving the client a much better quality of life.

Why do you plan to take the majority of these services away? Why would you make it extremely difficult to get additional psychological intervention services through the exceptional client protocol? It makes no financial sense for the state of Kentucky or therapeutic sense for my client.

If the goal is to deinstitutionalize developmentally disabled adults and increase community placement, this new waiver will work in direct opposition of our goal.

If the goal is to save the state money on client services, this new waiver will work in direct opposition of our goal.

Speech therapists, physical therapists and occupational therapists are being allowed up to thirteen hours per month to provide their therapy services. They do not necessarily use all these hours, but they are given the professional discretion to make clinical judgments about their client's level of care and to provide their services accordingly.

Why would psychologists not be given the same discretion to make clinical judgments about their client's mental health needs? Needs that are far more likely, if not adequately addressed, to cause the client to be moved from their community living situation, to an institutional setting.

This proposed SCL waiver amendment will severely hinder the multi disciplinary treatment team approach, which was designed specifically to keep these fragile individuals out of ICF/MRs, state hospitals and psychiatric hospitals.

For individuals with dual developmental and intellectual disabilities and mental health diagnoses, this amendment will likely sabotage their ability to remain in the community.

It is problematic to lump psychologists, nutritionists and positive behavior support services into one category of intervention and service units with a very low number of service hours available.

While psychological services and positive behavior support services are quite different, they must co-exist where needed to maintain client stability in the community.

Psychologists provide intensive therapy services for SCL clients who are dually diagnosed to help them learn how to deal with emotional behavioral issues as well as inner personal dynamics.

Behavior supports focuses specifically on behavioral issues. They create behavior plans, train residential and day program staff on these plans and monitor client behavioral responses.

Behavioral support providers are not trained to provide individual and/or family therapy for any diagnoses, to assess for suicidal ideation, to work with clients on inner personal conflicts or grief issues or to provide psychological assessment services.

Obviously, a nutritionist is not trained to deal with any of the issues described above. Why would nutritionist services ever be included in a category with mental and behavior health services?

Psychologists offer so much to the SCL waiver program to improve client outcomes. We are more likely to be involved in cases of extreme social, emotional and/or behavioral problems when teams really need help and other providers cannot resolve the client's difficulties.

Psychological services are not an overused service in the SCL waiver program and,

thus, do not need heightened regulation to manage the cost of our services, quite to the contrary, we save the state thousands of dollars each year by keeping severely emotionally and behaviorally disturbed clients out of the ICF/MRs, state hospitals and psychiatric hospitals.”

(b) Response: Consultative clinical and therapeutic Service (CCTS) as written in the waiver and the proposed regulation allow participants the choice of selecting from a wider array of trained clinicians who are certified or licensed by the State. The previous waiver allowed only for these services to be offered by certified or licensed psychologists or those meeting criteria for behavior specialist, which does not require a certification or license. CCTS as they are proposed, enable a participant to utilize the services of a licensed or certified psychologist, counselor, dietician or nutritionist. The service of a behavior specialist may also be utilized. The services of each of these professionals may be used alone or in combination with other services listed.

The service was written to allow more freedom for the clinician because they may bill for providing training and technical assistance to paid and unpaid caregivers in addition to being able to create in-home treatments/support plans with the ability to monitor implementation and progress. The new service definition allows participants to have improved access to certified and licensed psychologists. Based upon the current regulatory definition, a participant can receive psychological services “only when the needs of an individual cannot be met by behavior modifications or other home and community based waiver services, shall the individual receive psychological services.”

Within the proposed regulation and the manual incorporated by reference, there is an Exceptional Supports Protocol which allows participants with intense behavioral, psychiatric and/or medical needs to request an increase in rates or units based on justified need.

(c) Comment: Dr. Laura Young stated, “Appendix F is the Kentucky Exceptional Support protocol. I had not read it until today. In this protocol in order to get additional psychological services, we are thrown in the same boat with behavior support, which I think is inappropriate, once again, for psychologists. If you look at No. 6 on Page 9 of the supports for community living policy manual, No. 6 states, requests for exceptional supports, based on the exceptional psychiatric or behavioral support needs of the participant must also include the following: A, documentation of completion of the expanded requirements for direct support professional, DSP credentialed in the area of positive behavior support. This has nothing to do with psychological intervention services.

B, documentation of the provider's ability to support people with exceptional psychiatric or behavior support needs, which may include implementation of specialized programs, established arrangements with network of community supports. This documentation pertains to a provider's overall or system wide capacity to provide these types of supports. I have my doctorate in clinical psychology. If that does not say enough about my ability to provide psychological intervention services, I don't know what will.

This has nothing to do with the service I provide.

C, a functional assessment and any supports developed based on that assessment, to include a positive behavioral support plan. This has nothing to do with psychological services. I don't do a functional assessment, when I see my clients for psychotherapy.

D, any notes from HRC and BIC for plans reviewed. Psychologists don't go through that process.

E, the form of communication utilized and as appropriate specified communication techniques, use of technology. Include a description of efforts toward functional communication.

F, quantitative data in the form of frequency, rate or duration should be provided for each target behavior identified in the positive behavior support plan. Once again, this has nothing to do with psychological intervention services.

If we are going to have Appendix F with an exceptional support protocol that addresses what I do with my clients, we need an entire section written that addresses how we get extra psychotherapy services, because not all of my clients have behavioral issues.

I have clients who have been raped. I have clients who are drug and alcohol addicted. I have clients who lose their parents and they are grief stricken and they become suicidal. That's not a part of a behavior support plan. This needs to be rethought."

(d) Response: DMS is revising the exceptional support protocol via an "amended after comments" regulation to accommodate circumstances when the individual needs increased behavioral health services.

(e) Comment: Christopher George, a board certified behavior analyst, a licensed behavior analyst here Kentucky, and executive director of Applied Behavioral Advancements, which provides services to over 300 people through the SCL waiver, stated, "Looking specifically at the role of the clinical--consultative, clinical and therapeutic service. Great title, put some things in and stuff. This is to be shared by about ten different clinicians, including a nutritionist, dietitian, marriage and family therapist, practical nurse, professional clinical counselor, psychological associate, licensed psychologist, psychological practitioner, licensed social worker, positive behavior support specialist. Those can kind of--those ten groups can be summarized into kind of dietary, behavioral and mental health issues.

What is interesting though is that in all three of those disciplines, they operate separately. They address different issues related to a person's well being and overall quality of life. Dietitians look at their overall health. Counselors, other mental health professionals there are looking at mental health issues and things that may be related to an axis one diagnosis. Behavior support professionals, we go in and actually help to train the individuals that support the people with the most severe things about, how to

interact with them, how do--how to start, you know, decreasing problematic behaviors. But, we not only do that, we increase the appropriate behaviors that people need. That may be job skills, that may be, you know, other social skills that are related in order for them to be a good, strong participant in the community and achieve the overall goals of this proposed regulation.

In looking at the duties for these folks, professional consultation, evaluation assessment of the participant, the environment and the system of support and written summaries and recommendations. That's a lot of things to assess. Okay? And, given--I know my folks have already done a very good job of representing that this is to be accomplished in forty hours a year. Providing treatment that's consistent with assessment results and diagnosis, evidence based or current best practice encompasses psychological treatment or counseling as indicated by the condition of the participant.

So, under clinical and consultative services it says that it must be provided treatment as consistent with assessments results in diagnosis. However, as a clinician, if I provide an assessment and a diagnosis and evidence based practice and I say, I need this number of units and things in order to successfully treat this, in line with the second part there evidence based practices and current best practice. But, those will be denied, because there is a cap on the limits for those services.

Other things that we're required to do. Coordinate program wide support participating a development of home treatment support plans, providing training and technical assistance to carry out recommendations, monitoring, completing a functional assessment, monthly service notes, documentation. Again, all of that's to be provided in forty hours.

When we look at the options and certainly I know that they Cabinet may come back and say that there's an exceptional rate protocol that is in place that will allow those with the most severe problem behaviors and mental health issues to get additional services. But, what about the individual that does not meet the criteria as set forth? And, I will state that I do believe that that protocol does need to be specified, as far as what the requirements are, what things are going to hit that, because what happens to the person who, because of their SIS, their HRC and those things, doesn't qualify for those. Suddenly their opportunity to access services that they may need, if they need a counselor for a short period of time or maybe for an ongoing period of time. If because of obesity and they say, you know, I'd really like to lose some weight, I'd like a dietitian. But, you know what, I'm already seeing a counselor, so I can't really lose weight. Unless they hit that exceptional rate protocol, they're choices are limited."

(f) Response: In the SCL waiver and proposed regulations, we have moved to practicing a more person-centered team process. The person centered team, which should include the professionals who have conducted evaluations and made recommendations for consultative clinical therapeutic services, will determine what services and supports are necessary for the participant across the array of available services. This will include taking into consideration any short- or long-term supports and the

level/intensity/frequency of those supports. As the team develops the plan of care (POC), they may submit a request for exceptional supports if the participant's needs exceed the annual limits. A request may also be made if the team projects that additional service units will be needed to achieve designated outcomes, such as short-term counseling or accessing a dietician in order to lose weight.

Utilizing the team approach and focusing on what is important for the participant in context to what is important to the participant alters the practice of service providers implementing on-going services/supports in isolation. This process gives the participant an increased opportunity to seek a more personal, meaningful and fulfilling life. Any time throughout the year a provider of consultative clinical therapeutic services determines additional units of support are warranted, the team should reconvene to consider the clinician's recommendations, determine any amendments that might need to be made on the POC, request exceptional supports based upon the revised POC, and submit the request for exceptional protocol to DBHDID as outlined in the SCL Policy Manual.

(g) Comment: Regarding documentation requirements for consultative clinical and therapeutic services, Christopher George stated, "As far as looking at the documentation, I will say that one of the new requirements in this is that a monthly service note is completed. Again, we get three hours a month under that current cap right there. We have to write a service note for every time that we provide a service. So, if I see someone one day, I have to write a detailed note for that. A monthly service note at the end of the month is redundant, it is in excess and is something that I request be removed from the current regulation.

(h) Response: DMS is removing the requirement for licensed or certified professionals to write a monthly summary from 907 KAR 12:010 in an "amended after comments" version of 907 KAR 12:010.

(i) Comment: Regarding the limit on consultative clinical and therapeutic services, Christopher George stated, "Just to give kind of perspective as far as where we're operating. Right now, for most folks, okay, for any participant within the SCL, their available options for behavioral and psychological services. Okay? They can have up to 624 units of behavioral monitoring services per year under the current regulation. In addition they can access up to 624 units for psychological services under the current regulation. That is a combined total of 1,248. This new proposed regulation reduces that from 1,248 to 160, that is a ninety-eight percent reduction in available services for individuals with the most problematic behaviors and the things that most--are most likely to prevent that individual from being a full participant. And, again, accessing and achieving the goals that the new regulation overall is trying to move us forward in supported employment, in community integration.

This cap needs to be removed, it needs to be based upon the clinical assessment of those who have the education and the experience and the expertise in working with those to say, these are the units that we need. We should be held accountable. But,

that--it should not be an arbitrary cap to insure that clinicians--that some clinicians who may not be operating with an ethical scope of practice and giving themselves more than they need. Okay?

But, we have processes in place. We have a certification review. We have review by our area administrators. The monitoring of those services should be sufficient.

As a clinician, I should be able to say, these are the units that I need, this is how I'm going to use these units and I should be accountable to using those units that way. That is my code of ethics as a board certified behavior analyst and a licensed behavior analyst. I do not need a regulation to say, you only get forty hours a months in order to determine how that is—a year excuse me.

Oh, one other issue that I want to bring up, and it's not clear and I know that this has happened in other states. That's an annual cap on units. Okay? So, if I have an individual who does not meet exceptional rate protocol and so they are, therefore, limited to 160 units per year, if that individual is with a particular provider providing behavior supports or those things or psychological service, any of those listed under the CCT, if for some reason that team becomes--says that those services have been ineffective, that they have not reached the goals, and they choose--and they decide that they are going to go with another service provider in order to provide those behavior or psychological services. If those 160 units have been utilized by someone who was not effective, at that point, when they come to the new provider, there are no units to remediate the poor clinical services that have been provided to provide for those individuals to have ongoing supports.

In looking at that annual cap, in addition to the things that are listed, specifically, for CCT. In another part of the regulation it discusses the fact that the person center coach must be supervised by the positive behavior specialist. Supervision--right now my agency--and we have master's level clinicians and board certified behavior analysts, I spend four hours a month in clinical supervision myself with master's level folks. The--the person centered coach, of whom we are to supervise has a high school diploma. If I require four hours, and that's just--that's not billable time, that's just me personally for a standard of excellence. Okay? However we choose supervising, get someone with a high school diploma to proficiency to perform the duties that they are required to do. Let's talk about person centered coaching for a second. Person centered coaching must be independent of the residential or day program where those services are provided. That means that if an individual is at a particular residential agency and there's a determination that a person centered coach needs to help support them in order to fulfill their goals on their plan of care. They cannot come from within that agency. However, behavioral services and psychological services could come from within that same agency.

So, as a clinician, if I said that I needed that, someone from another agency, would just send me someone. That relationship between the clinician and the therapist is critical. Okay? That needs to be a role and we need to have freedom to choose the person

centered coach that is going to be best. Maybe I want to choose someone to be the person centered coach that worked one on one in that individual's house for years and currently has another position, I should be able to hire them in. We need to remove the provision that they be independent of the residential or training provider.

They must be supervised by the positive behavior support specialist. If that individual --if the individual has chosen that they want to receive counseling services or psychological services, and they use those with their 160 units a year in order to receive those services. If at that time--but, the provision here is for the behavior support specialist to supervise that person centered coach. I am not ethically allowed to--ethically allowed to supervise someone that is under the diagnosis of implementing clinical or counseling, psychological services. So, the wording there needs to be that they will be supervised by one of those folks, because remember, there's ten folks listed that can provide the CCT. So, someone in addition to, that if it was chosen, if there was psychological services were the primary service and we needed to have a person centered coach, that the psychologist would be the person that was supervising them. Again, we need to have written in and have provision to have the units necessary, not only to provide the services that we do as masters and doctor level clinicians, but also to supervise the person centered coach with a high school diploma.

David Back, EdS. LPCA, with Homeplace Support Services also expressed concerns about the cap. He indicated that based on his experience the 160 units will expire "fairly quickly during the year (certification year); given my clients often have dual diagnoses and require both behavioral and psychological services" and asked "how can I ethically stop treating the client once the units expire?" He also indicated that having psychological and behavioral services under the same umbrella will place the "two services at odds, as the client who benefits from both will be forced to making a choice early in process as to which service will be terminated." He recommends no cap and that behavioral and psychological services be separated.

Jenifer Frommeyer, executive director of Dreams With Wings and mother of a child with Down syndrome, stated, "Consultative Clinical and Therapeutic Services are required to perform the following duties: Assessment and diagnosis on evidenced based or current best practice, coordination of program wide supports addressing assessed needs, participation in the development and revisions of support plans, training and technical assistance in carrying out recommendations and plans, monitoring of the fidelity of collected data in all settings where the plan is implemented. The payment caps on units to be used is 160 per year (240 per year for exceptional rate). These duties CANNOT be provided in line with ethical and best practice standards in only 40 hours per year. A good best practice Functional Assessment currently takes 10 hours before monitoring, development of a plan, or training begins. Therefore 1/3 of the total available units would be utilized on assessment alone. This regulation prevents this service from providing best practice services to the clients with the greatest barriers to their health, safety, and welfare."

(j) Response: The requirement for a person centered coach to be independent of the

service provider ensures that the participant's plan of care is effectively implemented utilizing person centered planning strategies and techniques and barriers are identified which challenge the success of the participant in achieving their plan of care goals.

The requirement for supervision of the person centered coach has been revised to require that the person centered coach work under the direction of the positive behavior specialist or other licensed professional.

In the SCL waiver and proposed regulations, we have moved to practicing a more person-centered team process. The person centered team, which should include the professionals who have conducted evaluations and made recommendations for consultative clinical therapeutic services, will determine what services and supports are necessary for the participant across the array of available services. This will include taking into consideration any short- or long-term supports and the level/intensity/frequency of those supports. As the team develops the plan of care (POC), they may submit a request for exceptional supports if the participant's needs exceed the annual limits. A request may also be made if the team projects that additional service units will be needed to achieve designated outcomes, such as short-term counseling or accessing a dietician in order to lose weight.

Utilizing the team approach and focusing on what is important for the participant in context to what is important to the participant alters the practice of service providers implementing on-going services/supports in isolation. This process gives the participant an increased opportunity to seek a more personal, meaningful and fulfilling life. An time throughout the year a provider of consultative clinical therapeutic services determines additional units of support are warranted, the team should reconvene to consider the clinician's recommendations, determine any amendments that might need to be made on the POC, request exceptional supports based upon the revised POC, and submit the request for exceptional protocol to DBHDID as outlined in the SCL Policy Manual.

(k) Comment: Amber Durham, a licensed behavior analyst with Applied Behavioral Advancements, stated, "I have served some of the most awesome people in the state with some of the most eccentric and interesting behaviors that are out there. Not all of them have been in crises. Not all of them have been this emergency situation that have had to been addressed. However, a lot of that lies in having some really good proactive and prevention strategies in place. And, just giving people a few choices in what they want to do that day can alleviate all kinds of behaviors that can happen down the road.

A lot of my time is spent, not only in monitoring, but in training the individuals who work with our participants. My concern with the cap that you guys are referring to in those regulations is having the time that is necessary to train the staff who are going to be working with these participants and making sure that they are covering those things up front so they don't have those behaviors in the long run, so it doesn't become an emergency, it doesn't become a crises.

So, with all that being said, you know, we've got this exceptional rate and all these

things and the regs are going to allow for us to ask for more units and all these things, that's--that's all well and good, given we're given--you know, we know the time frame on that and we can get in there and do what we need to do. My concern is for those folks who aren't necessarily in crises at that moment, but they will be, if those prevention strategies aren't trained on.

CLS staff, those of you who work with CLS staff, they're wonderful, but there's a high turnover rate. I might go in and train somebody, the next week I go and check in, oh, they got a new CLS staff, somebody else needs to be trained. So, there's a lot of that going on. In addition to that the person centered coaches that are going to be coming in, they're also going to have to be trained. The SCL waiver is going to allow for CLS staffing as well, they're going to have to be trained, there goes my units for the year. So, when the next person comes in, they haven't been trained, then all of a sudden, we've got a big old crises because they don't know what the prevention strategies are that are supposed to be in place for these people.

In addition to that, I'm wondering where our liability lies as clinicians? I know what my ethical responsibilities are and that is to step in and handle crises as necessary, because it's always client first. I'm wondering how much responsibility and liability is going to fall on the state for putting these regulations in place and for the folks who go in and say, oh, well, I've already put in my units for the year, sorry, figure it out and then it's our clients who suffer.”

Amanda Rupert, behavior analyst with over 12 years in the field of psychology and over 10 years in service to individuals with intellectual/behavioral disabilities, and concerned citizen, stated the following:

“HEALTH: The proposed changes greatly impact the overall health of each and every client in need of behavior supports. Particularly, fewer units and monitoring of the Behavior Support Plans by individuals with no procedural knowledge of Applied Behavior Analysis will undoubtedly lead to decreased physical and mental health of clients. I could give you a thousand case examples from my own clinical experience; however, I believe that a few examples in this area should suffice.

I have a client that is morbidly obese. Without behavior supports, this individual would likely die from complications arising from eating behavior. Behavior supports focus on supportive ways to ensure his health. This individual is prone to depressive behavior as well. Under my careful and ongoing guidance, direct support staff have learned positive ways to interact with him in order to decrease his depressive and overeating behavior. Without it, negative comments about his weight only made him want to eat more and become highly withdrawn. He is now healthy and happy and has recently obtained access to more fulfilling activities such as playing basketball. This was something he could not do prior to my involvement.

Another client has Type II diabetes. Under my guidance, staff have increased her behavior of checking sugar levels and eating more diabetic-friendly foods. Just like the

individual described above, this woman's health would be significantly affected by a lack of behavior supports. This would result in increased doctor's visits and hospitalizations for her.

Finally, I have a client that showed significant behavioral decline. Using the data, I presented information showing increased rates of aggression, verbal disruption, and social withdrawal to the team. I recommended medical treatment for this person. Staff reported that he had severe behavior problems when at the doctor and would often refuse to go. Under my guidance, he was able to go to the doctor several times with no problems. It was found that he had extremely low levels of oxygen in his bloodstream. Treatment resulted in a completely new individual; fully integrated with his friends and staff.

With all due respect to other professions and a complete understanding of the need for integrated care, Applied Behavior Analysis is the **only** empirically-proven treatment for behavioral issues including the ones described above. To decrease units/access to direct client care will only result in increased doctor's visits and general decline in physical functioning for all clients and an increase in monetary expenditures for the state in regard to medical treatment.

SAFETY: In addition to the above-mentioned issues, a lack of behavioral supports/implementation by untrained individuals will result in increased safety risks. Again, a **typical** case example may provide the necessary data for persuading you of the extreme need for behavior supports. As I have stated, this case is not an anomaly. It is the norm. I have one client that has eloped from a staffed residence and threatened to jump off a bridge. She has done this several times in which there has commenced searches with helicopters, police, and entire communities. She ended up being found each time and has been placed in the hospital, overnight, psychotropic medications have been increased, and medical inquest warrants have been issued. She has typically been placed in a psychiatric facility long term (up to several months). For her safety, the state pays \$900 per day to keep her there.

Since taking the case, I have trained all team members on how to prevent these behaviors. She has not engaged in challenging behaviors since training. I would add that "training" consisted of three months of small successes before her parents were completely on board. It required several late night phone calls, emails, and meetings (Probably totaling 40 or more hours beyond the initial training), before parents decided to implement the behavior plan and strategies that met their needs could be developed. This process is normal. In order to change a client's behavior, we must change caregivers' behavior. They have exhibited inappropriate caregiving/parenting behaviors for 20+ years and it does not change overnight. We must develop behavior plans for the parents and staff in order to shape their behavior for the benefit of the client's safety and well-being.

Clearly, you can see that the monitoring units provided by the proposed changes to SCL waiver will not suffice in addressing required behavior change. The result of this action

will undoubtedly be strain on psychological services, law enforcement, psychiatric services, and institutions. Consider how this will affect each and every client. Access to the world will basically be shut off. There will be an increase in safety—related issues.

Also consider how an increase in the services listed above will affect the safety/health/finances of the State of Kentucky. Remember that this is only a list of increased short-term expenditures (i.e. police, hospital admissions, medications). The long-term expenditures are innumerable but include increased stays in psychiatric hospitals, jails, and staffed residential homes (rather than at home with family). We spend millions on psychotropic medications, but you are proposing to cut services that could aid in the decrease of medications that negatively impact behavior and thus, safety, health, and welfare. This equates to medication prescription with no therapy; yet, the liability continues to lie with the Behavior Analyst. I understand the financial strain of government. HOWEVER, this is the most disadvantaged population in Kentucky. An increase in Behavior Supports has already and will continue to decrease long-term expenditures in Kentucky.”

(l) Response: Within the proposed regulation and the manual incorporated by reference, there is an Exceptional Supports Protocol which allows participants with intense behavioral, psychiatric and/or medical needs to request an increase in rates or units based on justified need. The participant and their team will know prior to development of the annual Plan of Care if they are in need of exceptional supports due to chronic or enduring issues based upon the assessment required in the new regulation, the Supports Intensity Scale (SIS). Individual results of the SIS, which are based upon normative data, will alert the participant and the team of high intensity support needs, especially in the areas of behavioral, psychiatric and medical needs. As the plan of care is developed, a request for exceptional supports can be made.

(m) Comment: Steve Zaricki, president of the Kentucky Association of Private Providers and executive director of Community Living, stated, “increase the cap of the consultative and other services to 240 units annually. This would give ten hours of assessment, one hour per week, on average, for the year.” Jenifer Frommeyer, executive director of Dreams With Wings and mother of a child with Down syndrome also requested that the cap be increased to 240 units annually for the same reasons cited by Steve Zaricki.

(n) Response: Units above the 160 unit cap can be requested through the exceptional supports protocol.

(o) Comment: Steve Zaricki, president of the Kentucky Association of Private Providers and executive director of Community Living, stated, clarify that there is no upper limit under the exceptional rate protocol for CCT or person centered coaching.”

(p) Response: The unit limit under the exceptional support protocol will be determined based on documentation submitted by the provider to justify need for the service.

(q) Comment: Dr. Adreanna Bartholome Spears, a licensed clinical psychologist stated,

“One comment I would like to make on that is about the wording. As Chris pointed out, this is a catch all category for almost a dozen different services. One of the big problems with that is that it doesn't specify, under the guidelines, what applies to behavior support, what applies to nutrition services, what applies to a licensed clinical psychologist.

As I read through the regulations I was very confused trying to figure out if I was supposed to be writing an assessment for an individual or if that just applied to a behavior specialist. Although we work very closely together, the psychologist and the behavior specialists do, our services are very distinct in their delivery and they should be treated as such. And, the way the regulation is written it dismisses the needs of those that are dually diagnosed and assumes that most of them will just be getting behavior support services. Doctor Young talked about the importance of keeping those two services separate and why. So, I'm not going to go into my lengthy explanation of why we need psychologists and behavior specialists.” Dr. Bartholome also stated, “The wording of the proposed regulation implies that Licensed Clinical Psychologists and Behavior Analysts are meant to focus as ‘technical assistants’ rather than as clinicians.”

(r) Response: In the SCL waiver and proposed regulations, we have moved to practicing a more person-centered team process. The person centered team, which should include the professionals who have conducted evaluations and made recommendations for consultative clinical therapeutic services, will help determine what services and supports are necessary for the participant across the array of available services. This person-centered process will include short- or long-term supports and the level/intensity/frequency of those supports. As the team develops the plan of care (POC), they may submit a request for exceptional supports if the participant's needs exceed the annual limits. A request may also be made if the team projects that additional service units will be needed to achieve designated outcomes, such as short-term counseling or accessing a dietician in order to lose weight.

Utilizing the team approach and focusing on what is important for the participant in context to what is important to the participant alters the practice of service providers implementing the same services/supports in isolation. This process gives the participant an increased opportunity to seek a more personally meaningful and fulfilling life. Any time throughout the year if a provider of consultative clinical therapeutic services determines additional units of support are warranted, the team will reconvene to consider the clinician's recommendations, determine any amendments that might need to be made on the POC, request exceptional supports based upon the revised POC, and submit the request for exceptional protocol to DBHDID as outlined in the SCL Policy Manual.

The consultative, clinical and therapeutic service was written to allow more freedom for the clinician to provide training and technical assistance to paid and unpaid caregivers in addition to creating in home treatments/support plans with the ability to monitor implementation and progress. With the proposed new service definition, participants have improved access to certified and licensed psychologists. In the current regulation,

a participant can only receive psychological services when the needs of an individual cannot be met by behavior modifications or other home and community based waiver services.

(s) Comment: Dr. Adreanna Bartholome Spears, a licensed clinical psychologist stated, "Due to the limitation of 160 units per year, the proposed changes would inevitably, in many cases, force a client to choose between psychological and behavior support services. Although there are some clients in need of only psychological or behavior services, the proposed amendment disregards the needs of the dually diagnosed individuals (i.e. individuals with an intellectual/developmental disability and with a mental illness). Based on the needs of the clients I have provided services to over the past five years, 40 hours per year would be insufficient and ineffective for treating the symptoms of a mental illness."

Dr. Bartholome also stated, "As a Clinical Psychologist, I am ethically obligated to abide by the code of ethics and the Kentucky Revised Statutes as they apply to psychologists. The code of ethics states, 'Psychologists strive to benefit those with whom they work and take care to do no harm. In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally.' In an effort to safeguard the welfare of a client, a psychologist should not provide psychotherapy services that are insufficient to adequately address the needs of the client. Under the proposed regulations, the limited number of units available for Consultative and Clinical Therapeutic Services will result in a failure to provide professional and quality services. As the proposed regulations stand, I will no longer provide behavior support services due to the risk of malpractice."

(t) Response: The standard cap on units was put in place based on past average usage. In the SCL waiver and proposed regulations, we have moved to practicing a more person-centered team process. The person centered team, which should include the professionals who have conducted evaluations and made recommendations for consultative clinical therapeutic services, will determine what services and supports are necessary for the participant across the array of available services. This will include taking into consideration any short- or long-term supports and the level/intensity/frequency of those supports. As the team develops the plan of care (POC), they may submit a request for exceptional supports if the participant's needs exceed the annual limits. A request may also be made if the team projects that additional service units will be needed to achieve designated outcomes, such as short-term counseling or accessing a dietician in order to lose weight.

Utilizing the team approach and focusing on what is important for the participant in context to what is important to the participant alters the practice of service providers implementing the same services/supports in isolation. This process gives the participant an increased opportunity to seek a more personal, meaningful and fulfilling life. Any time throughout the year if a provider of consultative clinical therapeutic services determines additional units of support are warranted, the team will reconvene to consider the clinician's recommendations, determine any amendments that might

need to be made on the POC, request exceptional supports based upon the revised POC, and submit the request for exceptional protocol to DBHDID as outlined in the SCL Policy Manual.

(u) Comment: Jessika Vance-Morgan, MS BCBA and board certified behavior analyst, expressed much concern regarding the reduced limit on behavioral services and provided background information about her approach and the amount of time she currently spends with clients and the amount of service they need. She also addressed the benefits of her clients and stated, "There is something powerful in teaching a client specific skills that will assist them to independently use the bathroom so they no longer require an adult changing garment or one-on-one staff assistance in the bathroom. These changes revolutionize the the quality of life for each of my clients."

She stated, "As I read over the proposed regulations, I quickly realized that the quality of service that I have provided each and every client during the last 3 years would no longer be available to my clients from me. I realized that if these regulations pass, the time spent with my client will reduce to 3 hours per months, which is much less than the 3 hours per week that my clients and their caregivers have previously benefited from. I understand that these new regulations propose that a 'person centered coach' fill the void that is created through the absence of a behavior specialist's presence, but I wonder how a high school graduate will have the immediate skills to reduce problematic behaviors and increase appropriate replacement behaviors. It took me 2.5 years in graduate school and another 2 years of graduate certifications to learn the skills necessary to provide empirically based services. Other questions that arose as I read through the regulations . . . how will I explain to caregivers that I can no longer provide the quality direct instruction that I was previously providing? What about my clients whom I have started to acquisition toward independent living skills? Who will pick up where I left off and continue to teach these individuals how to functionally communicate or engage in independent hygiene behaviors? When a client engages in dangerous and pervasive behaviors, whom should their caregiver call? If I am not able to provide these direct services, will my client end up in police or institutional care? How will my client obtain unrestricted access to their community if my services to them are reduced by 9 hours per month? Why has outside service providers, such as occupational therapists, received so many more hours per month of service time? Why would an occupational therapist receive 45 units per month, when I have only received 160 units per year? Much of the time, my clients are not even candidates for outside therapies until they have received behavioral services for some time. Clients who are physically aggressive, verbally aggressive, or engage in self-injurious behavior are often dismissed from clinics and treatment centers who provide these occupational or physical therapies.

I propose that a standard cap per client is removed from the regulations. Instead, I urge this committee to develop a person-centered approach to each person's behavior service plan. I would recommend that behavior intervention committees be reformatted and given the material necessary to critically review each client's behavior support plan and determine how many hours/units a behavior specialist would need in order to successfully reduce a client's problematic behaviors and increase appropriate

replacement behaviors. These committees would be responsible for overseeing a behavior specialist's data, monthly notes, and caregiver reports. A behavior specialist would report directly to this committee and would create a service-fading plan that would be monitored and enforced. This committee would abide by the guidelines produced by the behavior Analyst Certification board, which outlines what treatment for individuals with developmental disabilities should look like. The focus would be on addressing multiple treatment targets, and prioritizing a client's need across behaviors that may threaten the health and safety of themselves or others, behavior disorders that may be a barrier to one's ability to remain in least restrictive setting, and absence of developmentally appropriate adaptive, social, or functional skills.

A change in the SCL waiver does not need to become a decrease in the quality of services for my clients with intellectual and developmental disabilities. These individuals deserve as much as I can provide for them.”

(v) Response: The standard cap on units was put in place based on past average usage. In the SCL waiver and proposed regulations, we have moved to practicing a more person-centered team process. The person centered team, which should include the professionals who have conducted evaluations and made recommendations for consultative clinical therapeutic services, will determine what services and supports are necessary for the participant across the array of available services. This will include taking into consideration any short- or long-term supports and the level/intensity/frequency of those supports. As the team develops the plan of care (POC), they may submit a request for exceptional supports if the participant's needs exceed the annual limits. A request may also be made if the team projects that additional service units will be needed to achieve designated outcomes, such as short-term counseling or accessing a dietician in order to lose weight.

Utilizing the team approach and focusing on what is important for the participant in context to what is important to the participant alters the practice of service providers implementing the same services/supports in isolation. This process gives the participant an increased opportunity to seek a more personal, meaningful and fulfilling life. Any time throughout the year if a provider of consultative clinical therapeutic services determines additional units of support are warranted, the team will reconvene to consider the clinician's recommendations, determine any amendments that might need to be made on the POC, request exceptional supports based upon the revised POC, and submit the request for exceptional protocol to DBHDID as outlined in the SCL Policy Manual.

(w) Comment: Guardian Community Living indicated that the cap on access to professional mental and behavioral health services “appears to be discriminatory and a significant step backward.” They indicated that individuals with developmental/intellectual disabilities “experience a higher incidence of mental and behavioral health diagnoses than the general population” and that “there is a shortage of mental and behavioral health professionals who are trained and willing to support this population.”

Guardian Community Living also indicated that “professionals who support this population successfully must provide more coordination and training to nonprofessionals than those professionals supporting the general population” and that “capping these services increases administrative burden on professionals.”

They also stated, “When these types of services are capped, there is no parity between access to mental health service and medical services, further stigmatizing the dually diagnosed.”

(x) Response: In the SCL waiver and proposed regulations, we have moved to practicing a more person-centered team process. The person centered team, which should include the professionals who have conducted evaluations and made recommendations for consultative clinical therapeutic services, will determine what services and supports are necessary for the participant across the array of available services. This will include taking into consideration any short- or long-term supports and the level/intensity/frequency of those supports. As the team develops the plan of care (POC), they may submit a request for exceptional supports if the participant’s needs exceed the annual limits. A request may also be made if the team projects that additional service units will be needed to achieve designated outcomes, such as short-term counseling or accessing a dietician in order to lose weight.

Utilizing the team approach and focusing on what is important for the participant in context to what is important to the participant alters the practice of service providers implementing the same services/supports in isolation. This process gives the participant an increased opportunity to seek a more personal, meaningful and fulfilling life. Any time throughout the year if a provider of consultative clinical therapeutic services determines additional units of support are warranted, the team will reconvene to consider the clinician’s recommendations, determine any amendments that might need to be made on the POC, request exceptional supports based upon the revised POC, and submit the request for exceptional protocol to DBHDID as outlined in the SCL Policy Manual.

(y) Comment: Lili Lutgens, a licensed attorney, licensed clinical social worker and behavior support specialist stated, “In addition, the Cabinet is proposing to limit on a yearly basis CCTS units to 160, that is 40 hours per year or 3.33 hours per month. What’s more, per proposed regulation 907 KAR 12:010 Section 4(17), CCTS service units are to be shared by mental health professionals, PBSSs and nutritionists. Thus there will be competition for these units but a PBSS can’t even begin their job until having been awarded a sufficient number of units to meet the requirements for an FA as stated by the Cabinet in their SCL Policy Manual.

While the case manager, PBSS, involved mental health professionals, and/or nutritionist can request additional units as stated in proposed regulation 907 KAR 12:010 section 4, these exceptional support units are available only in extraordinary circumstances and the method for requesting such units as reflected by the SCL Policy Manual Appendix F

are onerous and time consuming. Thus there is no guarantee that there is payment available for PBSSs to perform a FA as defined by the Cabinet's SCL Policy Manual and required by both the regulations themselves at 907 KAR 12:010 Section 4(17) and the standards of the profession.

What's more, although the definition of PBSS itself fails to document the requirement that PBSSs supervise person centered coaches under the plan, the definition of person centered coach clarifies that such individuals must be supervised by a PBSS.

The term person centered coach (PCC) is defined at 907 KAR 12:020 Section 1(76) to include the requirement to “[assist] a participant and the participant's person centered team in implementing and assessing the effectiveness of the participant's person centered plan of care;” as well as the responsibility to “[train] a participant, family, designated representatives, 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.” The definition clarifies that a PCC must have a high school diploma or GED and two years of experience working with people with intellectual or developmental disabilities or complete 12 hours of college coursework in a human services field.

907 KAR 12:010 Section 4(14)(a)1b clarifies that a PCC “must be supervised by a positive behavior support specialist in the settings where the POC is implemented and through discussions with and observations of the person centered coach implementing the plan and reporting data” This then adds to the duties imposed upon PBSSs under proposed 907 KAR 12:010 again with no express provision for payment.

While the Cabinet can argue that the PBSS assigned to a case may not be the PBSS who actually supervises the PCC, the PCC will be implementing the BSP written by the PBSS actually assigned to the case. In addition, even if the PCC were supervised by another PBSS, say a supervisor within the employing agency, this person would be required to provide the supervision “in the settings where the POC is implemented” and thus this person would be required to work without provision for payment.

Again, the Cabinet may well argue that the units for supervision are also to come from the CCTS units but as noted above, these units are to be used to meet a specifically listed set of responsibilities and are also limited in number and shared by three separate professions. Thus there is no guarantee that there will be adequate compensation to perform the level of supervision required to ensure that the PCC monitors and implements the plan and/or trains other members of the team in a manner that meets the standards of the profession and thus is not negligent.

It is true that many states have adopted a model in which PBSSs and aides, referred to by the Behavioral Analyst Certification Board as behavioral technicians, work together and that under this model the PBSS supervises the technician who is responsible for the routine work with the client and team under the plan. However, typically the PBSS is able to choose the technician with whom they work so that they have the ability to

select technicians who are competent for the job thereby reducing the risk of liability to the PBSS. In addition, the states adopting this model fund the supervision PBSSs provide to the behavioral technicians unlike Kentucky which has failed to ensure payment for this service.

In sum, the definition of PBSS and the requirements placed upon the PBSS by 907 KAR 12:010 and 907 KAR 12:020 are good in that they require individuals providing PBSS services to meet the standards of the profession and provide quality services. However, the failure of the Cabinet to expressly provide payment for drafting a functional assessment as defined in the SCL Policy Manual and the failure of the Cabinet to expressly provide funding for proper supervision of any PCCs working with a covered individual leave PBSSs with one of two choices, work for free or risk malpractice.

If the proposed regulatory provisions regarding PBSSs as discussed above are passed as written, I will no longer provide behavior support services through the Supports for Community Living Program; the risk of malpractice is simply too high. In reality, as a licensed attorney and licensed clinical social worker, it is my recommendation that no one provide PBSS services to the State of Kentucky through the SCL program until the regulations are amended to reflect express provision for payment for all services rendered pursuant to the regulations and Policy Manual and as required by the standard of practice of the profession, that is express provision for payment of a PBSS for the FA and supervision of PCCs.

Ultimately, 907 KAR 12:010 and 907 KAR 12:020 will reduce the availability of PBSS services to recipients of SCL services. For those individuals with behaviors that risk their ability to remain in the community, many will wind up back in the care of ICF-MRs, once again raising the cost of care for Kentucky taxpayers and reducing the quality of life available to the service recipients. But for a subset of the population, especially those with a aggressive and/or sexually inappropriate behaviors, the ultimate risk is that they will wind up in the facilities of last resort, the county jails that are unequipped to provide them with the protection much less services that they need.”

(z) Response: Within the proposed regulation and the manual incorporated by reference, there is an exceptional supports protocol which allows participants with intense behavioral, psychiatric and/or medical needs to request an increase in rates or units based on justified need. The participant and their team will know prior to development of the annual plan of care if they are in need of exceptional supports due to chronic or enduring issues based upon the assessment required in the new regulation, the Supports Intensity Scale (SIS). Individual results of the SIS, which are based upon normative data, will alert the participant and the team of high intensity support needs, especially in the areas of behavioral, psychiatric and medical needs. As the plan of care is developed, a request for exceptional supports can be made.

The participant and their team should discuss the needs of the person during the person centered team planning process and determine if exceptional supports will be needed due to chronic or enduring issues based upon past history and the assessment required

in the new regulation, the Supports Intensity Scale (SIS). Individual results of the SIS, which are based upon normative data, will alert the participant and the team of high intensity support needs, especially in the areas of behavioral, psychiatric and medical needs. As the plan of care is developed, a request for exceptional supports can be made.

(aa) Comment: Dr. Sheila Schuster, on behalf of the Kentucky Psychological Association and over 670 psychologists which it represents, stated, "We would call your attention to the Definitions section of 907 KAR 12.010 in which the terms "Homocidal Ideation" and "Suicidal Ideation" are defined (p. 12, line 4 (40) and p. 24, line 3 (98) respectively), as are "Abuse" "Neglect" and definitions of "Illicit Substances" and "Prohibited Drugs". We assume that these definitions indicate the acknowledgement by the Cabinet of some of the significant problems which are found within the SCL population and which must be addressed if participants are to be maintained in community placements. Our psychologists have identified these issues, along with other significant clinical concerns such as post-traumatic stress disorder (PTSD) possibly from sexual and physical assault, depression, psychosis, obsessive-compulsive disorders, anxiety reactions and other emotional problems. The existence of these significant psychological disorders co-occurring with the individual's development/intellectual disabilities complicate the treatment approaches and call for highly-skilled providers of psychological services.

It appears the expectations delineated in this subsection far exceed the upper limit for annual units of service (160 fifteen minute units per year) for all the identified Behavioral Health professionals listed in this subsection. What is the rationale for allowing significantly more units of service and use of clinical judgment by providers of occupational, physical and speech/language therapy while it is being denied for providers of psychological and positive behavioral support services? The latter service categories (psychological and behavioral) may be more predictive and supportive of the individual's ability to be transitioned to and maintained in the community than are the former (OT, PT, SPLT).

It should also be noted that while the upper limit for units of services is insufficient, the quarterly hour unit rate is being drastically reduced from \$38.79 to \$22.50. This represents a per unit rate reduction of 42%. This very significant cut in reimbursement to psychologists is one that is not matched in cuts to any other service providers!

It is our opinion, based on clinical experience, that the insufficient upper limit for units of services per year combined with the significantly reduced unit rate will make vital behavioral health services (psychological and positive behavioral supports) referenced in this section unavailable for SCL participants.

The SCL program is committing to a total expenditure of \$3,600 annually for all services included in this subsection. We believe this figure is grossly inadequate. It will force SCL participants during their respective Plan of Care meetings to select what is their most pressing need at that particular point in time, as opposed to adequately

addressing those service and support needs which may be chronic and ongoing. This change to psychological services reduces the person-centered thinking of vital behavioral health services and supports for all SCL participants and appears to be an inadequate per member per month capitation model.

We acknowledge that consultative clinical and therapeutic services are eligible for the exceptional supports and, therefore, the upper limit of units may be increased on a case-by-case basis. However, the information provided in Appendix F with regard to the exceptional support protocol is inadequate. It focuses primarily on positive behavioral support services – and only minimally touches on psychological services. It relies on a crisis team to be available in a timely manner and to have the clinical expertise to make judgments on extending complex clinical services. Utilizing this approach, we cannot be confident that behavioral health, and in particular psychological services, will be accessible to the SCL participant in the needed frequency, duration, quality or timeliness of care.

Therefore, it is recommended that psychological services must continue to be provided to all SCL participants who are in need of these services as they are now being provided through the current SCL regulations: 907 KAR 1:145 and 1:155. This can be accomplished by inserting the current language for psychological services from 907 KAR 1:145 and 1:155 into the new proposed SCL regulations: 907KAR 12:010 and 12:020. This will insure current and future SCL participants will have timely access to much-needed psychological services.”

Dr. Schuster summarized that the result of the policy would, “Significantly reducing access to Psychological Services and to Positive Behavioral Support Services for SCL participants by placing a very restrictive cap on the number of available monthly units of services to meet the individual’s needs.” Dr. Schuster also recommended that, “The upper limit for Behavioral Health services should at least match that provided for other therapies – occupation, physical and speech/language.”

Dr. Schuster also recommended that, “An Exception to the service limit should be created specifically for Psychological Services and a review mechanism that is professional peer-to-professional peer should be established.”

(bb) Response: Units above the stated cap may be requested through the Kentucky Exceptional Supports Protocol which is incorporated by reference.

(cc) Comment: Christopher George, a board certified behavior analyst, a licensed behavior analyst here Kentucky, and executive director of Applied Behavioral Advancements stated the following:

“CONCULTATIVE CLINICAL AND THERAPEUTIC SERVICE:

- 1) The regulation outlines consultative and clinical therapeutic services which replaces Behavior Support Services and Psychological Services in the previous regulation. The total number of available units for Behavior Support Services and Psychological

services was 624 units for each service, for a combined total 1248 units. The current regulation caps these services at 160 units a year, which is an 88% reduction in the medically necessary assessment and interventions for participants with Axis I and Axis II diagnoses.

- 2) In addition to the 88% reduction in available psychological and behavioral services, this regulation adds dietary and nutritional services into 'consultative and clinical therapeutic services'. This results in three services sharing the 160 units a year. This severely limits a participant's options or choices related to services that they are able to access to address health related, psychological, and behavioral needs. If a participant was overweight, dealing with the loss of a loved one, and having difficulty with socially appropriate behavior at their ADT (and did not meet criteria for exceptional supports) that participant would have to choose between which issue in their life they would like to choose to receive services. Again, this greatly limits a participant's choice to the medically necessary services.
- 3) The regulation states that clinicians providing CCT can perform the following functions: consultation, evaluation and assessment of the participant, the environment and the system of support, providing treatment, coordinating program wide support, developing and revising home treatment plans or support plans, monitoring, and a functional assessment. These services are critical to the participants overall quality of life as well as providing clinical guidance to the participant's team. The services cannot be adequately completed by any clinician, let alone shared with several different disciplines with only 160 available units a year.
- 4) Providing treatment should be consistent with assessment results and diagnosis, is evidenced based and best practice, and includes psychological treatment or counseling as indicated. However, a clinician who completes an evaluation and determines that evidence based practice and best practice exceeds 3 hours a month (assuming 10 hours to complete an evaluation) they will be unable to perform their clinical duties in accordance with this regulation. Based upon my experience and within the standard of practice set out by the Behavior Analyst Certification Board, the minimum number of hours necessary to monitor a behavior support plan is 1 hour a week. Although, I am not a psychologist, I know that the minimum number of hours that most request to provide meaningful clinical results is 1 hour a week.
 - a. **QUESTION: At a meeting with members of DDID after the application had been sent to Medicaid, we were told that the reduction in units to 120 units a year (that was the cap at the time) was not just an arbitrary number, but was based upon actual usage data. Will DDID please include a detailed explanation of where the data was pulled from and how the data was processed to come up with an 88% reduction in behavioral and psychological services?**
 - b. **QUESTION: Will DDID please provide a detailed description of the philosophy/vision behind combining these services. Please provide a detailed account of the departments vision of how the combination of services, and huge reduction in available units will help to protect the health, safety, and welfare of the participants.**

- c. **QUESTION:** This cap is an annual cap on services. If a provider was providing behavioral services through CCT and ‘burned through’ all of the units in 2-3 months, and the team determined that the behavior support provider was not doing a good job and there was little success in the overall plan and wanted to switch to a new provider, would the new provider have to work for free? Would additional units be provided to the new provider or will the participant have to wait 9 months to get additional services (given that they do not meet criteria for exceptional rate)?
- d. **QUESTION:** The regulation requires that treatment should be consistent with assessment results and diagnosis and based upon evidenced based and best practice. Will DDID please explain in writing how an arbitrary cap that limits a clinicians ability to recommend treatment that may be evidence based and best practice is supported by this regulation. Will DDID please explain in writing how they will address denials of a clinician’s recommendation for treatment if those services require more units than the 160 annual cap?
- e. **QUESTION:** The regulation lists many different duties that can be performed under CCT services, many of them related more to leading and shaping the multidisciplinary team, rather than specifically providing services to a participant. It appears as though this may allow the units for CCT to be misused or used to perform tasks that may not have a direct impact on the client. Will DDID, please clarify conditions under which the team should utilize CCT to guide the team rather than provide a direct service to the client.
- f. **QUESTION:** CCT covers three disciplines and are required to share a very limited number of units. If the team requested enough units for a positive behavior support specialist to complete a functional assessment, and allocated the remaining units to a psychologist to do counseling, does the positive behavior support specialist have any other regulatory or ethical responsibility to be an active member of the participants team if they no longer have any approved units to provide the service?
- g. **QUESTION:** The Person Centered Coach is regulatory required to be supervised by a positive behavior support specialist. If the approved units for CCT run out prior to the end of the annual POC year, will the positive behavior support specialist be required to continue to supervise the PCC for free?

(dd) Response: Regarding (a), based upon paid claims records from 7/1/09 to 6/30/10, the following figures are the average units per service per person:

Functional assessment of behavior	30 units
Behavior support plan (BSP)	20 units
Monitoring of BSP	74 units
Psychological services	81 units

The total average units for functional assessment, monitoring and psychological services was 185.

Maximums in proposed regulation:

Consultative clinical and therapeutic services which includes: 160 units

- Functional assessment
- Monitoring
- Psychological services
- Counseling
- Nutritionist/Dietitian

Regarding (b), with more involvement of clinicians in the person's team; payment for on-site training and monitoring; and greater accountability, there should be a more significant impact of these services which translates to a need for less units for some people. An individual who's assessed needs suggest they require more supports can utilize the Exceptional Supports Protocol to request additional units of these services **beyond 160 units.**

Regarding (c), yes, additional units would be approved with appropriate justification.

Regarding (d), typically evidenced based and best practices do not dictate the amount of therapeutic interventions to be used. That is based upon the individual. The Person Centered Team shall review the clinician's recommendations in context of what is important for the participant and what the participant deems important to them. The Case Manager will submit the Team's overall plan for prior authorization. If the Team determines there is a need for additional units, they will follow the exceptional supports protocol and submit a request for those additional units. Additional units will be handled through the exceptional supports protocol.

Regarding (e), all professionals providing services are expected to work together as a part of the person centered team. Utilizing the team approach and focusing on what is important for the participant in context to what is important to the participant alters the practice of service providers implementing on-going services/supports in isolation. This process gives the participant an increased opportunity to seek a more personally meaningful and fulfilling life. The CCTS was written to allow more freedom for the clinician because they may bill for providing training and technical assistance to paid and unpaid caregivers in addition to being able to create in home treatments/support plans with the ability to monitor implementation and progress. Actually, with the new service definition, participants have improved access to certified and licensed psychologists. Based upon the definition in the current regulation, a participant can only receive psychological services under the following condition: "Only when the needs of an individual cannot be met by behavior modifications or other home and community based waiver services, shall the individual receive psychological services:"

Regarding (f), if the functional assessment conducted by the positive behavior support specialist results in a behavior support plan, the positive behavior support specialist has both a regulatory and ethical responsibility to actively participate on the participant's Team. Additional units required above the cap may be requested through the exceptional supports protocol.

Regarding (g), the requirement for the supervision of the person centered coach has been revised to reflect that the person centered coach works under the direction of the Behavior Specialist or other licensed professional. Authorization of supports and units for those supports will be based upon individual needs as outlined in the person centered plan of care. For people whose assessed support needs exceed the upper limits the Exceptional Supports Protocol is in place. The Protocol outlines how the person and their team can request additional supports.

(6) Subject: Establish Reimbursement Mechanism for Registered Nurse or Licensed Practical Nurse Requirements

(a) Comment: Steve Zaricki, president of the Kentucky Association of Private Providers and executive director of Community Living, and Jenifer Frommeyer, executive director of Dreams With Wings and mother of a child with Down syndrome, both requested that the regulation offer a specific reimbursement mechanism for any requirement for RN or LPN tasks, such as medication administration and the health risk screening tool.

(b) Response: The residential rates were increased by \$4.00 per person/per day to offset the additional costs. Obtaining medication administration training has always been the responsibility of the provider. Agency registered nurses are trained by DBHDID at no cost to the provider. Payment arrangements for the training of non-licensed staff are between the employer and employee or contractor.

Medication administration training will be available using a hybrid method of training delivery, which includes completion of a portion of the training requirement on the Kentucky College of Direct Support (CDS) which is available to providers at no cost to the agency. The remaining portion will be performed face-to-face by an RN Trainer who has completed the DDID RN Trainer Training. The time for completion of the training will be the agency's responsibility. Agencies may consider working collaboratively to access and pay for an RN Trainer for medication administration training to assist with the costs.

The initial HRST will be completed by a nurse (RN or LPN) contracted or employed by the provider agency. Subsequent HRST updates shall be completed by provider staff.

(7) Subject: Positive Behavior Support Plan Reimbursement

(a) Comment: Dr. Bittman expressed that very often a positive behavior support plan needs to be revised often during the year and that, "as challenging behaviors are reduced and replacement behaviors take their place, the PBSP will need to be revised

and re-trained.” Dr. Bittman continued, “As often occurs, when new challenging behaviors manifest themselves during the year, the PBSP will need to be revised and re-trained. As staff turnover occurs, the new staff will need to be trained on the PBSP. As progress is made during the year, changes to the pro-active components of the plan, the reactive strategies of the plan, the interactive guidelines of the plan, the reinforcement schedules, etc., will all have to be revised and re-trained. It is very rare that the original PBSP is the same plan that is in place at the end of a 12 month period. At times, there will be the need to develop a completely new PBSP, especially when there is a significant change in the Individual’s life situation: new job, new residential program, etc.

A new PBSP usually takes about 6 hours (24, 15 minute units) to develop. Revisions, depending on how comprehensive they are, can take anywhere from 2 to 3 hours and then re-training will take an additional 1 hour.

The rate for Positive Behavior Support Plans MUST be restructured in order to allow the professional the time necessary to make timely and necessary revisions and keep the PBSP a good treatment intervention. Without needed revisions to the PBSP (as the Individual and his/her challenging behaviors and environmental situations change) the quality and effectiveness of the original PBSP will deteriorate significantly until it causes more problems than it solves.”

Dr. Bittman stated that “the rate for Positive Behavior Support Plan should be restructured to include 2 to 3 hours every quarter for clinically necessary revisions and/or updates and the re-training needed to train staff on the changes to the BSP.”

Jenifer Frommeyer, executive director of Dreams With Wings and mother of a child with Down syndrome, and Steve Zaricki, president of the Kentucky Association of Private Providers and executive director of Community Living, stated, “No reimbursement for plan revisions/updates: Positive Behavior Supports provides for the development of a plan to address the acquisition of skills for community living for the reduction of significant challenges which interfere with ADLs, social interaction, or work. The waiver requires that the plan be revised when necessary. Many of the plans for participants with the most challenging behaviors require multiple revisions during a year and often the development of a completely new plan. This service is billed as one unit of service and does not allow for reimbursement of the additional revisions and/or development of a new plan. The requirements coupled with the reimbursement rate will severely decrease the quality of the plans developed.”

Jennifer Frommeyer stated that, “A positive behavior support plan currently requires approximately 4-6 hours to develop and revisions often take 2-3 hours when revised as necessary.”

Steve Zaricki stated, “A positive behavior support plan currently requires approximately 4-6 hours to develop and revisions often take 2-3 hours coupled with additional training.”

Jenifer Frommeyer also stated, “Many of the plans for participants with the most challenging behaviors require multiple revisions during a year and often the development of a completely new plan. This service is billed as one unit of service and does not allow for reimbursement of the additional revisions and/or development of a new plan. The requirements coupled with the reimbursement rate will severely decrease the quality of the plans developed. A positive behavior support plan currently requires approximately 4-6 hours to develop and revisions often take 2-3 hours coupled with additional training.”

(b) Response: In the SCL waiver and proposed regulations, we have moved to practicing a more person-centered team process. The person centered team, which should include the professionals who have conducted evaluations and made recommendations for consultative clinical therapeutic services, will determine what services and supports are necessary for the participant across the array of available services. This will include taking into consideration any revisions to a positive behavior support plan. As the team develops the plan of care (POC), they may submit a request for exceptional supports if the participant’s needs exceed the annual limits.

Utilizing the team approach and focusing on what is important for the participant in context to what is important to the participant alters the practice of service providers implementing the same services/supports in isolation. This process gives the participant an increased opportunity to seek a more personal, meaningful and fulfilling life. Any time throughout the year if a provider of consultative clinical therapeutic services determines additional units of support are warranted, the team will reconvene to consider the clinician’s recommendations, determine any amendments that might need to be made on the POC, request exceptional supports based upon the revised POC, and submit the request for exceptional protocol to DBHDID as outlined in the SCL Policy Manual.

(8) Subject: Person Centered Coach Rate

(a) Comment: Dr. Stanley Bittman, a licensed psychologist and president of Behavior Associates, LLC, expressed that the person centered coaching rate, which may seem high for a high school graduate or person with a GED, is too low. He cites the extensive travel involved (two to four hours a day) for PCCs as a key reason while the reason is inadequate as he has to pay the individual eight hours a day in salary and benefits. As a result of the proposed reimbursement rate, Dr. Bittman stated, “I will not be able to provide this service and this service (Person Centered Coach) is one of the best changes to the Medicaid waiver.” He also stated, “At one of the early meetings about the Amendment, we were told that the DDID Department did not want providers to skimp on the pay rate or the benefits paid to PCC’s. I agree with that wholeheartedly and I follow the value with all my employees. I do not want high turnover and then high training costs to replace unhappy employees.” He cited the benefits he provides employees and stated, “I will not be able to hire PCC’s, pay for their travel time and pay them a decent salary and the fringe benefits I pay my other employees. I simply will not

be able to provide this important service.”

Dr. Bittman recommended that the person centered coach rate be increased to consider travel time. He indicated in his situation the average travel time per day is two to three hours.

Dr. Bittman does not request that travel time be separated as a reimbursement component but that the rate be increased in order to compensate for travel time. He provided calculations (indicating that the \$5.75 rate equates to \$23.00/hour and that eight hours of a PCC’s time equals \$184.00/day and that if three hours are spent traveling (round trip) to an SCL location there would only five hours of billable time. He divided the daily cost of \$184.00 by five hours (billable time) to result in an hourly rate of \$36.80 or \$9.20 per fifteen minute unit. Dr. Bittman stated, “At this suggested rate, I would be able to pay a decent salary (about \$12.00 per hour), cover the fringe benefits I would have to pay since the above fringe benefits are already part of my employee policies, and I would be able to cover the travel time for the PCC that is not billable as a separate service.”

(b) Response: The services of a person centered coach will not be mandated by either Medicaid or the DBHDID. If the clinician believes there is a barrier such as travel time to the provision of the coaching service for a participant, the clinician should discuss it with the participant and their person centered team to explore alternatives. Are there person centered coaches closer to the participant with whom the clinician is willing to work? Decisions should be based on the best interest of the participant and provision of information so informed decisions can be made.

(9) Subject: Need for a Standard Psychological Service Rather Than Exceptional Support to Consultative Clinical and Therapeutic Services

(a) Comment: Dr. Stanley Bittman, a licensed psychologist and president of Behavioral Associates, LLC, and Dr. Sheila Cooley-Parker stated, “The Consultative and Therapeutic Service does not provide for the psychological services as a standard needed service (as does the current regulation) . . . Psychological services are needed as a standard available service like behavior services, speech therapy, occupational therapy, physical therapy etc. The need for psychological services is NOT an ‘exceptional situation.’” Dr. Bittman and Dr. Cooley-Parker proceeded to explain the importance of psychological services and recommended that psychological services be granted their own category of service or that units within consultative clinical and therapeutic services be “to allow for mental health counseling when needed.” Dr. Bittman and Dr. Cooley-Parker also stated that, “it should not be treated as an ‘exceptional’ situation since more than half the population has a dual diagnosis.” Dr. Bittman and Dr. Cooley-Parker indicated that if it’s included into consultative clinical and therapeutic services that the unit limit be increased rather than requiring a request for an exceptional support consideration. Dr. Bittman and Dr. Cooley-Parker recommended a range of sixteen units per month at the beginning (of a person’s counseling/therapy), tapering to eight units towards the middle of therapy and four units toward the end.

Dr. Bittman and Dr. Cooley-Parker also emphasized the importance and value of psychological services for an individual's overall treatment plan. They stated, "Having an individual with behavior problems and also a diagnosed mental health problem, only getting behavior services, is like treating half the person."

Dr. Bittman and Dr. Cooley-Parker also indicated that the "lack of appropriate mental health services will lead to an increase in increased calls for the police, increased psychiatric hospitalizations, greater use of psychotropic medications, greater risk of injury to the Individual themselves, other individuals, and staff. IT will lead to greater problems on the job in supported employment, and more likely, losing supported employment positions. All of these are high priority goals and objectives of the entire SCL program. They will all be compromised."

In the SCL waiver and proposed regulations, we have moved to practicing a more person-centered team process. The person centered team, which should include the professionals who have conducted evaluations and made recommendations for consultative clinical therapeutic services, will determine what services and supports are necessary for the participant across the array of available services. This will include taking into consideration any short- or long-term supports and the level/intensity/frequency of those supports. As the team develops the plan of care (POC), they may submit a request for exceptional supports if the participant's needs exceed the annual limits. A request may also be made if the team projects that additional service units will be needed to achieve designated outcomes, such as short-term counseling or accessing a dietician in order to lose weight.

Utilizing the team approach and focusing on what is important for the participant in context to what is important to the participant alters the practice of service providers implementing on-going services/supports in isolation. This process gives the participant an increased opportunity to seek a more personal, meaningful and fulfilling life. Any time throughout the year a provider of consultative clinical therapeutic services determines additional units of support are warranted, the team should reconvene to consider the clinician's recommendations, determine any amendments that might need to be made on the POC, request exceptional supports based upon the revised POC, and submit the request for exceptional protocol to DBHDID as outlined in the SCL Policy Manual.

Regarding 907 KAR 12:020, Section 1, subsection 5 "exceptional support", Marie Burkhart, executive director of Cumberland River Homes, Inc., stated, "This proposed regulation does not include psychological services as a standard service as the current regulation does. Our current regulation has a separate rate and service code for these services. In the proposed regulation, the psychological services come under the consultative and therapeutic services and addressed as an 'exceptional situation'. For our clients, we do not believe psychological services, in most cases, are an exceptional situation. Most of our clients have dual diagnoses. In fact, clients in our population have higher percentage mental health problems than do the general population. They should

not have to be addressed as an 'exceptional situation'.

Recommendation: I request that psychological services (especially mental health counseling) be a standard service with standard units available, if needed in dual diagnoses situations. I request this have its own category of service or units within the consultative and therapeutic service category be increased to allow for mental health counseling if needed. I also request that clients be allowed the choice of their provider, rather than having to travel many miles to the regional comp centers or other traditional medical models in therapist's offices. Our agency recently encountered a situation where one of our clients, who is autistic, needed therapy. One of the agencies that we contract services with, was willing to provide therapy services, in our agency to this client. This client's psychiatrist worked from the regional comp center. We called the psychiatrist's office to see if they would continue seeing our client as the psychiatrist if we contracted therapy services from the agency that would come to our agency. We were told that the psychiatrist could not continue to see our client(s) unless the clients also used the therapist who worked through the comp center. We recommend the clients be given the choice of where to get their services."

(b) Response: Consultative clinical and therapeutic service (CCTS) as written in the waiver and the proposed regulation allow participants the choice of selecting from a wider array of trained clinicians who are certified or licensed by the state. The previous waiver allowed only for these services to be offered by certified or licensed psychologists or those meeting criteria for behavior specialist, which does not require a certification or license. CCTS as they are proposed enable a participant to utilize the services of a licensed or certified psychologist, counselor, dietician or nutritionist. The service of a behavior specialist may also be utilized. The services of each of these professionals may be used alone or in combination with other services listed. The service was written to allow more freedom for the clinician because they may bill for providing training and technical assistance to paid and unpaid caregivers in addition to being able to create in home treatments/support plans with the ability to monitor implementation and progress. The new service definition allows participants to have improved access to certified and licensed psychologists. Based upon the current regulatory definition, a participant can only receive psychological services "only when the needs of an individual cannot be met by behavior modifications or other home and community based waiver services, shall the individual receive psychological services."

Within the proposed regulation and the manual incorporated by reference, there is an exceptional supports protocol which allows participants with intense behavioral, psychiatric and/or medical needs to request an increase in rates or units based on justified need.

(10) Subject: Choice of Mental Health Professional

(a) Comment: Dr. Stanley Bittman, a licensed psychologist and president of Behavioral Associates, LLC, and Dr. Sheila Cooley-Parker, a licensed counseling psychologist indicated it is equally important to allow an individual to choose his/her own provider

and that therapy is more effective if provided at the individual's location (residence/day program, etc.) "rather than having to travel hours to a traditional medical model location in a therapist's office." Dr. Bittman and Dr. Cooley-Parker also stated, "I attended a meeting where a DDID official stated that individuals in the SCL program may have to go to the nearest mental health center to get mental health counseling. This is contrary to the service values stated by DDID – individuals MUST be able to choose the professional from whom they want to get a service. Not be forced to go to a particular service provider."

Dr. Bittman and Dr. Cooley-Parker cited reasons to support his position regarding freedom of choice of provider and noted that community mental health centers will not provide services in the individual's life setting (residential, day program, etc.) but, instead, will have to "travel to a 'medical model office' in the MHC building to see a therapist in his/her 'medical model' office – not in the individual's 'natural' setting." Dr. Bittman and Dr. Cooley-Parker indicated that an individual will be more receptive to counseling in his/her own environment, notes the extensive travel time involved in transporting an individual to a community mental health center rather than seeing the individual at the SCL provider site where therapy can be provided to more individuals (at the SCL provider site) due to the lack of travel time. Dr. Bittman and Dr. Cooley-Parker also indicated that a consulting psychologist, when providing services at the SCL provider site, can also consult with the individual's case manager and other staff involved in serving the individual and noted the importance of such communication.

Dr. Bittman and Dr. Cooley-Parker noted that he has worked in a community mental health center for about seventeen years and stated, "I have found that very few psychologists in general are trained or experienced in working with people with intellectual deficits (ID) and other developmental disabilities (DD)." Dr. Bittman and Dr. Cooley-Parker indicated that an individual is better served by mental health professionals who specialize in working with individuals with ID and DD.

Dr. Bittman and Dr. Cooley-Parker also emphasized the importance of an individual's psychologist and behavioral service provider coordinating services as well as communicating and stated, "At times the communication and coordination between these two service providers needs to happen on a weekly basis, not just at monthly or quarterly team meetings." Dr. Bittman and Dr. Cooley-Parker continued, "This will not occur if the psychology services are not provided on site at the SCL program. I am not aware of any psychologists or psychiatrists at MHC who even attend or participate in the individual's team or annual planning meetings."

Dr. Bittman and Dr. Cooley-Parker provided a comparison of providing service "off-site" at a community mental health center versus "on-site psychological services" (no travel time required by staff) and also displayed an example of four counseling sessions a month comparing the amount of time lost for the individual and staff when services are provided at a CMHC compared to on site. The latter comparison indicated a total of 80 hours per month of individual time lost and 80 to 160 hours of staff time lost when services are provided at a CMHC compared to only 40 hours per month of individual

time lost and no staff time lost when services are provided on site.

Dr. Bittman and Dr. Cooley-Parker recommended, “that the Individual be given the choice of who and where he/she gets mental health counseling. Here is another opportunity to treat the individual as though they are living in the community and have the same choices as everyone else.”

(b) Response: The consultative clinical and therapeutic service requirements do not require a participant to obtain services through the community mental health centers.

(11) Subject: Developmental Disability Definition

(a) Comment: William S. Dolan, staff attorney supervisor of P & A, stated, “We urge the Cabinet to change the definition of ‘developmental disability’ to clarify that individuals with developmental disabilities can access SCL services. The proposed definition allows the Cabinet to continue its practice of excluding anyone who has a developmental disability from SCL because it interprets the ‘an impairment of general intellectual functioning and adaptive behavior similar to that of a person with an intellectual disability’ to mean an SCL applicant must have an IQ of approximately 70 or below. This interpretation contravenes Kentucky’s SCL statute, KRS 205.6317, which specifically states SCL is for individuals with either intellectual or developmental disabilities.

We suggest using the Michelle P. developmental disability definition. See 907 KAR 1:835 § 1(16). By using the same definition, Kentucky’s ID/DD waivers will be consistent and Michelle P. recipients with developmental disabilities won’t have to fear being cut-off from SCL residential services when the need arises just because they are not diagnosed as ID. We are mystified as to why the Cabinet would create a bifurcated ID/DD waiver system that, for lack of a better phrase, abandons the DD population when they need residential waiver services.”

(b) Response: The SCL waiver and Michelle P waiver, as approved by the Centers for Medicare and Medicaid Services (CMS), are not identical. Amending the definition of developmental disability as suggested would alter the intent of the program and would require CMS approval. DMS is not amending the definition as requested.

(12) Subject: Exceptional Supports and Exceptional Supports Protocol

(a) Comment: William S. Dolan, staff attorney supervisor of P & A, stated, “Exceptional supports are limited to a full POC year in sub-section (1)(b). As POCs are developed yearly, we assume that exceptional supports can be available with each succeeding POC year. If not, then some providers might not want to serve SCL recipients who need an array of intense services because the supports could be halved after the first year of service.”

(b) Response: That is correct.

(c) Comment: William S. Dolan, staff attorney supervisor of P & A, stated, “We are concerned that the “exceptional supports protocol” process will not be administered in a timely manner. For example the Cabinet is making significant changes to behavior supports. Behavior supports are often the cornerstone of successful community placements. These services need to be fluid and not hamstrung by potential bureaucratic barriers. Delays could cause irreversible deterioration in the person or circumstances. Also, will recipients be allowed to appeal, pursuant to 907 KAR 1:563, an exceptional protocol denial?”

Mr. Dolan also stated the following:

“And, our concern is then, and I guess, the exceptional support protocol is in one of the appendix to the regulations that, you know, the speed at which then, if someone has to go through the exceptional support protocol, it's been our experience, and of course, at Protection Advocacy, when we get phone calls it's never anything is going well, there's always a problem and then there's usually an emergency. And, then our response usually is, I hope the behavior support people are there and they are the ones who usually rescue the situation or can point folks in the right direction. So, with that cut back that everyone has talked about, that we're concerned that if folks have to go through this protocol then to get access to these behavior supports, how quickly will that be able to happen? Because I would think it have to be almost instant or fairly quickly. And, if it ends up being days or whatnot, then it's--that's very troubling.

And, also then if you're denied, will the person actually be able to appeal that? Will there be some sort of due process mechanism, because that is a request for additional services and we didn't see anything in there that would allow somebody to appeal. So--

Of course, as a PMA system, we're always interested in process and getting an opportunity to be heard by a neutral decision maker. So, we wanted to see some clarification on that.”

(d) Response: Under the current process, providers are able to provide services and submit a revised plan of care within fourteen days. This process is not changing. In a crisis situation it is expected that providers act in good faith and provide services necessary to ensure the health and safety of the participant. Review of requests for exceptional supports in response to a crisis situation will be expedited by the Department. Denials will have the option for appeal as with any service denial.

(e) Comment: Jenifer Frommeyer, executive director of Dreams With Wings and mother of a child with Down syndrome, and Steve Zaricki, president of the Kentucky Association of Private Providers and executive director of Community Living, stated, “Exceptional Rate Protocol: The limit on exceptional supports for Consultative Clinical and Therapeutic Services and Person Centered Coach may not exceed two times the SCL upper rate limits. This means that the most at risk participants with the highest risk for health, safety, and welfare, may only get up to 80 hours a year or 6-7 hours a month of services from a Master's level Behavior Analyst/Specialist and/or Doctoral Level Psychologist. Many of the participants with the most severe problem behaviors in the

SCL program require 12 hours a month of services from a behavior analyst in addition to 4 hours of month of services from a psychologist for mental health issues. These services cannot be provided in 6-7 hours a month. This limit does not allow the most at risk clients with the most severe problem behavior and mental health issues to access the services necessary to help them stabilize and maintain appropriate community placement, much less prepare them for integrated employment.”

Jenifer Frommeyer also requested that the regulation “clarify that there is no upper limit under the exceptional rate protocol for CCT or person centered coaching.” She also requested that the regulation “allow positive behavior supports (writing of the plan) to be included as an exceptional support so that the most intense plans that may need major revisions can be covered.”

(f) Response: The unit limit under the exceptional support protocol will be determined based on documentation submitted by the provider to justify need for the service.

(g) Comment: Christopher George, a board certified behavior analyst, a licensed behavior analyst here Kentucky, and executive director of Applied Behavioral Advancements stated the following:

“EXCEPTIONAL SUPPORTS:

- 1) The regulation provides a definition of exceptional supports but does not explain how this process will work.
- 2) Exceptional Supports allows for CCT and PCC to be increased, but does not include Positive Behavior Supports. With the most difficult clients, it is often necessary to re-write an entire plan. Positive behavior supports is billed as a 1 time unit. Decreasing the likelihood that a positive behavior specialist will complete a major revision for free.

a. QUESTION: Will DDID please explain in more detail how the process of approval for exceptional supports will work? Can this process be started at any time during the POC year? If the request for exceptional supports is denied, is there an appeal process or will the participant have to wait until their next POC year?

b. QUESTION: Who will be approving the exceptional supports? Does this committee require that a professional clinician in the area that the exceptional supports be provided have to approve the request?

c. QUESTION: Will DDID please clarify in writing that there is no upper limit on CCT or PCC for those clients who qualify for exceptional supports?

d. RECOMMENDATION: Include Positive Behavior Supports (writing of the plan) as an exceptional support to cover major revisions to a behavior support plan as necessary.”

(h) Response: Regarding (a), a request for exceptional support may be submitted at any time as the person centered team deems necessary. Denials will have the option for appeal as with any service denial.

Regarding (b), clinical staff at the department will make these determinations based upon the plan of care, other annual assessments and documentation currently required.

Regarding (c), the unit limit under the exceptional support protocol will be determined based on documentation submitted by the provider to justify need for the service.

Regarding (d), if at any time throughout the year the team determines that a positive behavior support plan is not effective and is in need of revision or updating, a request for exceptional supports may be submitted as outlined in the SCL Policy Manual.

(i) Comment: Christopher George, a board certified behavior analyst, a licensed behavior analyst here Kentucky, and executive director of Applied Behavioral Advancements stated, "Finally, the exceptional rate protocol. The exceptional rate protocol is not clearly defined. I do recognize that it lists the--the documents that are to be provided for review. There is no criteria set for what shall constitute a determination about whether or not someone has reached that. And, again, as I spoke of earlier with that 160 cap, if someone does not meet that exceptional rate protocol because of those limits that are put in place, they're choices have been eliminated as far as the options that they have in order to access services. And, it's just basically saying, well, I kind of got some significant stuff going on, but it's really not significant to get the services that I need, so I guess I'm just going to have to deal with that cap. And, I don't think that that's clear. I think that we need to specify in that exceptional rate protocol. Also in looking the exceptional rate protocol covers a number of different things, including residential ADT, respite services, person center coaching and other services that are there. That process, in order to get a rate increase for those, there may be a longer process to go through and do that.

When I have an individual that, because of decompensation in mental illness or behavior they have a move and transition, the gentleman runs out in the street and attacks someone in their car and starts attacking community members and we have a great need, I don't have two weeks to hear back from the Cabinet about whether or not my client now hits the exceptional rate protocol. There needs to be provisions within that exceptional rate protocol for emergency approval of crises services to be provided to individuals and that process needs to be streamlined and expressed in such a way that it is very clear what time lines we are up against, when we are faced with a crises at 11:00 o'clock on a Saturday night and how we are going to pay for and provide those services so that that individual can stay out of an institution, out of a psychiatric hospital or out of jail."

Mr. George also stated the following:

"Again, when I look at the exceptional rate protocol that is specified in this regulation, there are a few things that it says. The exceptional rate protocol means the set of rules to establish how the Department reviews an exceptional support request, approves exceptional support request revises a limit related to an exceptional support request or sets a standard related to an exceptional support request. Again, and I know that Doctor Laura spoke on this earlier, or it may have been you Adreanna, I apologize, one

of our fine doctors did. As far as looking at someone who--if we have a clinician that goes in and recommends and said these are the number of units that I need, these are the number of services I need to provide, the regulation states that the Department shall--the Cabinet shall be able to change the clinical recommendation and only approve part of the clinical recommendation that is there. I think that that falls outside of their scope of practice and it's unethical and I think they should be specified in there that those decisions are being made by someone with a--with the same degree as that clinician, that is supporting that or recommending for that--those exceptional rates. Again, the exceptional rate protocol is as referenced in the policy manual as referenced by this regulation, is unclear about how that process will work.

I do ask that that be specifically detailed in greater detail. And, specifically in relation to not only how that applies to behavior supports, as Doctor Laura had pointed out there. but, that also that it be specified in relationship to mental health issues and psychological services.”

(j) Response: Under the current process, providers are able to provide services and submit a revised plan of care within fourteen days. This process is not changing. In a crisis situation it is expected that providers act in good faith and provide services necessary to ensure the health and safety of the participant. Review of requests for exceptional supports in response to a crisis situation will be expedited by the Department.

(k) Comment: Steve Zaricki, president of the Kentucky Association of Private Providers and executive director of Community Living, stated, “Provide specific process details for requesting exceptional rate protocol and the approval/denial process.”

(l) Response: Units or cost above the limits may be requested through the exceptional supports protocol and will be reviewed based on justified need. The process is stated in the Kentucky Exceptional Supports Protocol which is incorporated by reference into 907 KAR 12:020. The process is also stated as follows:

“The process for an exceptional supports request requires submission of a Plan of Care (POC) that reflects a higher level of supports as determined by the Supports Intensity Scale (SIS) and Health Risk Screening Tool (HRST). As applicable, service must be medically justified and physician ordered. Exceptional supports are authorized based on specific information concerning the individual’s needs and the plans to address those needs. DDID management staff must review and authorize any exceptional rates or units.

The exceptional support needs identified through the robust assessment process, are not intended to become an indefinite part of an individual’s support system. These supports may come and go throughout a person’s life. A plan for gradual withdrawal of these exceptional supports, shall be established and accompany the plan of care with all exceptional support requests.

Prior to requesting consideration for Exceptional Supports, the person's team shall evaluate the effectiveness of plans to greatly reduce, or eliminate the impact of triggers, precursors, and environmental factors. Preventive services from the regional Community Mental Health Center (CMHC) DD Crisis Service and the regional ICF/DD Mobile Crisis Team should be sought to assist in this process as needed to ensure that appropriate preventive techniques and person centered planning are in place before exceptional supports are requested.

Consideration of an exceptional support requires submission of the following documentation to DDID:

1. Cover letter stating the participant is currently in an institution awaiting finalization of transition/discharge planning to the community; or the participant is at risk of not maintaining their life, friends, home and work in their community; and the assessed needs of the participant based upon the SIS and/or HRST indicate an intense level of supports is required to promote their health, wellness and stability.
2. Team approved Plan of Care (POC) documenting the enhanced service delivery needed (e.g., specific enhanced staff training requirement or credentialed employee, time of day enhanced staffing ratio required, number of hours of professional staffing, or oversight required) including any support needs for which enhanced professional treatment and oversight is warranted. (to include dietary, psychological, or positive behavior support services)
3. The POC shall include frequency of data review by team and consideration of criteria for reduction of these supports; and information about alternative measures attempted.
4. Cost analysis or projected budget for the supports provided for the participant.
5. Requests for additional supports needed in the area of skilled nursing shall include the following additional documentation:
 - a. Specification of hours of necessary RN direct support required for delivery of identified nursing care that is not delegable per 201 KAR 20:400.
 - b. Plan to obtain and monitor clinical outcome data with criteria for reduction of supports as relevant to medical condition.
 - c. Specification of additional direct support staffing requirements in amount and time of day with criteria for reduction of these supports; including completion of the expanded requirements for credentialed DSP in the areas of Health Support if appropriate; and
 - d. Assessed exceptional needs of the participant documented by the SIS and the HRST with a copy of physician's orders when applicable.

6. Requests for exceptional supports based on the exceptional behavioral health or behavioral support needs of the participant must also include the following as applicable:

- a. Documentation of completion of the expanded requirements for direct support professional (DSP) credentialed in the area of positive behavior support;
- b. Documentation of the providers' ability to support people with exceptional behavioral health or behavioral support needs which may include implementation of specialized programs, established arrangements with network of community supports. This documentation pertains to a provider's overall or system wide capacity to provide these types of supports;
- c. A functional assessment and any supports developed based on that assessment to include a positive behavioral support plan;
- d. Any notes from HRC and BIC for plans reviewed;
- e. The form of communication utilized and, as appropriate, specified communication techniques/use of technology. Include a description of efforts toward functional communication;
- f. Quantitative data in the form of frequency, rate, or duration should be provided for each target behavior identified in the positive behavior support plan. This data must include the most recent three (3) month period of continuous data collection for each targeted behavior or behavioral health symptom. Data should be in an objective, numerical, and graphical form;
- g. Documentation, which may include clinical notes, to indicate that ongoing behavioral health services are necessary to achieve the desired outcomes specified in the Plan of Care (POC); and
- h. Behavioral Health Plan, Crisis Prevention Plan and notes from debriefing sessions with CMHC and ICF/IID Mobile Crisis Services.

Requests for exceptional supports shall be in accordance with the following procedures:

The Team, through the case manager, is responsible for submitting a written request for an exceptional support for a participant with exceptional needs, along with required supporting documentation, to DDID.

The specified enhanced service delivery requirements for a participant with exceptional needs shall become part of case management monitoring of service delivery. Data should be reviewed by the person's team at regular intervals to determine if continuation of exceptional support meets all the above stated requirements. Information shall be submitted to DDID as outlined:

Exceptional supports above the established standard rate or unit limit will be prior authorized for a maximum of six (6) months and requires a minimum review by the person centered team and written summary of progress submitted to DDID.

No Prior Authorizations for exceptional supports will be automatically extended.

If the needs of the participant change prior to the review date (change in needs such that the person needs more or less supports), DDID must be notified and a new exceptional request must be submitted.

In order to ensure continuity of care, prior to any transfer to a new provider, a new request for exceptional support shall be submitted to DDID meeting all above requirements. Approval of this new exceptional request support by DDID is required prior to any reimbursement above the Medicaid ordinary rate or limit for the waiver service.”

(m) Comment: David Volkner, vice president of ResCare Residential Services, asked, “How are the allocations determined above the upper limit payment for Residential Level I services, assuming that the individual qualifies for the additional authorizations under the Exceptional Support Protocol? In other words, does the protocol allow for a matrix or assessment that determines a variety of increased rates or is there a set add-on rate to cover the cost of supporting those with exceptional support needs?”

(n) Response: Determinations will be made by clinical staff at the department based upon documentation provided by a person’s team which reflects the need for exceptional rate or units of service. The exceptional rate will be based in part on projected cost of the service submitted by the requesting agency. The exceptional support protocol is in the SCL policy manual incorporated by reference in the regulation.

(o) Comment: Oyo Fummilayo, member of the Commonwealth Council on Developmental Disabilities, stated the following:

“Exceptional support protocol.

The first specific aspect of these regulations upon which we'd like to comment is the switch from a flat enhanced rate to an individually determined exceptional support protocol. We think it is much more appropriate to determine the amount of exceptional support on an individual basis rather than offer a flat rate of \$125,000 to those individuals who have left a facility.

Now, common sense indicates that some individuals will need less support and some individuals will need more support. By allowing any individual in the SCL program to be considered for the exceptional support protocol and determining the amount on an individual basis, we see the exceptional support protocol as a tool that can give more people the option of moving into the community and staying in the community.

We do, however, want to be given more information concerning how the amount of exceptional support protocol will be determined. The exceptional support protocol is such an important concept that we feel everyone affected by the SCL program will benefit from more details and a better understanding.”

(p) Response: Determinations will be made by clinical staff at the department based upon documentation provided by a person’s team which reflects the need for exceptional rate or units of service. The exceptional support protocol is in the SCL policy manual incorporated by reference in the regulation.

(13) Subject: Environmental Accessibility Limit

(a) Comment: William S. Dolan, staff attorney supervisor of P & A, stated, “Sub-section (9)(b) places a \$8,000 lifetime maximum on environmental accessibility. We suggest making it an \$8,000 limit on a per household basis similar to the per approved community transition service limit. Otherwise, recipients might be prevented from moving to a more appropriate setting because they can’t make modifications to a new home.”

(b) Response: The \$8000 lifetime maximum may be divided and used for more than one residence but the total available per person in the approved waiver is \$8000.

(14) Subject: Goods and Services Limit

(a) Comment: William S. Dolan, staff attorney supervisor of P & A, stated, “Sub-section (10) limits goods and services to \$1,800 per year. The current SCL regulation does not have this restriction. We suggest making goods and services subject to the Exceptional Supports Protocol as some recipients have a daily need for certain goods and services which might surpass the \$1,800 limit or their ability to get other items like augmentative communication devices, etc. could be curtailed.”

(b) Response: In the new system, specialized medical equipment and goods and services will both be available to any SCL participant who is eligible and chooses to use these services. Augmentative communication devices may be requested through specialized medical equipment.

(15) Subject: Mileage Reimbursement Limit

(a) Comment: William S. Dolan, staff attorney supervisor of P & A, stated, “Sub-section (19) 2. limits mileage reimbursement to two-thirds of the rate that those that serve the Commonwealth receive. We would recommend using the actual 200 KAR 2:006 § 8(2)(d) rate because gas is not the only transportation expense. A vehicle used to transport SCL recipients will also be subject to wear and tear.”

(b) Response: There has been significant analysis of the ramifications of all changes in the SCL waiver to ensure budget neutrality. DMS is not making the requested change.

(16) Subject: Add Personal Assistance Services to Collateral Services

(a) Comment: William S. Dolan, staff attorney supervisor of P & A, stated, “Sub-section (22) allows certain collateral services to overlap other SCL services. We suggest adding personal assistance services to the list. The new SCL places an emphasis on competitive employment. Some SCL recipients will need assistance with ADLs while working. If the supported employment service does not cover ADL assistance, then another SCL service needs to be available. Also, as personal assistance is not available to those in staffed residences, will the residential provider be required to assist with ADLs while the recipient is at work?”

(b) Response: It should not be necessary to add personal assistance to the list of collateral services that overlap other SCL services. If an employment specialist is present at the worksite providing either job training or long term support services there is no reason that the employment specialist cannot provide assistance to the participant. If there is no employment specialist present and the participant is not comfortable with a natural support in that role, the participant would be able to receive personal assistance services as long as they do not have residential services on their plan of care. If they do receive residential services, personal assistance on the job site is part of the residential service definition. Residential services are a twenty-four hour per day, seven day per week service.

(17) Subject: Participant Directed Services Reimbursement

(a) Comment: William S. Dolan, staff attorney supervisor of P & A, stated, “Please confirm that a PDS budget will be based on a recipient’s plan of care (POC) and that the budget can be adjusted based on need during the POC year. According to the new SCL regulation, a POC [e]mpowers the participant or the participant’s designated representative to create a life plan and corresponding plan of care for the participant that is based on the participant’s preferences, ideas, and needs[.]’ 907 KAR 12:010 § 1 (78) d. (internal citation omitted). We hope that the Cabinet will not use the current PDS (CDO) budget process that is based on historical or average per capita costs and which forces recipients and support brokers to navigating the burdensome budget adjustment process that includes the artificially high ‘imminent institutionalization’ test.

(b) Response: A waiver participant’s plan of care should be person centered and based on identified needs using the assessment tools (SIS, HRST and any other assessment or evaluation given).

(c) Comment: William S. Dolan, staff attorney supervisor of P & A, stated the following: “And, the last quick point too is on CDO, which is now PDS, so consumer directed option, which is now participant directed services, there’s a--where folks have to do any employment related expenses or costs associated with that. It used to be if somebody had to get a criminal background check and those sort of things, then that was already paid for and didn't come out of the pocket of the individual consumer. And, now, we're

reading the regulation to say that the person--consumer who will actually have to pay for the administrative AOC back--criminal background check, CPR training and all the other trainings that are required under PDS. And, of course, since the foundation of PDS is flexibility, we'd want to hope that--or hope that the Cabinet can put in the--allow people to choose, you know, to actually put that in their budget and then take that cost--administrative cost out of their budget, if they want to or even allow them to take it out of their own pocket or even have their employees pay. But, as we read it now, I think it's just up to the individual or the individual's PDS employees to pay for those costs. So, we'd hope for some flexibility there.”

(d) Response: These requirements will be handled through the fiscal management entity as a part of the individual budget.

(18) Subject: Employment Related Administrative Costs

(a) Comment: William S. Dolan, staff attorney supervisor of P & A, stated, “Sub-section (1)(b) 2. requires recipients to pay for employment related administrative costs. We suggest allowing the recipients the choice of incorporating these costs like criminal background checks, first aid, and CPR training, etc. into the budget because the foundation of PDS is choice. Some recipients may prefer to pay these costs out-of-pocket or have their employees pay so they can maximize the monies available for services while others, like those who get Social Security benefits, might want the costs to come out of the budget because they have limited income.”

(b) Response: These requirements will be handled through the fiscal management entity as a part of the individual budget.

(19) Subject: Residential Services Reimbursement/Adult Foster Care Reimbursement

(a) Comment: Thomas P. Laurino with Choices Unlimited, Inc., stated the following: “This goes directly to a concern that I have and I've had for a long time about the difference in rates on different, you know, residential placements.

For the longest time there has always been a difference in rate between what we call staff residents and those individuals being placed in what we call adult foster care. I've never understood why they are at different rates, because essentially they're serving the identical purposes of having residential placement for some people.

Personally, if anything, I think the adult foster care should be at a higher rate because I do personally thing that it's a better placement because persons with a family and just not living in a house somewhere with two unrelated individuals that they may or may not know, but that's neither here nor there.

I'm not going to spend time trying to address the difference in the programs. But, I think they should, at least receive the same among of funding, it makes no sense to me.

But, what really doesn't make sense to me is the--the attempt by Medicaid to do what I call a shell game. It's a very interesting thing that they did with the home providers and the adult foster care. I know there was a lot of home providers that are concerned because they say they are losing their respite. The reality is what Medicaid has done, they increased the amount of reimbursement for those people in what they call residential two, they increased the amount to basically compensate the elimination of respite. It's really up to the individual agencies to decide how they want to pay respite providers. If an agency chooses to keep all of the money and tell them, well, they eliminated respite, well, then they just get a windfall. I think that's kind of an unfortunate event. Most agencies probably will continue to provide respite for those individuals that are in residential two or what we better know as adult foster care, the problem is, is that if you do the math it doesn't come out quite the same.

The agency still--if they continue to pay their providers the same, and one of my real concerns is after all these years--I mean, there is not an agency in the State of Kentucky that can pay Medicaid providers any more than they probably already are, because respite pays nothing. It's the lowest paid service available. So, if you continue to pay them, what you've been paying them, that means in our--today's economy, they don't get a raise like everybody else in America. Well, that's fine. But, I think after all these years, they deserve a little raise.

But, instead, the agency probably may even have to cut them back. I mean, most agencies are embarrassed to say, well, we can't--we're going to pay you minimum wage, now they may have to, because the numbers do not actually compensate the agency completely for the difference. In other words, they're paying a little more for adult foster care, yeah, you can pay and continue to have the same amount of respite, but not exactly, it doesn't quite come out that way.

At least it should--it should be no worse than it is today, if anything it should be more."

(b) Response: Regarding respite for residential providers – there is a change in the way that Family Home (FHP) and Adult Foster Care (AFC) providers will receive time off for relief of the caregiver. Respite is not a paid service for residential providers, but time off from the job is expected for the Level II residential provider. Level II residential providers (Adult Foster Care and Family Home Providers) are paid a flat rate for residential services by the certified SCL provider agency.

Contractual agreements between the SCL provider agency and the contracted Level II residential provider should include Level II residential provider time off from the job. Arrangements for the ongoing care of the person receiving residential services should be identified by the team and planning should occur for continued residential treatment services during these times. As long as residential services are provided, the SCL provider agency will continue to receive Medicaid waiver residential reimbursement for the care of the person receiving residential services.

The rate for FHP and AFC services has been increased to offset this change in respite.

We did this in collaboration with FHP and AFC providers to ensure that this would not disrupt this important residential option for people.

(c) Comment: David Volkner, vice president of ResCare Residential Services, asked, “Is the technology daily rate for technology services expected to be a supplemental rate in conjunction with Residential I and II rates? If not, then the proposed rates will not cover the cost associated with residential and technology services.”

(d) Response: No, the technology assisted residential is a stand-alone service for participants who are able to function without direct staff support on site at all times.

(21) Subject: Direct Support Professional Reimbursement

(a) Comment: Steve and Melanie Tyner-Wilson expressed concern that the regulation does not address the need to pay a sustainable wage to direct service professionals.

(b) Response: It is not within our authority to establish a salary scale for direct support professionals. It is within our authority, and we are currently endeavoring, to establish quality standards for the provision of services that will give the families of waiver participants relevant, quality, outcome-driven information to assist with service choices.

(21) Subject: Supported Employment Reimbursement

(a) Comment: Steve and Melanie Tyner-Wilson expressed support for the increased rate for supported employment and decreased rate for adult day training and described them as reasonable changes that will assist providers to increase services.

(b) Response: Thank you for your support.

(c) Comment: Jerry McDonald, program director of Links of Kentucky, stated the following:

“Supported Employment: What is the purpose of such a drastic rate increase for Supported Employment? SCL supports and reimbursement are not available for SE until verification that all funds from OVR have been allocated for the participant. The OVR funds are allocated for assessments, development of Person-Centered Employment Plan, Person-Centered Job Selection, Job Development, and Job Placement, with 60 days of successful employment. Only after this has been completed, is the participant eligible for SE supports through SCL waiver. These would include only the support necessary for maintaining the job placement, and communicating with employer. The increase in SCL rates for SE specialist will have little impact on job selection, job development, or job placement, as these supports are funded through Office of Vocational Rehabilitation. The training on workplace conduct and problem solving, workplace safety, and communication skills with employer and co-workers has been shifted to the Day Training Staff who are not trained in this area and who are not reimbursed enough to provide the individualized supports that may be required for the

participant to remain employed. An increase of Day Training rate to \$2.75 / unit will enhance the ability to provide more individualized supports. Decreasing the SE rate to \$8.00/unit should enable to SE specialist to provide adequate supports, and the reduction could be added into the Day Training rate.”

(d) Response: When participants have exhausted their access to services through vocational rehabilitation, then lose their job, no additional funding is available through vocational rehabilitation unless there has been a change in the impact of the participant’s disability. In addition to providing long-term support, SCL funding may be accessed if there is a need to develop a new job, train and become independent in a new job, or (if it has been many years since the original job was obtained) to conduct additional discovery. The role of career planning and development through day training is to provide training that could be valuable for any job. The role of supported employment is to identify the right job for the person, assist the participant with obtaining that job, training the participant to be successful in the desired job, and assisting them with maintaining long-term employment in that job. The proposed day training rate in Kentucky will be among the highest in our geographical area, will provide a substantial contribution to provider’s fixed costs and overhead beginning at the one staff member to two participant level, and, when combined with community access and supported employment, will provide an opportunity for providers to significantly increase their income.

(22) Subject: Fund New Personnel Requirements

(a) Comment: Jenifer Frommeyer, executive director of Dreams With Wings and mother of a child with Down syndrome, stated, “Make appropriate funding available for added/new personnel requirements that are not funded or underfunded with current draft of regulation, i.e. mandatory drug testing, increased training requirements, etc., if funding is not made available, then the requirements should be removed from the regulation.”

Judy Erwin, director of regulatory compliance with the Zoom Group stated, ““Daily contact notes will be required for each Day Training contact under the proposed regulation. We request that this requirement be removed as it is unfunded and we already complete monthly summary notes.”

(b) Response: What you are referring to as unfunded requirements are in reality procedures designed to ensure the health, safety, welfare of program participants and ensure the provision of quality services to help participants live in the community as valued citizens. As there has always been the expectation of maintaining health, safety, welfare and quality programming in the SCL waiver these elements are appropriately defined as costs of doing business. In addition to the activities that have been identified as causing an increase in costs, there are many changes designed to reduce costs. The incorporation of a maximum two-year certification period is one example. Medicaid’s prospective payment system is designed to reimburse providers for the direct cost of providing a service plus a contribution to cover the appropriate share of reasonable

fixed costs.

In terms of additional training requirements the Department has assumed the total cost of the College of Direct Support training curriculum which is a cost to providers in most other states.

The department also now offers, at no cost to the providers, quarterly webinars to provide topics and information pertinent to current best practice in the DDID field. DDID has also moved all trainings to the College of Direct Support, enabling providers to only utilize one system which provides administrative tracking of completion and attendance by provider agency staff, in order for them to better maintain personnel records. This information does follow an employee to their new provider agency if they change employers.

The per-contact note enables direct support professionals and others to record and better communicate daily life activities that impact a person's supports and services. The per contact note offers real-time information which has greater substance and meaningful data creating a summary that should be used by the person centered team as they make decisions about whether or not the person's needs are being met, and supports the opportunity to change goals and objectives more timely.

(23) Subject: Behavior Support Specialist Reimbursement

(a) Comment: Lili Lutgens, a licensed attorney, licensed clinical social worker and behavior support specialist stated, "My second comment concerns the requirements for positive behavior support specialists (PBSSs) versus the rate of compensation the regulation ensures for their work. In short, the Cabinet's failure to ensure proper compensation for PBSSs either requires PBSSs to provide hours of free service to the Cabinet each month in order to meet the standard of practice in the profession or risk a suit for malpractice because the units provided are not sufficient for PBSSs to meet the standard of care required of them.

As you know, currently behavior support specialists are paid at a rate of \$133 per hour. The regulation specifies up to 10 hours to draft a functional assessment and an additional 6 hours to draft a behavior support plan when one is necessary.

Pursuant to proposed regulation 907 KAR 12:020, the Cabinet proposes to pay PBSSs \$665 per behavior support plan (BSP). The regulation thus provides for payment for writing a BSP but does not reflect any designated payment for drafting a functional assessment (FA).

The standard in the profession, however, is to draft a FA prior to a BSP for multiple reasons. First, without a better understanding of the client's situation including examination of background materials, interviews with caregivers, and observations, it is impossible to determine if the alleged challenging behavior is truly a challenging behavior or what many PBSSs call "junk behaviors," that is behaviors that might bother

caregivers but in fact are not problematic but simply different. Caregivers often have difficulty understanding the difference between a behavior that is abnormal in the sense that it is damaging or disruptive versus simply atypical, that is different from the norm. Individuals with intellectual disabilities have the right to be themselves and this includes behaviors that are merely atypical. Only truly challenging behaviors on the client's part should be targeted for treatment.”

(b) Response: The payment for a functional assessment is included in the scope of consultative, clinical and therapeutic services which reads as follows:

“(b) Include all functional assessment components specified in the Supports for Community Living Policy Manual.”

A recommendation from the Behavior Intervention Committee should be a part of the documentation submitted with a request for exceptional supports in the area of consultative clinical and therapeutic supports. Any additional units required for a functional assessment should be determined through the person centered team process and submitted as well.

(c) Comment: Christopher George, a board certified behavior analyst, a licensed behavior analyst here Kentucky, and executive director of Applied Behavioral Advancements stated the following:

“REIMBURSEMENT

3) This regulation reduces the reimbursement rate for Behavior support professionals by 38% and psychologists by 42% This is a huge reduction in reimbursement rate that places behavioral and psychological services on the same rate as other therapies that only require a bachelor’s degree. Positive behavior support specialists and psychologists have additional education requirements for advanced graduate degrees. This is a discrepancy that provides no incentive for clinicians to seek advanced degrees (i.e. additional time in school and increased student loan debt for the same reimbursement rate for someone with a bachelor’s degree).

4) Most psychologists and positive behavior support specialists are contractors and only receive payment for billable services. In my agency most clinicians average just at 20 hours a week of billable services, due to travel between locations and non-billable requirements (i.e. progress notes, etc). All of their expenses are paid out of pocket and relative to the other therapies do not see clients in a clinical setting where they are able to bill back to back for appointments. This severely limits a clinician’s ability to provide a reasonable income for their families. I have already lost two of my best clinicians who have decided to move out of state due to the upcoming cuts (both in reimbursement rate and available units). I have spoken to several other providers who have clearly expressed that they will stop providing behavioral and psychological services if the regulations are approved without change.

a. QUESTION: Will DDID please provide in writing the rate analysis that was used to justify a 40% (on average) decrease in reimbursement rate for the most highly qualified clinicians?

- b. RECOMMENDATION: Please increase the reimbursement rate by \$4/unit from \$22.50 to \$26.50 a unit. This would be only a 20% decrease from current rates which would help the Cabinet to control costs while retaining clinicians with the most advanced educational degrees.”**

(d) Response: According to the United States Department of Labor Bureau of Labor Statistics Occupational Outlook Handbook, the median salary for practicing psychologists in May 2010 was \$68,640 per year (\$33.00 per hour). This figure seems to be confirmed by various other sources putting the salary range of clinical psychologists between \$45,475 (approximately \$22.00 per hour) and \$104,397 (approximately \$50.00 per hour). For comparison’s sake, the proposed Kentucky rate of \$90 per hour equates to \$187,200 per year and the quoted existing rate of \$155 per hour equates to \$322,400 per year.

The hourly rates for counseling through the Medicaid waivers in states contiguous to Kentucky are as follows:

Ohio	Indiana	Illinois	West Virginia	Virginia
\$54.74	\$71.48	\$37.00	\$40.08	\$57.20

It should be noted that Virginia does offer a payment of \$92.65 per hour for crisis stabilization with significant limitations to the quantity of services which can be delivered.

The current approved hourly rate for psychological services through impact plus services for children with significant mental health needs in Kentucky is \$78.40 for services from a psychologist and \$147.00 for services from a psychiatrist.

The proposed rate for psychological services in the SCL waiver is **still** significantly higher than the reimbursement rates in contiguous states. The rate should allow providers to easily cover reasonable wages for psychologists, reimburse travel expenses, and generate a significant contribution toward their fixed costs.

(24) Subject: Reimburse for Supervision of Person Centered Coaches

(a) Comment: Regarding the requirements in 907 KAR 12:010 regarding person centered coach supervision, Dr. Sheila Schuster, on behalf of the Kentucky Psychological Association and over 670 psychologists which it represents stated, “Those psychologists who also provide Positive Behavioral Support services are very concerned about the creation of a new level of provider with inadequate education and training to provide the level of services outlined in the regulation. Of concern is the requirement in the regulation that Positive Behavioral Support service providers would be responsible for supervising these Personal Coaches. There is no provision in the regulation for reimbursing PBSS for this supervision time and no allowance for them to

have any input on the selection and training of the Personal Coaches for whom they would be responsible. We believe that this not a workable extension of services and will likely drive PBSS providers out of the SCL system.

While we are invested in maintaining the integrity and sustainability of the SCL program and working with the Cabinet to assure its financial viability, we have raised concerns about the financial cost to the Commonwealth of individuals not being able to be sustained in their community placement – and, more importantly, of the tremendous impact on the individual and his/her family and providers if behavioral health services are not available. Providers of psychological and behavioral support services are available to meet with Cabinet officials to suggest other ways of assuring that SCL services remain focused and available as needed.”

Dr. Schuster also stated, “If Personal Coaches as service providers are to be created, then training and educational criteria need to be increased and reimbursement created for their supervision by Positive Behavioral Support Service providers.”

(b) Response: The requirement for supervision of the person centered coach has been revised to require that the person centered coach work under the direction of the positive behavior specialist or other licensed professional.

(25) Subject: Public Hearing

(a) Comment: Tara Sorgi Pelfry, a board certified behavior analyst, wrote the following regarding the public hearing:

“I found the public hearing to be quite discouraging. Despite the requirement to RSVP, the number of guests who squeezed into the designated room exceeded the Room's Fire Code by over 100 people and wasn't accessible to person's in wheelchairs. The majority and remainder of those in attendance stood in the hallway the first hour until the room was made larger after public out roar. Even after the room was enlarged, the placement of the podium and microphone did not permit approach by those in wheelchairs, causing the hearing coordinators to hold the microphone while individuals with disabilities spoke from a different area of the room. Does the Cabinet plan to adhere to fire safety codes and ADA accessibility codes during future meetings in the state's Human Resources Building when addressing future issues with the SCL waiver?”

(b) Response: Yes, it does.

(26) Subject: Cap Salaries and Benefits of SCL Provider Executives/Managers/Cap Provider Cut of Medicaid Reimbursement and Require Better Pay for Direct Support Staff

(a) Comment: Annelle S. Fulmer, sister of an SCL participant, stated “I know there have been several newspaper articles discussing how much some of the CBO's of the

agencies caring for the mentally disabled are being paid, and it is appalling. I agree this makes everyone believe these agencies are making more money than they should and there is room for reductions in payments. However, I believe this exists with only a limited number of agencies. I would propose you make legislation that caps the salaries and benefits of management of the various agencies to ensure they are not excessive. If an agency has excess income after expenses (which include a limited salary and benefits to management), it should be returned to the Medicaid system annually.”

(b) Response: This request is not within the scope of this regulation. We are currently endeavoring, to establish quality standards for the provision of services that will give the families of waiver participants relevant, quality, outcome-driven information to assist with service choices.

(c) Comment: Wade T. Mullins and Wendy Wheeler-Mullins, parents of a daughter with autism, stated, “The proposed regulation to increase the education level of the direct support workers to a bachelor's degree and the proposed regulation to increase the rate of reimbursement for Supported Employment are welcome changes. The disability of autism is a very complicated disability with communication challenges, social and behavioral challenges, and sometimes intellectual challenges as well. As a group, individuals with autism need someone who has a high level of training in order for the worker to work successfully with the individual. Part of the current problem for us is that the home health agency keeps 55% of the money that is billed to Medicaid and only pays the direct support/community living support worker \$10 per hour. This is not a living wage. You are asking someone to work with a person who is very involved, and who may not be easy to deal with/manage, but the agencies are paying them a wage that is not commensurate with their level of responsibilities. There needs to be some way for the state to set a reasonable level of cost that the agency is allowed to take off of the top of the Medicaid reimbursement for administrative costs. This will help to insure that families can find and keep quality employees.”

Patti Parsons, mother of a son with autism spectrum disorder, and Vicky Roark, grandmother of an individual with autism spectrum disorder, stated, “I am pleased to see that the payment for Community Access (formerly Community Living Support) workers will be increased, and I hope there is a way to monitor agencies to see that they will pass along the increase and pay a living wage to the direct services providers.”

Marie Allison, mother of an SCL participant, stated, “There are increases in the amount of reimbursement agencies can pay for various categories. There is no requirement that the increased amount of reimbursement be spent on the direct support staff. I suggest there be a limit to the overhead percent an agency can charge to a percent such as 10 %. The remainder of the funding must be spent on paying the direct support staff. This way persons who accept employment as direct care providers will be adequately paid and be able to afford to provide long term assistance to those they support, rather than leaving for jobs that pay a similar wage that do not require as much skills. Persons with disabilities need continuity of service and this would increase that being provided.”

Stephanie Sharp, chairperson of the Commonwealth Council on Developmental Disabilities on behalf of the council, stated the following:

“One key issue is that these regulations do not address the need to pay the sustainable wage to direct support professionals. This is an issue that we hope to work on in other forums. But, as a whole, we applaud the Department of Behavior and Developmental and Intellectual Disabilities for the direction they have taken in creating these regulations.”

(d) Response: It is not within the scope of this regulation to establish a maximum percentage of overhead for an SCL certified provider. We are currently endeavoring, to establish quality standards for the provision of services that will give the families of waiver participants relevant, quality, outcome-driven information to assist with service choices.

(27) Subject: General Support for the Regulations

(a) Comment: Wade T. Mullins and Wendy Wheeler-Mullins, parents of a daughter with autism, stated, “We approve of the proposed regulations for the 907 KAR 1:145, 907 KAR 1:155. 907 KAR 12:010, and 907 KAR 12:020 for the Supports for Community Living Services. The proposed regulations for the SCL Waiver are a positive step for individuals with developmental and intellectual disabilities in Kentucky.”

Patti Parsons, mother of a son with autism spectrum disorder, and Vicky Roark, grandmother of an individual with autism spectrum disorder, stated, “I am writing in support for the new regulations for the Supports for Community Living waiver. I have been following developments for the past year, and I can tell that a lot of thought went into plans for improving services to people with developmental disabilities in our state. We in Kentucky should be very proud of having such dedicated professionals at the Department of Behavioral Health, Intellectual and Developmental Disabilities.

I particular I am very pleased with some of the new services that will be available: Community Guide, Person Centered Coach and Natural Supports Training. These services will help ensure that people receiving waiver services will be able to live up to their potential and be able to pursue their own interests. I also really like the Shared Living concept to allow people to remain in their own home. In addition I am glad to see the emphasis the Department is putting into getting people out in the community, and that with the Natural Supports Training there will be much more of a chance to individualize the services that our loved ones will be able to receive.

I know that some families and agencies are fearful of change, in particular that their loved one will lose their right to attend Adult Day Health and/or Sheltered Workshops. I think there is some disinformation floating around and tha the new regs as written will allow for a wide range of options for individuals. Perhaps there needs to be a better job of educating the public on the positive aspects of the new regs.

Again, I want to commend the people who worked so hard to bring this waiver to

fruition. I urge its passage!”

Stephanie Sharp, chairperson of the Commonwealth Council on Developmental Disabilities and Oyo Fummilayo, member of the Commonwealth Council on Developmental Disabilities, expressed support for the changes on behalf of the Council on Developmental Disabilities. Ms. Sharp elaborated regarding the counsel by stating the following:

“Counsel is made up of twenty-six members appointed by the Governor. Over sixty percent of our members are individuals with developmental disabilities or family members of individuals with developmental disabilities. The Council is authorized by Federal public law and by the Kentucky Revised Statutes. Our mission is to create change through visionary leadership and advocacy so that people have choices and control over their own lives.”

Ms. Sharp stated the following:

“My fellow Council members and I work to create change so that individuals with developmental and intellectual disabilities have choices and control over their own lives. After reviewing and discussing the proposed new SCL regulations, as a Council we have concluded that the proposed regulations represent a tremendous positive step in that direction. Several of our individual members have made comments that illustrate the Council's overall feelings. One member said, person centered is woven into these regs, is a huge INAUDIBLE not one fits all. Another member described these regulations as an opportunity to really tailor the supports to the person and that's a tremendous step for Kentucky.”

Ms. Sharp also stated:

“As individuals with disabilities, family members of individuals with disabilities and advocates for individuals with disabilities, we feel these regulations represent a terrific increase in person centered thinking compared to the current SCL regs.

The focus on community inclusion, opportunities for individualization and flexibility and matching of services with outcome and evidenced based practices are--stand to benefit the SCL participants and to expand participants choices and control over their own lives.

While we do request more information or changes in the areas noted above, overall, we believe these regulations represent a tremendous positive change for SCL participants and it is our hope that they move rapidly through the approval process so that participants may begin to exercise and enjoy the many options that will be made possible by these regs.

On behalf of the Commonwealth Council for Developmental Disabilities, thank you for considering our comments.”

(b) Response: Thank you for the support.

(28) Subject: Clarify in Introduction that the Participants, not the Providers, are the Focus of the Program and Through Whom Funding Flows

(a) Comment: Wade T. Mullins and Wendy Wheeler-Mullins, parents of a daughter with autism, stated, "Something we have noticed since we have worked with several different home health/provider agencies within Kentucky is that some agencies do not focus on person-centered decision making for the client, but are more inclined to want to do what the **agency** wants to happen for the individual. It might be helpful for there to be some comment somewhere in the regulations to remind everyone that the reason that the agencies even exist and are able to provide these Supports for Community Living Services for a fee is the individual with the disability, and the need for their individual needs to be served. We have experienced situations with agencies where they took the attitude that they would tell the individual and the family how the individual would be served by the agency (with no alternatives offered). This is an odd attitude, since the individual with the disability is the customer of the agency and that the company would not even be able to access the funding stream to run their business if it were not for the person with the disability who needs services. We think it would be beneficial to clarify somewhere at the start of the regulations (like an introductory Executive Summary) that the person with the disability is through whom the funding flows, not that this funding is somehow for the agencies and it is theirs to share with the individual with the disability, while making sure they make a good profit for all their administrative levels in their company."

(b) Response: DMS is revising the Necessity, Function, and Conformity paragraph by stating that funding for the program is associated with and generated through SCL waiver program participants rather than SCL waiver service providers.

(29) Subject: New Regulations' Push for Community Involvement is Much Needed

(a) Comment: Wade T. Mullins and Wendy Wheeler-Mullins, parents of a daughter with autism, stated, "We have always strived to include our daughter in regular community activities. Because she is a participant in a Medicaid waiver for individuals with developmental disabilities, she is out in the community nearly seven days a week. This is very important for her. Without the support of the Medicaid waiver services, she may not be able to get out in the community every day. For many individuals with disabilities, they are often stuck at home with their parents. It takes a lot of effort to plan and make sure community involvement works for some individuals. The push in the new regulations to increase the community involvement of individuals with developmental disabilities is much needed. For some individuals it takes additional planning and interventions to make community involvement successful, but this involvement needs to be the goal for all individuals. Our daughter has a pretty stereotypical presentation of autism and tends to speak in 2 to 3 word utterances. Communication is a huge problem for her. We know there are families who would think a person like this would be best served in a Day Treatment program or for her to spend her day in a Sheltered

Workshop. This is old-fashioned thinking. It is a lot more work, but most individuals with developmental disabilities CAN be involved in the community when given the support and interventions that they need. The proposed regulations are a good way of encouraging all of us to have the ultimate goal for our loved ones with developmental disabilities to be as fully included in the community as they can.”

Patti Parsons, mother of a son with autism spectrum disorder, and Vicky Roark, grandmother of an individual with autism spectrum disorder, stated, “In addition I am glad to see the emphasis the Department is putting into getting people out in the community, and that with the Natural Supports Training there will be much more of a chance to individualize the services that our loved ones will be able to receive.”

(b) Response: Thank you for the support.

(30) Subject: Community Access Reimbursement Increase

(a) Comment: Patti Parsons, mother of a son with autism spectrum disorder, and Vicky Roark, grandmother of an individual with autism spectrum disorder, stated, “I am pleased to see that the payment for Community Access (formerly Community Living Support) workers will be increased, and I hope there is a way to monitor agencies to see that they will pass along the increase and pay a living wage to the direct services providers.”

(b) Response: It is not within our authority to establish a salary scale for these workers. It is within our authority, and we are currently endeavoring, to establish quality standards for the provision of services that will give the families of waiver participants relevant, quality, outcome-driven information to assist with service choices.

(c) Comment: Jerry McDonald, program director of Links of Kentucky, stated the following:

“Community Access: Requiring a degree + 1yr exp for provider seems excessive for the type of support to be provided. It is an enhanced direct support, but requirements are similar to those of the Case Manager or Supported Employment Specialist. It will be difficult to hire and retain people with a degree in that type of position. Perhaps requiring a 2 year degree or experience would be more in line with the support, and then reimbursement could be brought down to around \$6.00 per unit individual, \$4.00 per unit group. It would still be adequate for a community based support, without taking so much away from other supports.”

(d) Response: Community Access is designed as a service which enables a participant to seek a designated positive impact on their life. After the outcome has been established it is the responsibility of the community access worker to either provide the participant with training to continue the situation independently or negotiate a scenario where the situation is continued through the use of natural supports. This level of responsibility and problem solving merits a degreed staff member; or, a staff member

with significant relevant experience. The median salary for an entry level degreed human services worker in Kentucky is \$21,066 with a two standard deviation range of \$17,189 to \$26,419. Payroll and unemployment taxes increase this to a mean of \$23,098 with a range of \$18,924 to \$28,860. This equates to a unit cost of \$2.29 to \$3.50 with a mean of \$2.80. (Salary data source: Salaries.com, Frankfort, KY data) The proposed payment rate for Community Access is \$8.00 per unit.

For candidates without a college degree, there is a provision to substitute relevant experience for years of education. The Department is also finalizing a credentialing system to afford additional opportunities for staff to meet the requirements.

(31) Subject: Let Participants Choose Which Regulations Through Which To Receive SCL Services

(a) Comment: Steve Shannon, executive director of The Kentucky Association of Regional Mental Health/Mental Retardation Programs, Inc, (KARP), stated (and Shannon Ware, president and CEO of Bluegrass Regional Mental Health-Mental Retardation Board, Inc., supported Mr. Shanon's comments), stated, "It is recommended individual participants be provided the opportunity to fully have a person centered thinking and philosophical system of services and supports by empowering them to be able to select the pair of regulations from which they shall receive services and supports: either 907 KAR 1: 145 & 155 or 907 KAR 12:010 & 020. This can be accomplished by deleting the language referencing the transition from 907 KAR 1:145 to 907 KAR 12:010 based upon the individual's birth month (page 1 & 2). Also, by including language indicating the participant shall be able to select the pair of regulations from which their respective services and supports will be selected, provided and monitored.

The proposed transition plan based upon participant's month of birth is not a phase-in plan from an individual participant perspective since they would not have a choice but to transition to the new regulations (907 KAR 12:010 & 020)."

(b) Response: DBHDID and DMS have established a system that was approved by the Federal Centers for Medicaid and Medicare (CMS) that will allow people to transition from old to new services during the month of their birthday. This will provide time for people to work with their chosen case manager and person centered team to develop a plan of care that is based on needs identified in the Supports Intensity Scale (SIS) assessment and allow certified provider agencies to shift their business plans to changes in rate structure that promote community employment and participation in community life.

(32) Subject: Delay Implementation

(a) Comment: Shannon Ware, president and CEO of Bluegrass Regional Mental Health-Mental Retardation Board, Inc., stated, "Specific concerns with the regulations have been well communicated, but these issues notwithstanding, I believe the more pressing

issue at hand is the long term effect on the provider system under the new regulations and how such could ultimately have a negative impact on the system of care and the goals of individuals served by the system. I ask for your consideration of a reasonable delay in executing the regulations to allow for a global review of issues to be fully considered, and so that a more cautious implementation can be established, with real collaboration and input from all community partners, consumers, and families, and with sensitivity toward continuity of care. I believe all parties understand the national trends and direction that dictate the evolution of services, but I believe there is a state-wide consensus that the proposed regulations require additional modifications and that further discussion would be beneficial.”

(b) Response: We agree that it is important that Kentucky recognize the national trends and direction that dictate the evolution of services. The proposed regulations that support the Centers for Medicare and Medicaid Services (CMS) approved SCL waiver document, do not take away any current services or choices. Instead, the proposed regulations set forth opportunities for providers to offer people in SCL waiver services greater choice and receive a higher reimbursement rate which should lead to more access to community clubs, groups, organizations and supported employment options.

The collaboration between DDID and other stakeholders, which included representatives of KARP and KAPP, HB 144 membership, family members, advocates and providers has been consistent throughout this process. Beginning in 2008, public meetings and forums have been conducted involving providers, family members, and individuals in SCL services to help identify what was important to and for people in order to design a person-focused system. With the CMS-approved SCL waiver, the proposed regulations offer positive changes for Kentucky citizens with disabilities to have the choices and opportunities of a real life in their community as people with disabilities in other states do.

We will continue to hold additional forums and public meetings across the state in order to help people and their advocates understand the advantages of the flexibility of the waiver program and the enhanced opportunities it offers. The long term effect of these changes shall result in a great opportunity for participants in the SCL program to realize their individualized goals.

(33) Subject: Intellectual Disability Definition

(a) and (b) Comment and Response: DMS is revising the intellectual disability definition to make it match the revised definition being made to 907 KAR 12:010 which is made in response to a public comment request to insert the language “had an onset before” eighteen (18) years of age.

(34) Subject: Supported Employment Clarification

(a) and (b) Comment and Response: DMS is adding the words “On-Site” to “Supported Employment” in the upper payment limit table as on-site supported employment is the

correct term.

SUMMARY OF STATEMENT OF CONSIDERATION
AND
ACTION TAKEN BY PROMULGATING ADMINISTRATIVE BODY

The Department for Medicaid Services (DMS) has considered the comments received regarding 907 KAR 12:020 and is amending the administrative regulation as follows:

Page 2
Necessity, Function, and Conformity paragraph
Line 3

After “disability.”, insert the following:

Funding for the SCL waiver program is associated with and generated through SCL waiver program participants rather than SCL waiver service providers.

Page 3
Section 1(6) and (7)
Lines 1-7

After “(6)”, delete the following:

“Exceptional supports protocol” means the set of rules that establish how DBHDID:

- (a) Reviews an exceptional support request;
 - (b) Approves an exceptional support request;
 - (c) Revises a limit related to an exceptional support request; or
 - (d) Sets a standard related to an exceptional support request.
- (7)

Page 3
Section 1(8)
Line 8

Renumber this subsection by inserting “(7)” and by deleting “(8)”.

After “mean”, insert the following:

⋮
(a) and lowercase “A”.

Page 3
Section 1(8)(a)1.
Line 9

Renumber (a)1. by inserting “1.”, and deleting “(a)1.”.

Page 3
Section 1(8)(b)
Line 23

After “(b)”, insert the following:

An intellectual disability that had an onset before

Delete the following:

“Which occurred prior to the individual reaching eighteen (18) years of age.

(b) Which is demonstrated before an individual reaches

Page 4

Section 1(9) to (14)

Lines 2, 8, 14, 16, 17, and 18

Renumber these six subsections by inserting “(8)”, “(9)”, “(10)”, “(11)”, “(12)”, and “(13)”, respectively, and by deleting “(9)”, “(10)”, “(11)”, “(12)”, “(13)”, and “(14)”, respectively.

Page 5

Section 3(2)

Upper Payment Limit Table

Row Containing Consultative, Clinical and Therapeutic Upper Payment Limit

After the row containing the consultative, clinical and therapeutic upper payment limit of \$22.50, insert a return and the following:

<u>Day Training through December</u>	<u>15 minutes</u>	<u>\$2.50</u>
<u>31, 2013</u>		

Upper Payment Limit Table

Row Containing Day Training Upper Payment Limit (\$2.20 per 15 minutes)

After “Day Training”, insert “effective January 1, 2014”.

Page 7

Section 3(2)

Upper Payment Limit Table

Before “Supported Employment”, insert “On-Site”.

Page 9

Section 4(1)(c)

Line 18

After “with the”, insert “Kentucky”.

Page 12

Section 9(1)

Line 3

After “The “”, insert “Kentucky”.

After “Protocol””, insert “November”.

Delete “July”.