Kentucky Cabinet for Health and Family Services

Medicaid 1915(c) HCBS Waiver Redesign Project:
Frequently Asked Questions (FAQs)

Last Updated: January 14, 2020
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Section 1: Document Background

The Department for Medicaid Services (the Department) on behalf of the Cabinet for Health and Family Services (the Cabinet) is publishing this Frequently Asked Questions (FAQs) document to provide timely updates and respond to stakeholder questions about redesign of the Cabinet's 1915(c) Home and Community Based Services (HCBS) waivers. The questions included in this FAQs document are a combination of submitted questions from stakeholders and anticipated questions identified by the Department.

Please Note:

- For better clarity, the Department has modified some questions from the original submitted format.
- Stakeholders have submitted questions that are not related to the 1915(c) HCBS waiver redesign project to the Medicaid public comment inbox. Those questions will not be responded to in this FAQs. The Department will reply directly to those individuals.
- If your question was not addressed in this document and you did not receive a reply, please email MedicaidPublicComment@ky.gov.

We thank you for your continued interest in the 1915(c) HCBS waiver redesign process. We value your feedback and consider it an important part of the waiver redesign project. Please send any additional feedback and/or questions to the Department by emailing MedicaidPublicComment@ky.gov or by calling (502) 564-7540.
Section 2: Navigant's Assessment Activities

Q1: What are the 1915(c) HCBS waiver assessment areas?

There are three (3) assessment areas:

1. **Stakeholder Engagement** – which focused on obtaining stakeholders’ thoughts, opinions, and experiences with 1915(c) HCBS waivers.
2. **Operational Redesign** – which focused on assessing the way in which the Cabinet is organized and conducts waiver administration and oversight activities.
3. **Waiver Redesign** – which focused on reviewing existing 1915(c) HCBS waiver applications, regulations, and other policies to understand how current programs are designed, and what strengths and weaknesses exist due to design.

Q2: How did the Cabinet and Navigant choose the assessment areas?

The Cabinet selected Navigant following a competitive procurement completed in April 2017 to assess the 1915(c) HCBS waiver programs. The procurement Navigant responded to required them to review program oversight and administration, quality of care, and service delivery, and to improve provider and participant experience. Assessment areas were developed to obtain the necessary level of information to respond to the requests within the procurement.

Q3: Is the 1915(c) HCBS waiver redesign being done in phases?

The redesign activities are proposed to take place in two (2) phases:

1. **Phase One** – Began in April 2017 and continues through mid-2020. The Cabinet will continually assess the impact and improvements achieved as changes are implemented.
2. **Phase Two** – Anticipated to begin in late 2020. During this phase, the Cabinet may choose to assess what waiver configuration and activities are the best fit for the Commonwealth.

Q4: What work is currently being completed to redesign the 1915(c) HCBS waivers?

Navigant has completed its initial assessment of Kentucky’s 1915(c) HCBS system. The final report was released to the public on September 20, 2018 and can be found here: [https://chfs.ky.gov/agencies/dms/dca/Documents/kyhcbsassessmentfinalreport.pdf](https://chfs.ky.gov/agencies/dms/dca/Documents/kyhcbsassessmentfinalreport.pdf)

The Cabinet’s official response to Navigant’s recommendations was published on October 15, 2018 and is available online using the following link: [https://chfs.ky.gov/agencies/dms/dca/Documents/DMS%20Response%20Final%20PDF.pdf](https://chfs.ky.gov/agencies/dms/dca/Documents/DMS%20Response%20Final%20PDF.pdf)

In the Cabinet’s official response, the Cabinet highlighted three (3) priority Groups (A, B, C) and the
timing of the upcoming activities of these Groups. Activities have already begun for Groups A & B. Activities for Group C are not scheduled to begin until late 2019. Here is a brief explanation of each priority Group:

- **Priority Group A** – Department activities **beginning Fall 2018**, anticipated implementation by Summer 2019. This Group addresses:
  1. Areas that need to be updated to comply with Centers for Medicare and Medicaid Services (CMS) guidance and
  2. Program administration and consistency.

- **Priority Group B** – Department activities **beginning Fall 2018**, anticipated implementation by Fall 2019. This Group addresses:
  1. Participant directed services (PDS) policies;
  2. The rate setting methodology;
  3. The use of assessment data to develop an independent assessment method; and,

- **Priority Group C** – Department activities **beginning late 2019** and beyond. This Group addresses:
  1. A quality improvement strategy;
  2. Potential future assessment of Long Term Services and Supports (LTSS) needs; and,

### Q5: What are the next steps in the 1915(c) HCBS waiver redesign process?

As we continue to work on identified processes, additional activities will start in late 2019 (in priority Group C). This includes activities to enhance the Commonwealth’s 1915(c) HCBS waivers to reflect national best practices, to use a robust quality improvement strategy, and to assess potential future needs of participants in 1915(c) HCBS waiver programs. Please see Q4 for a more specific 1915(c) HCBS waiver redesign timeline.

### Q6: How did the Department identify what redesign activities to move forward with first?

When prioritizing which recommendations to adopt first, the Department considered the needs of participants, stakeholder feedback, and financial constraints. The Department’s current response plan will continue through 2019 and beyond. Although the Department plans to move quickly to initiate implementation, it will be deliberate as it moves forward to ensure that reforms are well designed and effectively implemented, without flooding the public with changes. These activities have already started (in priority Groups A & B).
Q7: Where do I find a copy of Navigant’s recommendations?

Date Added/Revised: 12/14/18

On September 20, 2018, the Cabinet released Navigant’s final Assessment Recommendations Report. This report was released following Navigant’s assessment of Kentucky’s 1915(c) HCBS waivers and includes a series of findings and recommendations intended to improve the Commonwealth’s 1915(c) HCBS waiver programs. You can access the Assessment Report online using the following link: https://chfs.ky.gov/agencies/dms/dca/Documents/kyhcbsassessmentfinalreport.pdf. Documents are also available in an alternative format by contacting the Department at MedicaidPublicComment@ky.gov or by calling (502) 564-7540.

Q8: Which 1915(c) HCBS waivers have been reviewed?

Date Added/Revised: 5/31/18

All the existing 1915(c) HCBS waivers, including:

1. Acquired Brain Injury (ABI) waiver
2. Acquired Brain Injury – Long Term Care (ABI-LTC) waiver
3. Home and Community Based (HCB) waiver
4. Michelle P. Waiver (MPW)
5. Model II Waiver (MIIW)
6. Supports for Community Living (SCL) waiver

Q9: How did the Cabinet and Navigant review the waiver language?

Date Added/Revised: 1/8/2020

The Cabinet and Navigant conducted a full, appendix-by-appendix review of all waiver language across the six (6) current 1915(c) HCBS waivers. The project team and Navigant subject matter experts reviewed language and compared each waiver to identify areas that could be strengthened, standardized, or restructured to better clarify processes, expectations, and to meet federal requirements. These revisions are drafts and are not considered final until CMS formally approves.

Q10: Does the Cabinet expect to change 1915(c) HCBS waiver regulations within the Kentucky Administrative Regulation (KAR)?

Date Added/Revised: 1/8/2020

Yes, the Cabinet is updating waiver-related KARs based on the appendix-by-appendix waiver review process as state regulations will need to be aligned with any CMS-approved waivers. The Office of Legislative and Regulatory Affairs (OLRA) anticipates submitting all updated KARs to the Legislative Research Commission (LRC) in mid-January 2020. A 30-day public comment period will be held for updates to waiver-related KARs.
Section 3: Governance

Q11: What is the 1915(c) HCBS governance team and what is their role in overseeing waiver redesign?

Date Added/Revised: 12/14/18

The Cabinet governance team is made of State leaders and decision makers in 1915(c) HCBS waiver program management. This includes the Medicaid Commissioner, executive leadership from the Cabinet, and the Governor’s office.

The role of the governance team is to help guide the redesign process and make important decisions about project activities and the future of home and community based services. They are also responsible for monitoring the ongoing success of the 1915(c) HCBS redesign project and help Cabinet staff work through any issues or concerns as they arise. Together, these State leaders have many years of experience overseeing community based programs and several have direct experience with disability populations who need home and community based services. The types of decisions brought to the governance team cover a wide variety of topics.

In addition, the governance team is supported by colleagues from departments who contribute to home and community based services delivery, including:

- Department of Aging and Independent Living (DAIL)
- Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID)
- Department for Community Based Services (DCBS)
- The Cabinet for Health and Family Services (the Cabinet) Office of the Ombudsman
- The Cabinet for Health and Family Services (the Cabinet) Office for Administrative and Technology Support (OATS)

Section 4: Covered Services

Q12: Some of the service definitions are confusing and do not accurately portray what they offer or cover. Will service definitions be addressed through waiver redesign?

Date Added/Revised: 1/8/2020

All waiver service definitions were considered for revisions that would improve and clarify the terms of that service. The Department’s first round of proposed service definition updates were included in the waiver amendments released for public comment on March 15, 2019. A second round of proposed service updates were made following the conclusion of the 1915(c) HCBS Rate Study in September 2019. Those updates were released for formal public comment between November 8, 2019, and December 10, 2019. The Department is reviewing the comments received and will make waiver revisions as needed.
Q13: Who will or could lose services as a result of these proposed changes to 1915(c) HCBS service definitions?

Date Added/Revised: 1/8/2020

In the first round of proposed waiver amendments released on March 15, 2019, the Department updated service definitions to standardize services that were similar across waiver programs. While the names of service types were adjusted to make terms consistent across all 1915(c) HCBS waivers, the nature of services remained the same.

The Department made further updates to Appendix C: Participant Services of each waiver application based on the results of the 1915(c) HCBS Rate Study, which was completed in September 2019. Those proposed waiver amendments were released for formal public comment on November 8, 2019.

Services were categorized in one of five ways:

1. **Unchanged**: Current service did not receive any change other than name standardization or change in proposed rate.
2. **Unbundled**: Current service includes multiple services, which will receive an individual rate and be billed separately.
3. **Modified**: Current service resulted in a substantial change in the description and/or requirements
4. **Added**: Proposed service not previously available in the waiver.
5. **Removed**: Current service withdrawn from the waiver application due to:
   a. Sustained lack of utilization;
   b. Duplication by other waiver services; or
   c. Listed in the waiver but never authorized by State regulation.

Proposed updates to Appendix C: Participant Services of each waiver can be found in the amended waiver applications. The Department also released a summary of proposed updates in waiver-specific “What Does This Mean to Me?” documents. All of these resources are available on the Department’s Division of Community Alternatives (DCA) website at [https://chfs.ky.gov/agencies/dms/dca/Pages/default.aspx](https://chfs.ky.gov/agencies/dms/dca/Pages/default.aspx).

The Department reserves the right to deny a requested service when it is considered inappropriate or unnecessary, which is a continuation of current waiver policy.

Q14: Is the Michelle P. Waiver (MPW) going to change its allowable service units so that if you don’t use them, you lose them?

Date Added/Revised: 12/14/18

The Cabinet is planning to revise its service allocation requirements to address stakeholder concerns that there is “one size fits all” approach to service allocation and usage requirements. The Department plans to adjust the Michelle P. Waiver 40-hour a week service allocation standard to be more individualized to a participant’s needs as they have been assessed. However, for the time-being the 40-hour limit is not changing due to the potential impact on the Medicaid budget.

Proposed waiver revisions will also reflect changes to how services can be spread out over time in a participant’s person-centered service plan to allow participants to use services when they are needed.
Our goal is to avoid a “use it or lose it” culture, so that participants can make better use of services when they are needed. The Cabinet also wants to reduce waste and misuse of services as a part of this process.

Q15: Will occupational, physical and speech therapies continue to be offered through the ABI, ABI LTC and Michelle P. waivers?

Date Added/Revised: 4/11/19

In the waiver amendments made public on March 15, 2019, the Department proposed removing occupational, physical and speech therapy from the Michelle P. waiver. The Department has determined the services were duplicative of services offered under the Medicaid State Plan, which all Medicaid enrollees can access. Participants will continue to have access to these services as they do today through their State Plan benefit.

The ABI and ABI LTC waivers will continue to offer therapies through the 1915(c) HCBS waivers (i.e. occupational and speech therapy will be available under ABI and occupational, speech and physical therapy will be offered under ABI LTC). The therapies offered under the ABI and ABI LTC waivers are specialized to the needs of the ABI population and intended to maintain the participant’s level of functioning.

Q16: I heard the Department plans to change services after the rate study is complete. Which services will be changed after the rate study?

Date Added/Revised: 1/8/2020

The Department made updates to Appendix C: Participant Services of each waiver application based on the results of the 1915(c) HCBS Rate Study, which was completed in September 2019. Those proposed waiver amendments were released for formal public comment on November 8, 2019. Services were categorized in one of five ways:

1. **Unchanged**: Current service did not receive any change other than name standardization or change in proposed rate.
2. **Unbundled**: Current service includes multiple services, which will receive an individual rate and be billed separately.
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   a. Sustained lack of utilization;
   b. Duplication by other waiver services; or
   c. Listed in the waiver but never authorized by State regulation.

Proposed updates to Appendix C: Participant Services of each waiver can be found in the amended waiver applications. The Department also released a summary of proposed updates in waiver-specific “What Does This Mean to Me?” documents. All of these are available on the Department’s Division of Community Alternatives (DCA) website at https://chfs.ky.gov/agencies/dms/dca/Pages/default.aspx.
Q17: What is the intention of the Homemaking Services in the Michelle P. waiver?

Date Added/Revised: 5/17/19

Homemaking is a service currently offered under the Michelle P. waiver. The intention of this service is to assist participants with performing general household tasks and chores such as meal preparation and cleaning. The service is intended for participants that cannot manage these tasks by him or herself or do not have natural supports available to assist with common household tasks.

Homemaking is different from personal care. While personal care is intended to assist participants with activities of daily living, such as, mobility, dressing and bathing, homemaking is limited to household tasks and chores. The amended MPW application includes a personal care service as well.

Q18: Will the Department consider adding music therapy as a waiver service? Why or why not?

Date Added/Revised: 5/17/19

During the formal public comment period in March 2019, several stakeholders recommended adding music therapy to the 1915(c) HCBS waiver services menu. The Department acknowledges music therapy as a beneficial service to improve the lives and health of participants, however, the Department does not have a budget for adding services at this time. Once the 1915(c) HCBS Rate Methodology Study is complete, the Department will evaluate the fiscal impact of any additions to service menus. The Department may take this recommendation under consideration in Phase Two of waiver redesign.

Q19: Will the Department consider allowing participants to access waiver and hospice services at the same time? Why or why not?

Date Added/Revised: 5/17/19

Waiver participants are already allowed to access waiver and hospice services at the same time, however, those services must not be duplicative. This means a waiver participant cannot receive a waiver service that is also available through hospice. With HCB2, waiver services are bundled. This makes it difficult to figure out which ones are duplicative and which ones are not. Under the amended 1915(c) HCBS waiver applications released in March 2019, the services have been unbundled. This will make it easier to determine which services are not duplicative. Hospice should be able to provide those non-duplicative services.

Q20: Will the Department continue the Money Follows the Person (MFP) program through a 1915(c) waiver? Will community transitions be a waiver service?

Date Added/Revised: 1/8/2020

MFP has assisted 760 Kentuckians with transitioning from institutional facilities into the community. In January 2019, Congress extended the MFP Demonstration Grant, which allows Kentucky to continue accepting referrals until CMS closes the program.
DMS currently offers Community Transitions through the Supports for Community Living (SCL) waiver. DMS will evaluate the need to offer transition services in other waivers and, based on our findings, we may consider this recommendation in Phase Two of 1915(c) HCBS waiver redesign.

Q21: Will the Department consider adding supported employment services to the HCB waiver?

Date Added/Revised: 5/17/19

During the formal public comment period in March 2019, several stakeholders recommended adding supported employment to the HCB waiver services menu. The Department recognizes supported employment as a beneficial service that encourages participants to remain active in the community and the workforce, but the Department is not considering adding any services to the HCB Waiver at this time. The Department may take this recommendation under consideration in Phase Two of waiver redesign. The Department encourages 1915(c) HCBS waiver participants to seek and maintain employment in the community using available supports, whether those supports are through the waiver or other resources.

Q22: Within the definition of non-specialized respite released in March 2019 it states that the service will be limited to “unpaid primary caregiver”. How is “unpaid primary caregiver” defined? Can a legally responsible individual hired as a PDS worker use the respite service to give themselves relief?

Date Added/Revised: 1/8/2020

Respite services are intended to provide a break from caregiving to a participant’s primary caregiver. Participants may receive non-specialized respite services as long as the respite services are delivered using an employee who is not also the primary caregiver.

Based on comments received during the March 2019 1915(c) HCBS waiver public comment period, the Department has revised the definition of non-specialized respite to clarify that paid caregivers, including legally responsible individuals and parents, are permitted to use respite services, so long as there is a separate employee providing respite to the paid caregiver, in support of the participant.

Q23: Can you clarify what the difference is between a statutory service and an extended state plan service?

Date Added/Revised: 7/25/19

Statutory and extended state plan services are terms used by the Centers for Medicare and Medicaid Services (CMS) to categorize 1915(c) HCBS waiver service types. CMS defines four categories as follows:

1. **Statutory Services**: services specifically contained in §1915(c) of the Social Security Act and 42 CFR §440.180. Statutory services include:
   a. Case management
   b. Homemaker services
   c. Home health aide services
d. Personal care services  
e. Adult day health services  
f. Habilitation services  
g. Respite care services  
h. Day treatment or other partial hospitalization services, psychosocial rehabilitation services and clinical services

2. **Extended State Plan Services:** Each state provides services under their traditional Medicaid program. These are commonly referred to as “Medicaid State Plan” services. The services included in a 1915(c) waiver cannot duplicate services provided under the State Plan. When a state wants to exceed the amount, duration, or frequency of a State Plan service but otherwise the scope and definition of the service remains the same as the State Plan service, the service is considered an “extended state plan” service.

3. **Other Services:** Other services are services not expressly authorized by §1915(c) of the Social Security Act but have demonstrated to be necessary to assist waiver participants to avoid institutionalization and function in the community; for example, shared living or personal emergency response systems.

4. **Supports for Participant Direction:** Supports for participant direction services are available to participants who choose to self-direct some or all of their waiver services. When a state provides the opportunity for participants to direct some or all of their waiver services, the state must make available certain supports to waiver participants who do so. These supports include “financial management services” and “information and assistance” to support waiver participants in directing and managing their services.

**Q24:** Is the state proposing changes to Adult Day Health Center services?

**Date Added/Revised:** 7/25/19

**No,** the Department does not propose changing qualified provider types for waiver services at this time. However, the Department wants to clarify and update provider qualifications for staff with direct contact with participants. The Department also wants to standardize provider requirements and certification processes across waivers to reduce administrative burden on providers to demonstrate compliance and encourage providers to serve multiple waiver populations.

**Q25:** Is Adult Day Health still available in the SCL waiver?

**Date Added/Revised:** 7/25/19

**Yes.** In the amended 1915(c) HCBS waiver applications released in March 2019, DMS did not change the current mode of delivering Adult Day Health Center (ADHC) Services in the SCL waiver. ADHC are qualified providers to deliver day training services. Please refer to the provider qualifications section under Day Training for qualifications for ADHCs to deliver the service. DMS issued a provider letter in early May to clarify the definition of Day Training in SCL. Please refer to this link for a copy of the letter: [https://chfs.ky.gov/agencies/dms/ProviderLetters/amendedwaiverclarification58.pdf](https://chfs.ky.gov/agencies/dms/ProviderLetters/amendedwaiverclarification58.pdf).
Q26: Will the Department clarify the service definition of Adult Day Health regarding “when a participant is receiving ADHC services, all personal care needs should be addressed within that service”?

Date Added/Revised: 1/8/2020

When the Department added this language to the ADHC definition, the intention was to remind the ADHC that it is responsible to take care of any personal care needs that arise for a participant while they are attending an ADHC. For example, if a participant needed assistance with toileting it would be the ADHC’s responsibility to take care of that need. The phrase was not intended to dictate that all personal care needs must be met in the ADHC setting, as this would be a duplication of services.

Personal care needs, such as bathing, dressing or grooming, can take place before or after attendance at the ADHC and should be driven by the participant’s desires as determined through the person-centered planning process. The Department reviewed and edited the language published in March 2019 and released an updated ADHC definition in November 2019.

Q27: Can Community Access be used for provision of leisure activities?

Date Added/Revised: 1/8/2020

The goal of Community Access is to assist waiver participants in accessing the community and also in attending to or helping them learn how to attend to their personal care needs while in the community. All services must meet the definition established in the 1915(c) waiver application and applicable Kentucky Administrative Regulations.

Q28: What services are available through Early Periodic Screening, Diagnosis and Treatment (EPSDT)?

Date Added/Revised: 7/25/19

The Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit allows individuals under the age of 21 to receive all medically necessary services through Kentucky’s State Medicaid program. DMS is working to improve coverage for our younger waiver participants.

It is not the intention of DMS to reduce services for waiver participants younger than 21.

Q29: Are Goods and Services and Assistive Technology available for PDS participants?

Date Added/Revised: 1/8/2020

Yes, waiver participants who choose to self-direct some or all of their waiver services have access to Goods and Services and Assistive Technology. Both services will be obtained through a traditional service delivery model. The participant’s case manager/participant-directed case manager will assist the participant in accessing Goods and Services and Assistive Technology.
### Q30: How will assistive technology needs be identified?

Date Added/Revised: 10/10/19

Assistive technology needs may be identified by conducting the assessment, through conversations with physical therapists and case managers, and through the person-centered service planning process when goals and service options are discussed. The Kentucky Assistive Technology locator ([https://www.katsnet.org](https://www.katsnet.org)) is available for participants to identify assistive technology.

### Q31: Why were the service definitions updated for Occupational Therapy, Physical Therapy, and Speech Therapy?

Date Added/Revised: 7/25/19

The Department made several updates to service definitions to clarify their intention and permitted activities. The Department intends to continue monitoring and oversight activities to confirm waiver services are provided as intended.

### Q32: What HCB waiver services are available for those who meet chronic mental illness criteria?

Date Added/Revised: 1/8/2020

To access HCB waiver services, individuals must meet the financial and level of care criteria set forth in the 1915(c) HCBS waiver application. Once an individual meets level of care, he or she is eligible for any of the services offered under that waiver. After enrollment, the participant’s case manager will develop the participant’s person-centered service plan (PCSP) in collaboration with the participant. The case manager will use several sources, including the participant’s functional assessment, and conversations with the participant regarding their needs and preferences to develop the PCSP based on assessed need.

### Q33: Who is financially responsible when a waiver participant needs an interpreter service?

Date Added/Revised: 1/8/2020

It is the responsibility of a provider to ensure a waiver participant's communication needs are met while in their care. Providers who fail to provide information to participants in a manner they can easily understand risks violating CMS Federal Final Rule.

### Q34: Who is financially responsible for obtainment of communication devices?

Date Added/Revised: 1/8/2020

When a participant demonstrates a need for a communication device, it can be requested through Goods and Services.
**Q35:** We use our YMCA membership as a community activity and fitness facility. Will the price of membership still be covered by waiver services under Goods and Services?

**Date Added/Revised:** 10/10/19

DMS may consider a gym membership, and specifically YMCA membership, if it meets the Goods and Services definition in the KAR and aligns with a goal documented in the person-centered service plan. The membership must directly advance a PCSP goal and be monitored for use and advancement of the goal as part of case management.

**Q36:** Will the initial 30-day prior authorization still be required for the Acquired Brain Injury (ABI) - Acute waiver?

**Date Added/Revised:** 1/8/2020

“Service authorization,” as it will be referred to under the new regulation, 907 KAR 2:010 1915(c) Covered Services, will continue to be required for certain services. The time standards to complete a service authorization will remain the same for some services but will change for others. The goal is to have services in place timely for the individual. If a full plan can be entered initially, the 30-day prior authorization will not be required. Much of the specific service authorization requirements are set forth in service authorization resources issued by the Department. Those resources include standard operating procedures (SOPs), a Case Management Frequently Asked Questions (FAQ), Service Authorization Crosswalks for each waiver, and Quick References Guides for the Medicaid Waiver Management Application (MWMA). These items are available on the Department’s DCA website at [https://chfs.ky.gov/agencies/dms/dca/Pages/default.aspx](https://chfs.ky.gov/agencies/dms/dca/Pages/default.aspx).

**Q37:** Will there be exceptions to the requirement stating that “Services rendered prior to signed attestation of understanding of the contents of the PCSP by these parties will not be reimbursed” to allow for crisis events that occur on the weekend or holiday where the case manager cannot facilitate a signature in a timely manner?

**Date Added/Revised:** 10/10/19

Existing exceptions to allow for crisis events during the weekend or holiday will continue in all waivers. There may be some changes in the process by which these exceptions are granted.

**Q38:** What are the employee requirements for Community Access?

**Date Added/Revised:** 10/10/19

Community Access services may be provided by a community access specialist from a certified 1915(c) HCBS waiver agency meeting Department certification and training requirements, a qualified participant-directed services provider, or, if delivering a participant-directed service, may be provided by a legal guardian or legally responsible individual in accordance with Kentucky regulations.
Q39: Will the combination of the Community Living Support (CLS) and Community Access services change the intent of the service? Will there be new documentation requirements?

Date Added/Revised: 10/10/19

At this time, DMS is not planning to combine home and community support services and Community Access services. Services will be authorized based on a participant’s assessed need, the person-centered planning processes, and the participant’s person-centered service plan.

Q40: Will the exceptional support application be included in the new waiver?

Date Added/Revised: 1/8/2020

Exceptional supports may be considered under the modified Supports for Community Living (SCL) waiver in a similar manner as currently addressed. The participant will need to demonstrate an extraordinary circumstance related to the participant’s physical, psychiatric, or behavioral health. The participant will also need to show that such services are necessary to be provided in excess of the upper payment limit or unit limit for the service for a specified amount of time, and that services will meet the assessed needs of the participant. The exceptional supports process for SCL can be found in Provider Letter #A-49 at https://chfs.ky.gov/agencies/dms/dca/iddcsb/Documents/sclproviderlettera49.pdf.

Q41: Can nursing supports be provided for those who choose to blend their services in the Acquired Brain Injury Long-Term Care (ABI LTC) waiver? For example, if they reside at their own home, or home of a family member, can someone access nursing services for a medical condition?

Date Added/Revised: 10/10/19

Nursing services will continue to be a covered service under the ABI-LTC waiver in the same manner as they are currently covered.

Q42: Can a provider bill Personal Assistance for time during a Medicaid-funded medical/doctor appointment?

Date Added/Revised: 10/10/19

Yes, this is a permissible way to use personal assistance.

Q43: Can you clarify that Personal Assistance may not supplement educational services available under the Individuals with Disabilities Education Act (IDEA) for the Michelle P. waiver? Does this mean if someone is home schooled, or on home bound from school, that services cannot be provided during typical school day?

Date Added/Revised: 10/10/19
If the same services are available to the participant under the IDEA Act, these services may not be provided through the personal assistance service. If someone is home schooled or home bound from school and is receiving personal assistance services paid for through the IDEA Act, the service cannot be billed to personal assistance.

**Q44: Will Personal Assistance replace use of the term “Attendant Care”?**

**Date Added/Revised: 10/10/19**

**No.** Personal assistance and attendant care will be two separate services. Personal care is for an individual who is able to be alone and may only need short-term, daily or less frequent assistance. Attendant care is for individuals who require more continual care.

**Q45: Since Personal Assistance is only available for participants 21 years of age and over, how will this affect the almost 75% of Michelle P. waiver (MPW) population that is under the age of 21?**

**Date Added/Revised: 1/8/2020**

MPW participants under 21 should receive Personal Assistance through the state Medicaid program’s Early Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. If there is not adequate provider coverage through the EPSDT benefit, DMS will review the participant’s needs and may cover the service through MPW. This is the current DMS policy and this policy will continue under the amended 1915(c) HCBS waiver applications.

**Q46: How are respite services billed when provided in a residential location? What are the staffing requirements?**

**Date Added/Revised: 10/10/19**

If a respite service is being provided in a residential setting that aligns with the terms of the service definition as defined in the 1915(c) waiver application, it should be billed as a respite service. The staffing required would be that reflected in the service definition. In order to be authorized for reimbursement, the respite provider must be indicated as a designated provider of the service with signed attestation of understanding the contents of the person-centered service plan. The billing of respite is on a unit-basis but subject to annual caps.

**Q47: Why is the definition of Behavioral Supports different across waivers?**

**Date Added/Revised: 1/8/2020**

The term “Behavioral Supports” was split into two services called “Positive Behavior Planning” and “Positive Behavior Coaching.” DMS is proposing one service definition across the ABI, ABI-LTC, SCL, and MPW waivers for Positive Behavior Planning and one for Positive Behavior Coaching.

**Q48: Under the non-medical transportation service listed, could Uber or Lyft be utilized for this service?**

**Date Added/Revised: 10/10/19**
Yes. If the other service requirements are met, individual driving services such as a taxi or Uber are permissible forms of transportation. Supports for Community Living (SCL) is the only 1915(c) HCBS waiver under which non-medical transportation is a covered service.

Q49: Does the stipulation that consultative Clinical and Therapeutic Services cannot be billed concurrently mean the residential provider must stop billing for the services that is reimbursed at a daily rate? Does this mean the day program cannot bill while the person is actively receiving services?

Date Added/Revised: 1/8/2020

When a participant receives day training services, all personal care services delivered while the participant is present are built into the reimbursement rendered for that service and no other waiver services are billable while the day training session is occurring. An exception is made for services included in a participant’s person-centered service plan that are integral to a day training session and are provided at the same time as the day training session. It should be noted that these services may be billed within the same day, however, if an exception has not been approved by DMS for concurrent billing then only one service may be delivered at a time and timing of deliverable shall not overlap.

Section 5: Eligibility and Enrollment

Q50: Will the Department consider using a more technologically-friendly process to be used for enrollment applications and the recertification process (for example, an App for smart phones or tablets)?

Date Added/Revised: 12/14/18

The Department appreciates feedback on how to make the applications and recertification process easier in the future. An iPhone or Android app is not currently under development for use with existing Medicaid application processes.

Q51: Who will or could lose eligibility as a result of these proposed changes?

Date Added/Revised: 12/14/18

The first round of 1915(c) HCBS waiver redesign activities do not include changes to the 1915(c) HCBS waiver eligibility groups.

Q52: Will my amount of patient liability change through waiver redesign?

Date Added/Revised: 3/15/19

Based on stakeholder feedback from summer 2018, the Department is proposing changes to the way it calculates patient liability, listed in the waiver amendment under Appendix B-5, Post Eligibility Treatment of Income. The proposed changes are intended to reduce or eliminate patient liability for the majority of waiver participants.
Q53: Will eligibility for the Michelle P. Waiver change? Will participants over 18-years-old continue to qualify?

Yes, participants over 18-years-old will continue to qualify for the Michelle P. waiver. Eligibility for all 1915(c) waivers, including Michelle P., will remain unchanged at this time.

Q54: Are there specific guides for utilizing benefind for SCL waiver participant?

The online benefind system is available to all Kentucky families to access public assistance benefits and information. The benefind system is not specific to SCL or any other waiver. Please go to the benefind website at https://benefind.ky.gov/ for more information.

Q55: According to the HCB waiver application, the HCB waiver is available to aged, disabled physically and disabled other? What does “disabled other” mean? Does this language include individuals that are currently served by the HCB waiver that have intellectual disabilities, developmental disabilities and autism population?

The proposed 1915(c) waiver amendments released in March 2019 do not propose changes to the target groups of each waiver.

The Aged and Disabled Group selected in Appendix B-1-a: Target Group(s) is a preset option in the 1915(c) waiver application developed by CMS. The Aged and Disabled Group is the most inclusive of the options provided by CMS and is composed of individuals who otherwise would require the level of care furnished in a hospital and/or nursing facility. Within this group, CMS provides states the option to further narrow the target group by dividing the group into three major subgroups: aged, physically disabled and other disabilities, including individuals with intellectual disabilities, developmental disabilities and autism. For the HCB waiver to be inclusive, the Department has selected all three groups, thereby including individuals with intellectual disabilities, developmental disabilities, and autism.

Q56: Will the Department increase the number of persons serviced on the waivers?

DMS intends to request more waiver slots when lawmakers consider the state’s next budget in 2020, however, receiving those slots is contingent upon approval from lawmakers and CMS.

Q57: What phone number should case managers and providers use to contact the Department for help with forms (e.g., MAP 10 Form)?

The online benefind system is available to all Kentucky families to access public assistance benefits and information. The benefind system is not specific to SCL or any other waiver. Please go to the benefind website at https://benefind.ky.gov/ for more information.
Case managers and providers should contact the Department via the 1915(c) Waiver Help Desk at 844-784-5614 or 1915cwaiverhelpdesk@ky.gov.

Q58: Will the Department approve an HCBS applicant prior to the applicant moving to the community, if the in-home assessment is completed on the target home?

Date Added/Revised: 1/8/2020

The Department can start the assessment prior to the applicant’s discharge from their non-community based care setting (e.g., hospital or rehabilitation facility). However, there must still be an assessment in the participant’s community based dwelling before waiver approval.

Q59: If an applicant has been on a waiver waiting list for more than 365 days, they must submit new clinical documentation and verification. What will that look like? Who is responsible for ensuring that this is completed?

Date Added/Revised: 1/14/2020

Under the proposed policy in the amended 1915(c) HCBS waiver applications, waiver applicants who have been on the wait list for more than 365 days must submit new clinical documentation and verification once a slot in the waiver opens for them. The clinical documentation and verification varies by waiver and can include the functional assessment and any updated documentation. DMS is currently developing updates to the waiver-related Kentucky Administrative Regulations designed to address the management of current waiver wait lists, including responsible parties. Until this is finalized, the waiver applicant should use the same process as in their initial application.

Section 6: Participant-Directed Services

Q60: What are the criteria for hiring a legal guardian / parent?

Date Added/Revised: 10/10/19

The criteria for hiring a legal guardian may be found here: https://chfs.ky.gov/agencies/dms/dca/Documents/pdsonepager.pdf. DMS also held a webinar to review the criteria with stakeholders in September 2019. You can find a recording of the webinar here: http://chfs.adobeconnect.com/pav6i1vhqtgj/. A copy of the slideshow presented during the webinar can be found here: https://chfs.ky.gov/agencies/dms/dca/Documents/pdslriwebinar.pdf.

Q61: Is Participant-Directed Services (PDS) a waiver?

Date Added/Revised: 12/14/18

No, there is no “Participant-Directed Services” (PDS) waiver. Participants in five (5) out of six (6) 1915(c) HCBS waivers may elect to use PDS or a blended service delivery model, including:

1. Acquired Brain Injury (ABI) waiver
2. Acquired Brain Injury – Long Term Care (ABI-LTC) waiver
3. Home and Community Based (HCB) waiver

Updated: January 14, 2020
4. Michelle P. Waiver (MPW)
5. Supports for Community Living (SCL) waiver

To view which services are available under PDS, visit the Department website online using the following link: https://chfs.ky.gov/agencies/dms/dca/Pages/cdo.aspx.

Note: Model II Waiver is excluded from using PDS and blended services and only uses a traditional service delivery model.

Q62: Is the Consumer-Directed Option (CDO), the same as Participant-Directed Services (PDS)?

Date Added/Revised: 12/14/18

Yes, one of the terms that we are making consistent across all 1915(c) HCBS waivers is the use of the term participant-directed services (PDS). The title consumer-directed option will no longer be used in waivers. This change in name will not change a participant's services or service plan if their waiver used the term consumer-directed option (CDO).

Q63: Are parents (or other family members) being removed as community living supports (CLS) / participant-directed services (PDS) / consumer-directed option (CDO) employees? If so, will there be exceptions and what are they?

Date Added/Revised: 5/17/19

The Department received a high volume of comments from stakeholders about the need to hire legally responsible individuals, including parents, spouses, legal guardians, and legal representatives as PDS employees. The Department plans to allow this practice to continue. The Department has released proposed updated criteria to more clearly define when it is allowable to employ legally responsible individuals. The Department believes these proposed criteria offer improved clarity to the public and will support the Department in monitoring for any potential legal conflict of interest that can lead to program fraud, waste, and abuse, as well as participant abuse and exploitation.

Q64: Who is considered a “legally responsible individual” (LRI)?

Date Added/Revised: 5/17/19

An individual is considered a “legally responsible individual” for a minor child (any child younger than age 18) if the individual is the minor child’s:

- Parent,
- Stepparent,
- Adoptive parent, or
- Legal guardian appointed by a Kentucky District Court.

An individual is considered a “legally responsible individual” to an adult participant (age 18 or older) if the individual is the participant’s:

- Spouse, or
- Legal guardian appointed by a Kentucky District Court.
Q65: Are a participant’s siblings considered legally responsible individuals if they do not have guardianship or power of attorney?

Date Added/Revised: 5/17/19

No, a legally responsible individual only includes the individuals defined in the question and answer above. Other relatives of the participant, including siblings, are not included in the term “legally responsible individual” and are not required to meet the conditions to become a PDS employee.

Powers of attorney are not considered when identifying if someone is a legally responsible individual. It is important to note a power of attorney does not have the same legal meaning as a legal guardian. A legal guardian is appointed by a Kentucky District Court.

Q66: What are the definitions of a “primary caregiver” and “secondary caregiver”?

Date Added/Revised: 5/17/19

A primary caregiver is the person who provides the most unpaid care to the participant. A secondary caregiver is the person who assists the primary caregiver— or provides a lesser amount of support.

Example: The mother of the participant provides six (6) hours of unpaid direct care to the participant each day. This is outside of the paid caregiver’s time in the home. The grandmother of the participant provides one (1) to two (2) hours of care per day. In this case, the mother is the “primary caregiver” and the grandmother is the “secondary caregiver.”

Q67: Why are the LRI criteria necessary? Is this a CMS requirement?

Date Added/Revised: 5/17/19

CMS gives states the option to allow legally responsible individuals to serve as PDS employees. Kentucky chose to allow LRIs to become PDS employees to provide families the best options for care. However, CMS requires the Department to establish criteria to determine when it is appropriate for LRIs to become a PDS employee. The Department’s criterion is based on CMS guidance provided on pages 108 through 110 of the 1915(c) HCBS Waiver CMS Instructions, Technical Guide and Review Criteria and summarized below:

1. CMS asks states to confirm the legally responsible employee is providing “extraordinary” care rather than the care they are expected to provide by law. Care is considered “extraordinary” when it involves tasks above and beyond what you would do for a typical child of the same age or for an adult.

2. Because legally responsible individuals can impact the participant’s financial interests, CMS asks states to put safeguards in place to make sure waiver participants are not taken advantage of by those individuals.¹

To meet CMS’ guidelines, the Department decided on criteria for hiring legally responsible individuals as PDS employees, which allows Kentucky to continue receiving funding for the 1915(c) HCBS waiver programs.

¹ The 1915(c) HCBS Waiver CMS Instructions, Technical Guide and Review Criteria, pg. 108-110. Available at: https://wms-mmdl.cms.gov/WMS/help/version_36_1915c_Waiver_Application_and_Accompanying_Materials.zip
Q68: I am a PDS employee and family member of a participant. I know my family member very well and think I provide the best, highest quality, and most extraordinary care to my family member. How does the state and CMS define “extraordinary services” as it applies to hiring legally responsible individuals as PDS employees?

Date Added/Revised: 5/17/19

The CMS definition for extraordinary care is:

“care exceeding the range of activities that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization.”

This means a legally responsible individual must provide additional care for their loved one, based solely on their disability. In this case, “extraordinary care” is not related to the quality of care delivered but the tasks not ordinarily performed to care for an individual.

Example: The father of a 16-year-old daughter living with a disability assists her with feeding herself, bathing and toileting. The father is providing extraordinary care to his daughter typically not needed for other young women his daughter’s age.

Q69: Regarding the criteria for legally responsible adults as providers, specifically the criteria concerning participant need: doesn’t everyone on the Michelle P. Waiver require extraordinary care?

Date Added/Revised: 1/8/2020

The term extraordinary care refers in part to age-appropriateness of the need for care and the intensity of the care required compared to the participant’s non-disabled, age-matched peers. Certain populations served by the Michelle P. waiver have age appropriate care needs that are developmentally appropriate within age groups (particularly under the age of 5) for certain activities of daily living, including helping with bathing, dressing, toileting, etc. Additionally, assistance with intermediate activities of daily living like house cleaning, preparing food, grocery shopping, managing medications, etc. is care expected of a parent or legal guardian of minors regardless of their disability status. The intensity or frequency of these needs may be considered when determining whether the participant requires an extraordinary level of care compared to their non-disabled, age matched peers.

If a waiver participant meets the criteria as described for extraordinary care, they may hire an LRI as a PDS employee. DMS established the criteria to comply with federal standards and guidelines. The criteria must apply to all waiver participants who select PDS, regardless of waiver or population. The Kentucky criteria for extraordinary care is available at the following links:

https://chfs.adobeconnect.com/_a1154899231/pav6i1vhqtgj

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2 The 1915(c) HCBS Waiver CMS Instructions, Technical Guide and Review Criteria, pg. 109. Available at: https://wms-mmdl.cms.gov/WMS/help/version_36_1915c_Waiver_Application_and_Accompanying_Materials.zip
Q70: Are participants allowed to use the KARES system? If so, how?

No, the KARES system is an electronic background check process for providers who are licensed through the Cabinet. The participant’s fiscal management agency (FMA) manages background checks for PDS employees, and the participant does not have access to the KARES system. Providers can find more information on how to access KARES here: https://chfs.ky.gov/agencies/os/oig/Pages/kares-provider.aspx

Q71: What is a “common law employer”? What are their duties? What are the responsibilities of PDCMs to support participants during the process to become a “common law employer”?

A “common law employer” is the legally responsible employer of workers whom he or she hires, supervises, and discharges directly, as stipulated by the Social Security Administration.

Under the PDS option, the participant (or his or her representative) is considered the common law employer. This means the participant, or his or her representative, is responsible for the performance of necessary employment-related tasks using a financial management services (FMS) agency. FMS agencies act as the participant’s agent by performing payroll and other employment related functions to ensure that employer-related legal obligations are met. In the 1915(c) HCBS waiver amendments released in March 2019, common law employers (i.e. the participant) are responsible for the following activities:

- Recruit staff
- Hire staff
- Verify staff qualifications, including required certifications
- Direct service providers to obtain criminal history background investigations and required registry checks of staff
- Specify additional staff qualifications based on participant need and preferences
- Determine staff duties
- Determine staff wages and benefits, within limits established by DMS
- Schedule staff
- Orient and instruct staff in duties
- Supervise staff
- Evaluate staff performance
- Verify time worked by staff and approve timesheets
- Discharge staff

PDCMs can provide participants support and technical assistance as needed and requested by the
participant, but are not authorized by the Department to make employment decisions on behalf of the participant. Participants must independently hire, manage, and discharge employees to receive participant directed services.

Q72: What are the criteria for parents to remain a PDS employee for their son or daughter?

Date Added/Revised: 10/10/19

CMS gives states the option to allow legally responsible individuals to serve as PDS employees. Kentucky chose to allow LRIs to become PDS employees to provide families the best options for care. However, CMS requires the Department to establish criteria to determine when it is appropriate for LRIs to become a PDS employee that confirm the employee is providing “extraordinary” care to the participant and to make sure waiver participants are not taken advantage of by their LRI. To meet CMS’ guidelines, DMS decided on criteria for hiring legally responsible individuals as PDS employees, which allows Kentucky to continue receiving funding for the 1915(c) HCBS waiver programs.

DMS has released a “What Does This Mean to Me? Participant Directed Services (PDS) Edition” to explain the definitions and steps LRIs will need to take to become a PDS employee. The “What Does This Mean to Me?” document can be found at: https://chfs.ky.gov/agencies/dms/dca/Documents/pdsonepager.pdf. The Department also held a webinar to review the criteria with stakeholders in September 2019. You can find a recording of the webinar here: http://chfs.adobeconnect.com/pav6i1vhqgi/. A copy of the slideshow presented during the webinar can be found here: https://chfs.ky.gov/agencies/dms/dca/Documents/pdslriwebinar.pdf.

Additional details regarding the timeline and process for implementation and acceptable forms of documentation for LRIs will be provided in the future.

Q73: Does the employment status of parents and relatives / legal guardians affect whether they qualify as a PDS employee for a participant?

Date Added/Revised: 1/8/2020

If a legally responsible individual has reduced or eliminated employment in the past to meet the care needs of a participant, they meet the criteria where they can be hired as a participant’s PDS employee. This is one of several circumstances when employing a legally responsible individual is considered appropriate. Please refer to the PDS one-page document (https://chfs.ky.gov/agencies/dms/dca/Documents/pdsonepager.pdf) or the Legally Responsible Individuals as PDS Employees webinar presentation (https://chfs.ky.gov/agencies/dms/dca/Documents/pdslriwebinar.pdf) a full listing of criteria. Legally responsible individuals are not required to have, obtain, maintain or eliminate other employment to qualify as a PDS employee. In addition, holding another paid position does not exclude a legally responsible individual from approval as a PDS employee.

A legally responsible individual to a minor child is defined as a parent, stepparent, an adoptive parent, or a court appointed legally appointed guardian. A legally responsible individual to a participant age eighteen (18) or older is defined as a spouse or a court appointed legal guardian.
Q74: How will the state ensure the health, safety, and welfare of participants in PDS? What is the process if a PDS employee is suspected of harming a participant?

Date Added/Revised: 1/8/2020

The Department takes the health, safety, and welfare of waiver participants very seriously. If anyone is concerned about a PDS participant’s general safety, the individual should report any concerns to the participant-directed case manager (PDCM). If the concern involves abuse, neglect, or exploitation, the individual should contact Adult Protective Services or Child Protective Services at 1-877-597-2331 immediately. If the concern involves criminal activity, the individual should contact law enforcement immediately.

Q75: Do parents who serve as power of attorney for their adult children meet the criteria for legally responsible adult? Do they have to meet the criteria for legally responsible adults to be paid caregivers?

Date Added/Revised: 7/25/19

For adult participants (those over the age of 18), a legally responsible individual is defined as a spouse or legal guardian. An individual designated as the participant’s power of attorney is not considered an LRI and do not need to meet the LRI criteria. However, all potential providers must meet the provider requirements for the PDS service to be employed by a PDS participant, including background checks and training.

Q76: Will caregivers approved as LRI PDS employees prior to waiver redesign have to be re-approved?

Date Added/Revised: 7/25/19

The policy allows for any individual who meets the provider requirements for the PDS service to be employed by a PDS participant. However, to align with CMS guidance, legally responsible individuals must go through an additional approval process. Current PDS employees who are an LRI on the HCB or SCL waivers will NOT be required to go through this process because they have undergone a screening in the last several years. Current PDS employees who are an LRI on the ABI, ABI-LTC, or MPW waivers will be required to go through this process once the waiver amendments are effective pending approval for CMS.

Q77: Will the medical and communication needs of a participant be considered when a legally responsible individual applies to be their caretaker?

Date Added/Revised: 7/25/19

Approval of an LRI is based on the participant’s individual circumstances and a set of criteria developed by the Department to demonstrate the need for an LRI to act as a PDS employee. These circumstances include the unique behavioral and communication needs of the participant. More information can be found in the “What Does This Mean to Mean? Participant Directed Services Edition” document regarding the circumstances that make LRI PDS employment acceptable for child
and adult participants found on the DCA website here: 
https://chfs.ky.gov/agencies/dms/dca/Documents/pdsonepager.pdf. DMS also held a webinar to 
review the criteria with stakeholders in September 2019. You can find a recording of the webinar here: 
http://chfs.adobeconnect.com/pav6r1vhqtji/. A copy of the slideshow presented during the webinar 
can be found here: https://chfs.ky.gov/agencies/dms/dca/Documents/pdslriwebinar.pdf.

Q78: Is a parent who does not have guardianship or power of attorney over an adult 
child eligible to serve as the caregiver?

Date Added/Revised: 7/25/19

For adult participants, a legally responsible individual is defined as a spouse or legal guardian. 
Parents of adult participants who are not the participant’s legal guardian do not need to meet the 
criteria for legally responsible individuals. However, all potential providers must meet the provider 
requirements for the PDS service to be employed by a PDS participant, including background checks 
and training.

Q79: Will CPR / First Aid training and College of Direct Supports training be required 
for PDS employees in the future?

Date Added/Revised: 7/25/19

Training will be required for all PDS employees. However, PDS employers (i.e. the participant or their 
representative) can determine the certifications, such as CPR or First Aid, a PDS employee needs. 
This policy is designed to allow PDS employers more flexibility in the person-centered planning 
process and autonomy to hire their employees.

Q80: I am retired from my regular job and am now my relative’s PDS employee. 
How do the new LRI criteria apply to me?

Date Added/Revised: 7/25/19

Approval of an LRI is based on the participant’s individual circumstances and a set of criteria 
developed by the Department to demonstrate the need for an LRI to act as a PDS employee. Each 
LRI applicant will be reviewed independently and a determination will be made based on the criteria 
and documentation provided by the LRI.

The Department will determine if the relative is an LRI. This differs based on whether the participant is 
a child or an adult. If the retired individual is not an LRI, he or she would not need to meet LRI 
circumstances criteria.

If the retired individual is the participant’s LRI, the Department will review the participant’s and LRIs 
circumstances that make sure it is appropriate for the LRI to be a paid PDS employee. Retirement 
alone would not qualify as an appropriate circumstance.

More information regarding acceptable circumstances for an LRI to be a PDS employee can be found 
in the “What Does This Mean to Me? Participant Directed Services Edition” and can be found on the 
DCA website here: https://chfs.ky.gov/agencies/dms/dca/Documents/pdsonepager.pdf. DMS also 
held a webinar to review the criteria with stakeholders in September 2019. You can find a recording of

**Q81:** Who gathers information and makes the decision about whether legally responsible individuals meet criteria for PDS?

**Date Added/Revised:** 7/25/19

The Department for Aging and Independent Living (DAIL) will collect all documentation, review, and approve or deny LRIs as PDS employees.

**Q82:** If a parent is deemed ineligible to be a PDS employee, can they apply again in the future? Will the reason be included in the denial?

**Date Added/Revised:** 7/25/19

The criteria to be an LRI PDS employee are based upon the participant’s needs and circumstances. As the participant’s needs and circumstances change, the LRI will be allowed to reapply for approval. The approval process will continue in a similar way including denial letters.

**Q83:** Will the process for certifying legally responsible individuals who apply to become a PDS employee occur only once or will it be repeated yearly, every two years? Is the cycle random or based on the LOC year?

**Date Added/Revised:** 7/25/19

Plans for implementing the DMS policy on LRIs as PDS employees remain under development. Additionally, DMS will educate stakeholders on implementation through posts to the Division of Community Alternatives website ([https://chfs.ky.gov/agencies/dms/dca/Pages/default.aspx](https://chfs.ky.gov/agencies/dms/dca/Pages/default.aspx)), letters, and educational documents before updates take effect.

**Q84:** What is "independent advocacy" and why is it unavailable to Kentucky waiver participants?

**Date Added/Revised:** 7/25/19

Independent advocacy, as referenced here, is a paid service (definition below). The Department chose not to include independent advocacy as a paid service during waiver redesign. The **Department actively encourages** participants to work with independent advocates. However, as described in the waiver application, it is not a Department funded service.

Independent advocacy is defined as advocacy that is furnished on behalf of a participant by an individual or organization that does not provide other direct services (under either the waiver or the state plan) to the participant, perform assessments, or conduct waiver monitoring, oversight or fiscal functions that have a direct impact on a participant. Independent advocacy is person-specific advocacy rather than advocacy that is performed on behalf of a group of individuals collectively. A state may contract for independent advocacy or enter into agreements with individuals or organizations to furnish this advocacy as needed.
Q85: Will caregivers who were approved prior to the redesign be required to get approved again?

Date Added/Revised: 10/10/19

PDS employees who were approved prior to the redesign and provided services to participants in the HCB or SCL waiver will NOT have to be reapproved, as they are considered to have already been screened for appropriateness and potential conflict of interest. PDS employees in the ABI, ABI-LTC, and MPW waivers did not undergo any historical screening for appropriateness or conflict of interest prior to their approval. Therefore, PDS employees working for participants receiving ABI, ABI-LTC, and MPW services WILL be required to complete the review process to be approved.

Q86: Since the changes to “legally responsible adult” criteria will carry through all waivers now, when can parents start to be providers again under the HCB waiver?

Date Added/Revised: 10/10/19

Legally responsible individuals will be able to apply to act as a PDS employee for their children or spouses once the 1915(c) HCBS waiver applications and Kentucky Administrative Regulations (KARs) are approved and go into effect, but not before this takes place. Changes to waiver policy and KARs are not final until approved by CMS and Kentucky regulatory authorities.

Q87: Are children and adults with disabilities allowed to hire LRI and relatives as PDS workers? What are the differences for a child and an adult?

Date Added/Revised: 10/10/19

Yes, both children and adults can hire an LRI, in certain defined circumstances. These circumstances are explained here: https://chfs.ky.gov/agencies/dms/dca/Documents/pdsonepager.pdf. DMS also held a webinar to review the criteria with stakeholders in September 2019. You can find a recording of the webinar here: http://chfs.adobeconnect.com/pav6i1vhqtgj/. A copy of the slideshow presented during the webinar can be found here: https://chfs.ky.gov/agencies/dms/dca/Documents/pdslriwebinar.pdf.

Q88: How do I demonstrate / prove I tried to recruit a qualified PDS worker before applying to become an LRI PDS employee?

Date Added/Revised: 10/10/19

DMS is considering the supporting documentation needed to demonstrate circumstances exist that qualify the participant to employ an LRI as a PDS employee. DMS will notify stakeholders and post LRI requirements upon final DMS policy approval. DMS will also update the FAQs to include supporting document requirements.
Q89: If I hire someone, and they get hurt "on the job," who is responsible for Workers’ Compensation or its equivalent?

Date Added/Revised: 10/10/19

In PDS, the participant is the employer of record. It is the responsibility of the participant to maintain liability insurance or worker’s compensation insurance, should they wish to do so. The costs for both types of insurance must be absorbed by the participant; funds from participant directed services cannot be used to pay for these services. If the participant does not wish to maintain liability insurance or worker’s compensation insurance, then there will be no coverage in place.

Q90: What happens if someone I hire abuses my child?

Date Added/Revised: 10/10/19

In addition to contacting your local law enforcement agency to report suspected crime, the abuse, neglect, or exploitation of a minor should always be reported to the Kentucky Child Protection Branch at 1-877-KYSAFE1. If you encounter an emergency situation, always dial 911. Once these steps are taken, contact the participant’s case manager for assistance with reporting the incident to DMS.

Q91: Is a criminal history and/or background investigation required prior to hiring an employee? How would we know whether a Medicaid fraud has been substantiated? Would one of the four required screenings capture this information? Is there a cost?

Date Added/Revised: 1/8/2020

Kentucky Administrative Regulation 907 KAR 1:672 prohibits payment to entities who have been convicted of fraud or abuse of any publicly funded health program. The pre-employment background checks and screenings required by DMS provide the information necessary to determine if an LRI can be certified as a PDS employee. The Federal Office of Inspector General List of Excluded Individuals and Entities is used to determine if Medicaid fraud has been substantiated. There are costs associated with these pre-employment checks and screenings. Currently, the participant or the prospective employee is responsible for the financial costs associated with pre-employment requirements. Additional options are under review by DMS and may require CMS approval.

Q92: Why isn’t budget authority available through the PDS option in Kentucky?

Date Added/Revised: 10/10/19

Participant directed budget authority is a complex method for delivering services. Implementation of budget authority requires an administrative structure not currently supported by DMS and its providers.

Q93: What are the criteria for the communication barrier regarding legally responsible adults as providers?

Date Added/Revised: 10/10/19
DMS uses the assessment to assist with the determination of the support needs for a communication barrier. DMS will request additional supporting information from participants, their natural supports, and case managers when necessary.

Q94: Who is responsible for keeping track of drug screens, tuberculosis (TB) skin tests, and other employee requirements for PDS?

Date Added/Revised: 10/10/19

Participants and their natural supports are responsible for maintaining proper employee records for all PDS employees. The participant can request support from the participant directed case manager and fiscal management agency.

Q95: How will the increased training requirements for PDS employees (e.g., Professional Boundaries, Incident Reporting, Trauma Informed Care, annually required review of some topics) be handled for existing employees?

Date Added/Revised: 10/10/19

DMS will provide expectations and guidelines for new requirements for PDS employees as waiver redesign progresses and regulations and waivers are approved by regulatory authorities.

Q96: Does the training on abuse, neglect, and exploitation fall on every agency or just case management agencies as it seems to be worded in potential new regulations? Is it going to be the case manager’s responsibility to train direct service provider (DSP) employees yearly?

Date Added/Revised: 1/8/2020

All direct service providers, case managers, and participant-directed case managers, are required to complete training on abuse, neglect, or exploitation identification and reporting. Case management providers are not responsible to train direct service provider staff, as each Medicaid-certified provider must train its own employees.

Section 7: 1915(c) HCBS Assessment

Q97: Will the waiver redesign assessment tool be the same for children and adults or will it be different?

Date Added/Revised: 12/14/18

There are no immediate plans to introduce a new tool specifically for participants under the age of 18 years old. As part of 1915(c) HCBS assessment redesign activities, the Department plans to review existing tools. In addition, the Department will consider how assessment outcomes can be reviewed or “scored” to differentiate functional needs between adult participants and youth participants under the age of 18. This review would take place prior to the adoption of a new tool.
Q98: Will a 1915(c) HCBS assessment tool adequately assess needs for 1915(c) HCBS waiver participants?

Date Added/Revised: 12/14/18

The Department is considering how to improve 1915(c) HCBS assessment tools so that participant needs are effectively identified and drive service plan development, along with assessment processes. These planned updates to the assessment methodology will aim to improve data collection as well. The focus for immediate redesign is on improving assessor training on use of the current tools to promote inter-rater reliability. There are no plans to introduce new assessment tools during planned 1915(c) HCBS redesign activities for 2019.

Q99: Will DMS continue to require an in-home assessment prior to approving an HCB applicant?

Date Added/Revised: 7/25/19

Yes, the Department will continue to require in-home assessments. The Department requires in-home assessments to evaluate and assess the participant’s health, safety, and welfare in their home or living environment.

Q100: Who is included in “appropriate entity” that will complete the annual reassessment/re-evaluation for ongoing MPW LOC assessments?

Date Added/Revised: 7/25/19

The Department does not plan to change the entities that currently assess and reassess waiver participants. “Appropriate entity” is a collective phrase chosen by the Department to include the different parties that assess participants under each waiver (i.e. independent assessors for the HCB waiver, community mental health centers for Michelle P, waiver, etc.).

Q101: Can you clarify which Assessment/Supports Intensity Scale instrument will be used?

Date Added/Revised: 7/25/19

DMS does not plan to implement a new assessment tool at this time. DMS will continue to evaluate its current tools and reserves the right to select a new tool in the future.

Section 8: Access to Services

Q102: Why isn’t transportation available and affordable for 1915(c) HCBS participants, specifically in rural settings?

Date Added/Revised: 12/14/18
The Department recognizes the varied needs of 1915(c) HCBS waiver participants and their families, including the transportation needs of participants in different geographic areas of the Commonwealth. In an effort to create more customized services, the Department is improving the way it allocates resources and give participants more flexibility with their services in the future. The Department understands there is a need for transportation, especially in rural settings and will continue to consider how to assist participants with those needs.

**Section 9: 1915(c) HCBS Rate Setting Methodology Study**

**Q103: What was the purpose of the rate study?**

**Date Added/Revised: 1/4/2020**

The assessment of 1915(c) waiver services released in 2018 found a lack of transparency in the Cabinet’s rate-setting methodology across waiver programs, and varied and inconsistent payment rates across waivers for services that are similar in nature. The rate study established a rate-setting and payment methodology across all 1915(c) HCBS providers and service types informed by a study of the reasonable and necessary costs incurred by providers to serve waiver participants. The Department contracted with Navigant, a national leader in 1915(c) HCBS rate development and service delivery strategies, to conduct this study. The rate study began in November 2018 and concluded in September 2019.

**Q104: How did the Department consider stakeholder feedback about the rate study?**

**Date Added/Revised: 1/8/2020**

Stakeholder feedback was an integral part of the rate study.

- The Rate Study Workgroup consisted of participants and providers / provider association representatives reflecting the wide range of services and populations included in these important programs. The Workgroup met regularly throughout the project and provided feedback on key rate components and assumptions so the Department could make fully informed final decisions.

- The 30-day formal public comment period held from November 8, 2019, to December 10, 2019 coincided with the release of the proposed rate methodology and rates and was intended to encourage wider-ranging feedback. Please note that the above opportunities for stakeholder feedback are specific to this rate study and do not replace the overall 1915(c) HCBS stakeholder engagement strategy that the Department is implementing across the entire 1915(c) HCBS delivery system.

**Q105: Will the rates for providers be competitive so that the 1915(c) HCBS waiver programs attract and keep good employees?**

**Date Added/Revised: 1/8/2020**

The Department received feedback from providers regarding the need to attract and retain good employees for the 1915(c) HCBS waiver programs. The rate study included an examination of direct care worker wages, including wages reported by providers via a special survey, input from a Rate Study Work Group, and examination of Bureau of Labor Statistics data.
Q106: What is the status of the rate study? What is happening now and what will happen next?

Date Added/Revised: 1/8/2020

The rate study began in November 2018 and concluded in September 2019. In winter 2019, the Department released cost surveys to all 1915(c) HCBS waiver providers. Navigant developed these surveys to collect information on the total costs that providers incurred to deliver waiver services. The submission deadline for the surveys was April 5, 2019, and more than 100 providers across all waivers responded to the request for cost information. This sample of provider costs represents approximately 30% of the provider organizations delivering services under the waivers, and nearly 56% of the Commonwealth’s expenditures on waiver services.

The Department and Navigant analyzed the collected data and developed appropriate assumptions around reasonable provider costs and payment adequacy across services. The proposed, updated rate methodology and rates were shared with stakeholders during a webinar held in September 2019. This webinar is available on the Department’s Trainings and Webinars page at https://chfs.ky.gov/agencies/dms/Pages/training.aspx.

The Department released amendments to Appendices C, I and J of the 1915(c) waiver applications based on the outcome of the rate study on November 8, 2019 and accepted formal public comment on these updates until December 10, 2019. DMS will review and publicly respond to comments received between November 8, 2019, and December 10, 2019, as part of the process of having the amendments to the 1915(c) HCBS waiver applications approved by CMS.

Q107: How were rates determined?

Date Added/Revised: 1/8/2020

The approach used for rate setting was not strictly a cost-based rate methodology, but the Department and Navigant relied heavily on the cost data reported by Kentucky’s 1915(c) HCBS providers to reflect typical direct and indirect costs for service delivery. The resulting rate study was informed by current costs to ensure that new rates were fully aligned with re-designed services and compliant with the federal requirement that payments for waiver services be consistent with 1902(a)30(A) of the Social Security Act. Collecting existing cost and wage information from providers was critical to understanding the current costs incurred by providers to deliver services under the 1915(c) HCBS waivers. However, it is important to note that the rate study employed other valid data sources to develop rates and had to adjust rate assumptions to meet waiver budget-neutrality requirements.

Q108: Will the provider tax be eliminated?

Date Added/Revised: 1/8/2020

There is no change to the provider tax at this time. Federal guidelines state that taxpayers cannot be ‘held harmless’ for the tax. While there is safe harbor language that waives this requirement if the tax falls below 6%, waiver rates do not meet this requirement because states must comply with one of the three tests required for the hold-harmless requirement. The Commonwealth’s rate structure does not comply with all three tests to hold taxpayers harmless, therefore, there will be no change to the provider tax at this time.

Updated: January 14, 2020
Q109: Will rates be consistent across waivers?

Date Added/Revised: 10/10/19

Yes, rates will be made consistent across waivers. Where similar services have been standardized among the different waivers, their rates will be similar across waivers and will reflect the same direct care and non-direct cost assumptions. For additional information regarding the rate process, please refer to http://chfs.adobeconnect.com/pbawhclg0os1/ for the Rate Study Webinar provided by DMS on September 17, 2019.

Q110: Will the case management and PDCM rates be adjusted to reflect the travel time needed for monthly face-to-face meetings?

Date Added/Revised: 10/10/19

Case management and PDCM rates already factor the additional mileage costs for travel to monthly face-to-face meetings. Proposed rates for case management and PDCM are not based on staff productivity (i.e. the ratio of billable time to non-billable time), but rather are based on typical caseloads among providers. Caseload data from the Medicaid Waiver Management Application (MWMA) indicates that a caseload of 25 individuals is currently the median caseload of case managers across the system. Proposed rates are designed to support a monthly caseload of 20 individuals.

Q111: Will there be one blended rate for Adult Day Health?

Date Added/Revised: 10/10/19

The proposed adult day health care rate is not a blended rate. Proposed rates establish two rate tiers for adult day health care services, based on differences in the costs and staffing ratios reported in the cost survey by current service providers.

Q112: Will changing therapies to extended state plan result in any change in current rates for services or the units of service an individual may receive? Will this change mean that the service will now be billed through the state plan, or at state plan rates?

Date Added/Revised: 10/10/19

Therapy services delivered under the acute and long-term Acquired Brain Injury (ABI) waivers will continue to be reimbursed through the waiver, but therapies formerly provided under the other 1915(c) HCBS waivers will be billed through the Medicaid State Plan. Reimbursement rates for these services will change from current waiver rates to the rates specified by Kentucky’s Medicaid fee schedule and will be billed according to the allowed units of service to which these services are subject in the Medicaid State Plan.
Q113: Is the state proposing that the recognition for more intensive ADHC services be eliminated since the only rate listed for ADHC services is 2.83 per unit?

Date Added/Revised: 1/8/2020

ADHC services are not being eliminated. Two tiers of Adult Day Health services will be available in the HCBS waiver, Levels I and II, with Level II allowing for more intensive services. The ABI-LTC and Michelle P. waivers will continue offering only Level I services. As with the current SCL waiver, a specific rate will also be available for SCL Day Training services provided in a licensed ADHC.

Q114: Can you provide additional clarification for Community Access as it relates to MPW, regarding the suggested rate?

Date Added/Revised: 1/8/2020

Community access will be available as a service in the Michelle P. Waiver, with a proposed rate of $7.00 per 15-minute unit of service. Further definition of the Community Access service may be found in Appendix C of the Michelle P. Waiver application which is publicly available here: https://chfs.ky.gov/agencies/dms/dca/Documents/amendedmpwwaiver.pdf

Section 10: Waiver Configuration

Q115: Are the 1915(c) HCBS waiver programs going to be moved from Fee-for-Service (FFS) to Managed Care?

Date Added/Revised: 12/14/18

There are no formal plans to move the Commonwealth’s 1915(c) HCBS waiver programs into a Managed Care delivery model.

Q116: Does the Department plan to implement one “super waiver” to combine all 1915(c) HCBS waivers into one?

Date Added/Revised: 12/14/18

No, at this time the Department does not plan to change the number or types of 1915(c) HCBS waivers until we have completed the first phase of 1915(c) HCBS related activities. This was specified in the Cabinet’s response to Navigant’s program assessment, which was released to the public in October 2018.

Q117: Can the 40 hour per week cap be removed since there is now a financial cap for MPW?

Date Added/Revised: 10/10/19

No, the forty (40) hour per week caps under the Michelle P waiver (one for participant-directed services and one for certain other services in aggregate) have a different policy goal than the overall annual financial cap. The forty (40) hour caps address the amount of services provided by a specific PDS provider or specific aggregate services provided, placing a reasonable cap on such services to...
ensure appropriately assessed levels of care. The annual financial cap is applicable to all providers and services, creating a reasonable individual annual budget to maximize the volume of services available within a set funding limit.

Q118: Is there an annual financial cap/limitation for Michelle P waiver PDS services?

Date Added/Revised: 1/8/2020

Yes, under the MPW each individual receiving services has an annual expenditure limit of $40,000 per level of care year for PDS services or $63,000 per level of care year if services are a blend of PDS services and traditional services. The goal of the annual financial cap is to create a reasonable individual annual budget to maximize the volume of services available within a set funding limit. A participant needing less than this limit may participate on the Michelle P. waiver and receive the needed amount of services without reaching the designated cap.

Section 11: Case Management

Q119: Why are we changing the current case management approach?

Date Added/Revised: 12/14/18

The Department recognizes previous stakeholder feedback noted inconsistencies in participant experiences with case management. The process of improving the case management approach will streamline and clarify the guidelines that case managers use today to serve 1915(c) HCBS participants. As a result of additional training and clearer guidelines, service plans will be more tailored to participant needs. Also, the process to escalate any service issues with any of the individuals they care for will be clearer and more direct since new supports will be implemented.

Q120: What supports is the Department providing to case managers and participant directed case managers?

Date Added/Revised: 1/8/2020

The Department is supporting case managers to respond to the proposed changes by offering a significant amount of training about the role of a case manager and expectations for case management delivery. The Department’s goal is to provide training that is accessible and aligns with federal regulations and national leading practices. The training currently offered is intended to supplement existing case management training and knowledge. The role of the case manager in supporting a participant to select the blend of services best suited to their needs is not changing.

The Department launched a help desk for case managers seeking assistance. The 1915(c) Waiver Help Desk is providing case managers with timely guidance to help respond to case-specific questions, policy clarification and other types of assistance that may be needed. Access to timely information and guidance should empower case managers to be more effective and efficient in their role as they work with participants to complete person-centered service planning and coordination activities. The help desk can be reached at 844-784-5614 or 1915cwaiverhelpdesk@ky.gov. Case managers who have technical issues with MWMA or need help navigating the system can call the MWMA Contact Center at 1-800-635-2570.

The Department also released several resources for case managers related to service authorization.

The Department knows and has communicated with stakeholders that there may be additional training needed. We will continue to monitor the deployment of this updated process and offer strategies that support case managers as they employ the service authorization function.

Q121: Will case managers review and approve service units based on individuals’ needs? Will this policy apply to all waivers for all services?

Date Added/Revised: 5/17/19

As case managers review the functional assessment and work with participants to develop goals, they will also define needed services to help participants meet those goals. While there are some services that require additional review, many services will be approved based upon the case manager’s selection of services that address needs identified in the assessment. Any skilled services will be reviewed by the Department or its designee. Because Model II is limited to three skilled services, all services will require review.

Q122: What services will now be authorized by case managers?

Date Added/Revised: 5/17/19

Below are most of the services case managers will approve:

- Adult Day Health
- Attendant care
- Community access
- Community guides
- Community living supports
- Day training
- Community transitions
- Companion services
- Home and community supports
- Home delivered meals
- Financial management services
- Homemaking
- Non-specialized respite
- Positive behavior planning
- Natural Support training
- Case management
- Participant-directed case management
- Personal assistance
- Residential support I, II, III
- Shared living
- Technology assisted residential
- Transportation

The Department reserves the right, through case management agency billing and quality assurances audits, to require additional information to demonstrate the need for services.

Q123: Will case managers be given a measurable tool to determine service needs or is this based on their own perception of the participant assessment?

Date Added/Revised: 1/8/2020
There is not a single measurement tool that can guide case managers in selection and authorization of services. However, case managers received training from the Department regarding the review of assessments, participant goals that may inform service mix and determining intensity of services. Their training also included information regarding other services available to participants, for example, the Medicaid State Plan. The training is available on the Department’s Division of Community Alternatives website at https://chfs.ky.gov/agencies/dms/dca/Pages/default.aspx.

**Q124: What is the difference between a participant-directed case manager and traditional case managers?**

A case manager provides case management support and services for participants who seek the traditional service delivery option. Functions of the case manager include:

- Educating the participant about available services (waiver/non-waiver);
- Helping participants understand their role and the role of the case manager;
- Coaching the participant and helping to facilitate the person-centered service planning (PCSP) meeting;
- Completing the PCSP and coordinating attainment of signatures;
- Identifying risks to the participant and helping the participant understand plans that can prevent those risks;
- Conducting ongoing monthly contact to monitor participant's advancement to goals and developing any needed modification to the plan; and
- Completing annual recertification of the PCSP.

The participant-directed case manager provides case management to participants who opt for the participant-directed service delivery option. In addition to the functions outlined above for a case manager, the participant-directed case manager will have the following responsibilities:

- Facilitate self-assessment of participant’s support needs related to employer authority;
- Arrange or provide necessary support to participants as identified in the self-assessment, to offer needed assistance to execute employer authority;
- Monitor the participant’s execution of budget and/or employer authority and document any identified risks, challenges, and outcomes;
- Develop and/or review the PCSP; monitor the effectiveness of the PCSP; advance person-centered goals and objectives; and respond to changes in participant goals and objectives;
- Support selection and provide on-going coordination between the participant and the chosen Financial Management Agency (FMA); and,
- Monitor service improvement plans (SIPs), e.g. corrective action plans (CAP), for PDS employees.
Q125: Individuals currently called “support brokers” don’t provide case management services. Will these individuals be trained to become PDCMs and provide case management?

Date Added/Revised: 5/17/19

Support Brokers, also called Service Advisors, will receive training from the Department similar to those who provide case management for traditional services. These individuals will be called Participant Directed Case Managers (PDCMs) after the waiver redesign process. The new role is slightly different, as described in the question and answer above, and we are confident current support brokers and service advisors will continue to support PDS participants.

Q126: If case managers are expected to assist participants with accessing services outside of waiver, will they manage those services as well?

Date Added/Revised: 5/17/19

Coordination of care / services has always been an expectation and case managers will be expected to continue that function. Case managers are expected to connect the participant to the appropriate services, even those beyond waiver services. Connections may include making referrals, conducting phone calls and/or providing resource information. These non-waiver services are expected to be indicated as part of the person-centered service plan (PCSP) and the case manager is expected to monitor the service as it relates to the PCSP. The case manager is not expected to manage the service but should continue to serve as a resource to the participant as needed.

Q127: How will case managers be trained to assist participants in accessing services outside of the waivers?

Date Added/Revised: 5/17/19

Early in the 1915(c) HCBS waiver redesign process, stakeholders involved in the Case Management Subpanel recognized the need for additional resources that case managers can use to help participants understand services available to them. The Department is considering providing ‘options counseling’ training to case managers, which will help them gain expertise in reviewing services with participants. They and participants will also have access to a booklet that contains service information including services in waivers, the Medicaid State Plan and other services that may be known.

Q128: Are participant representatives or guardians expected to attend case manager visits in person?

Date Added/Revised: 5/17/19

A participant’s authorized representative or guardian is expected to attend the initial person-centered service planning meeting and any initial engagement meetings where decisions are being made. The authorized representative or guardian is also expected to attend the annual recertification.

It is recommended that on-going monthly contacts be attended by the authorized representative or guardian however there may be circumstances which prevent this from occurring. If the visit requires decision making or completion of paperwork, the authorized representative or guardian is expected to
be present. If the authorized representative or guardian is unable to be present for an on-going monthly contact, they should communicate with the case manager via an alternate method (i.e. via telephone) to provide a status update on the participant.

Q129: Will case management agencies continue to qualify as PDS case management providers?

Date Added/Revised: 1/8/2020

Currently, for the ABI, ABI-LTC, MPW and SCL waivers, case management services may be rendered through certified case management agencies, community mental health centers (CMHCs) and area agencies on aging (AAAs). For the HCB waiver, CMHCs and AAAs are approved as PDS case management providers.

Once the amended 1915(c) HCBS waiver applications are approved by CMS and the new Kentucky Administrative Regulations take effect, all case management agencies will be able to provide PDS case management as long as they meet the applicable provider qualifications.

Q130: How soon after the case manager authorizes the service can the service be delivered?

Date Added/Revised: 1/14/2020

The Department made updates to MWMA so certain services added by case managers are automatically and electronically approved after the case manager submits the Person-Centered Service Plan (PCSP). Services that are automatically approved are listed as “approved,” and services requiring Cabinet-level review are listed as either “CMA Review Required” or “Service Review Required.” Services should not be delivered until they have a prior authorization returned by MMIS.

Q131: How frequently will Case Managers and Participant-Directed Case Managers have to visit participant residences? Will the participant have to be present during the visit?

Date Added/Revised: 1/14/2020

Under the proposed policy in the amended 1915(c) HCBS waiver applications, case managers should visit the participant’s primary residence at least once every three months. The participant is required to be directly involved in all monthly face-to-face visits, regardless of the setting in which the visit takes place, in order to monitor the progress of the person-centered service plan and its impact on the participant. The participant may request others to be present during the face-to-face visit to provide additional input.

Q132: Is only one face-to-face visit required monthly in the Acquired Brain Injury (ABI) waiver?

Date Added/Revised: 7/25/19

Yes, pending CMS approval, only one face-to-face visit will be required per month for ABI waiver participants.
<table>
<thead>
<tr>
<th>Q133: In the definition for case management released in March 2019, do monthly notes count as a “face-to-face” visit?</th>
<th>Date Added/Revised: 1/14/2020</th>
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<tbody>
<tr>
<td>Face-to-face visits require case managers and the participant to meet in the same place at the same time at the participant’s home or in the community. This must occur on a monthly basis, pending CMS approval.</td>
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<tr>
<th>Q134: Can case manager face-to-face visits occur in the community so case managers can monitor services as they are delivered?</th>
<th>Date Added/Revised: 7/25/19</th>
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<tr>
<td><strong>Yes</strong>, participants will have choice in the location of the visit, including locations that are convenient and comfortable for them. The Department will require one quarterly visit at the participant’s home to assess the participant’s health, safety, and welfare in their home or living environment.</td>
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<tr>
<th>Q135: If a participant lives at home but does not receive any services in the home, will case managers be able to bill for the required home visit?</th>
<th>Date Added/Revised: 7/25/19</th>
</tr>
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<tbody>
<tr>
<td><strong>Yes</strong>, although the participant is not receiving any services in the home the Department requires one quarterly visit at the participant’s home to assess the participant’s health, safety, and welfare in their home or living environment.</td>
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<tr>
<th>Q136: Will case management agencies be required to provide a standardized case manager salary and technology devices, such as laptops, to ensure consistent delivery of services statewide?</th>
<th>Date Added/Revised: 7/25/19</th>
</tr>
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<tbody>
<tr>
<td>The Department cannot require an individual agency to follow a certain business model and, therefore, cannot dictate financial compensation or use of specific technology devices.</td>
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<tr>
<th>Q137: Who will provide waiver help desk services?</th>
<th>Date Added/Revised: 1/14/2020</th>
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<tbody>
<tr>
<td>The Department is providing help desk services for case managers, providers, and participants as of November 25, 2019. The 1915(c) Waiver Help Desk can be reached at 844-784-5614 or <a href="mailto:1915cwaiverhelpdesk@ky.gov">1915cwaiverhelpdesk@ky.gov</a>.</td>
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| Q138: Will note sheets continue to be a requirement for providers? | Date Added/Revised: 7/25/19 |
DMS is tasked with ensuring the health, safety, and welfare of all waiver participants and that the care provided meets the standards set within the 1915(c) HCBS waiver applications and the Kentucky Administrative Regulations. Note sheets will continue to be required in order to achieve these goals.

Q139: What role will case managers play in the participant-driven self-assessment? Is this a new requirement for case management? What will the self-assessment tool consist of? Who will be developing this tool, and will stakeholders have a say in the process?

Yes, use of the PDS Employer Responsibilities Review Tool (PDS ERT, formerly the self-assessment) is required for participants who elect to self-direct using participant directed services. Participants and participant-directed case managers are expected to use the tool to better understand the support needs of a participant to self-direct. The tool allows the participant to self-identify strengths and areas of support related to their responsibilities as a PDS employer. The tool may not be used to prevent a participant from self-directing.

The PDS ERT consists of a series of questions that a participant directed case manager will review with participants. The questions ask the participant to self-assess what type of assistance (if any) they need to complete the tasks associated with PDS.

DMS, DAIL, DBHDID, and other Cabinet staff developed the tool using research on approaches in other states and considering extensive stakeholder input received during the program assessment performed throughout 2017 - 2018. Stakeholders provided input on the tool’s format and use, through the Home and Community Based Services Advisory Panel (HCBS-AP) and the PDS Advisory Subpanel, which included a mix of participants who currently self-direct, participant representatives and caregivers, service providers and case managers.

Q140: Can clarification be made on the differences of the three types of case management (CM) for the Home and Community Based (HCB) waiver: Waiver CM, participant-directed case management (PDCM), and CM?

In the current HCB waiver, Support Broker services (which will become Participant Directed Case Management or PDCM) and Financial Management Services (FMS) are billed together. When the Department released the amended 1915(c) HCBS Waiver applications in March 2019, there was no way to separate the billing of PDCM and FMS and, therefore, the Department planned to keep the services together.

With the 1915(c) HCBS Rate Study now complete, the Department can separate PDCM and FMS. This change is now reflected in amendments to appendices C, I and J of the waiver applications released on November 8, 2019. This means when the amended waivers take effect HCB will have Case Management (which includes PDCM services) and FMS as separate services.
**Q141:** If Medicaid determines a case manager improperly authorized a service would the risk be on the case management (CM) agency?

**Date Added/Revised:** 1/8/2020

Any recoupment issued will be connected to the provider delivering the service in question. If the Department identifies that a case manager requested inappropriate services, we will provide technical assistance and reserve the right to issue corrective action. Justification for services should be documented if they are not supported by the functional assessment. Service notes should support the amount of services provided. Knowingly misrepresenting the level of need or services in the PCSP is considered an act of Medicaid fraud.

**Q142:** Can a set case management (CM) caseload maximum be established for providers to adhere to ensure quality of CM provision to participants?

**Date Added/Revised:** 10/10/19

DMS will not stipulate caseload caps in its waiver application at this time. Caseloads are managed at the provider level, including the maximum number of cases a case manager can effectively manage while still performing the total requirements as defined in the case management service definition.

**Q143:** Will three continuing education units (CEU) hours be provided exclusively by DMS or will providers be able to provide in-house training to staff?

**Date Added/Revised:** 10/10/19

DMS does not require case managers to earn continuing education units and DMS trainings will not provide CEUs. DMS will require case managers to document and demonstrate they have completed DMS-approved training as developed by DMS.

**Q144:** How should Case Managers ensure that PDS employees receive annual CEU training? Where would they access the CEU’s and what is the case manager’s responsibility to ensure they are from an appropriate source?

**Date Added/Revised:** 1/8/2020

The Department’s trainings will not provide CEUs. PDS employees are required to complete Department-approved training related to fraud, waste, and abuse; and abuse, neglect, and exploitation on an annual basis. PDS employees will be provided with access to department-approved training modules. All PDS employees shall maintain a copy of any training completions and provide proof of training to the participant-directed case manager upon request.

**Q145:** How does the new service authorization process that began on November 25, 2019 work? Is the case manager/PDCM approving or denying the PCSP he or she helped design with the participant?

**Date Added/Revised:** 1/8/2020
Except for select services that require Department-level review and approval, the Case Manager/PDCM is approving the plan they designed in concert with the participant and aligned with the Department’s standards and requirements. The steps involved with service authorizations are the same during the recertification process. The Department expects that services authorized are necessary to advance person-centered service plan goals in a way that also safeguards against potential fraud, waste, and misuse of services. Both CMs and PDCMs received training on the new service authorization process. Refer to Section 13, Participant Safeguards, for additional information regarding the Department’s reviews of PCSPs.

Q146: Will the Department be providing providers “Risk Mitigation Form” to prior to the release of regulations?

The Department has decided not to proceed with one standardized risk mitigation form. Case managers (CMs) and Participant-Directed Case Managers (PDCMs) will be required to identify risks as part of the PCSP process and will be required to document mitigation plans for any identified risks. The mitigation plan may be in the form of a goal, or the CM / PDCM may explain the plan in the narrative. If a case management agency utilizes their own form to document risks and corresponding mitigation plans, the Department will accept these forms as appropriate documentation. Provider developed forms must support risk evaluation and mitigation strategies as defined in Appendix D, Section 1E of the 1915(c) HCBS waivers. Future enhancements to MWMA will include a section for documenting risk mitigation.

Section 12: Centralized Quality Management

Q147: What is Centralized Quality Management?

Centralized Quality Management (CQM) is the process of organizing and strengthening 1915(c) HCBS waiver operations and oversight under one quality management business unit within the Department for Medicaid Services. It serves to centralize decision-making authority and responsibility.

Q148: Why are we changing the current quality management process?

The Department, as the single State Medicaid Agency, is responsible for the oversight and management of all 1915(c) HCBS waivers in Kentucky. The Cabinet is working toward centralizing quality management within the Department, including data management, operational tracking, and reporting to CMS. This centralization will improve the Department’s ability to monitor activities and report quality measures efficiently to CMS. The Cabinet also seeks to reduce duplication in monitoring to offer improved support to providers and allow them to focus their efforts on delivery of high-quality services to 1915(c) HCBS waiver participants.
Q149: Will the Department of Aging and Independent Living (DAIL) and Department of Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) still be involved in waiver operations?

Yes, both DAIL and DBHDID will continue to have important roles in supporting and leading certain parts of day to day operations of the 1915(c) HCBS waiver programs. As part of centralizing quality management, these departments will defer primarily to the Department of Medicaid Services as a "lead agency" who has final decision-making authority on a number of topics. However, both DAIL and DBHDID will continue to work with the 1915(c) HCBS provider network and have an active role in providing technical assistance, conducting provider monitoring and oversight, delivering training, and other quality management related activities.

Q150: How has the critical incident reporting process changed?

In June 2019, the Department updated its critical incident reporting materials to:

- Streamline waiver reporting requirements and processes across all 1915(c) HCBS waivers.
- Address deficiencies identified in Navigant's 1915(c) HCBS waiver assessment final report. The report can be found here: [link]

The updated incident reporting materials impact all service providers, case managers, and support brokers providing services to 1915(c) HCBS waiver participants. The updated incident reporting process is anticipated to occur in two phases. The first phase updated incident reporting materials. The second phase intends to develop a web-based system. Additional information and training sessions will be provided prior to implementation of the web-based system.

The Department hosted an informational webinar on May 7, 2019 to review the updated incident reporting materials. A recording of the webinar and the webinar presentation is available on the DMS Trainings and Webinars page at [link]. The updated incident reporting materials are posted on the Division of Community Alternatives (DCA) website at [link].

DMS held a second webinar for service providers, case managers and support brokers on May 22, 2019. The webinar covered requirements and best practices for conducting critical incident investigations. Providers can view a recording of the webinar and the webinar presentation are on the DMS Trainings and Webinars page at [link].

Q151: As a parent and representative of a participant, what do I do if I suspect someone I hired is abusing my child?

The parent or representative should immediately take steps to ensure the waiver participant’s health, safety, and welfare, and notify law enforcement (if a criminal activity is involved) and adult protective services by calling 1-800-752-6200 or child protective services by calling 1-877-597-2331. The parent or representative should also review the waiver participant’s crisis prevention and response plan (if
A service improvement plan or SIP is a method used to monitor and improve services delivered under the PDS care model. The SIP is not a new requirement. But may formerly be known as a "corrective action plan" (CAP). DMS is now expanding the SIP method to include traditional service providers.

**Q153: How will extended follow ups for critical incidents be handled when circumstances prevent submitting to the DMS within five days? How will DMS track the submission of this information?**

**Date Added/Revised: 10/10/19**

Per the *Incident Reporting Instructional Guide* ([available on the Division of Community Alternative’s website](https://chfs.ky.gov/agencies/dms/dca/Documents/irinstructionalguide.pdf)), the direct service provider or case manager must begin its investigation into the critical incident immediately upon witnessing or discovering the incident. The direct service provider or case manager must submit the *Critical Incident Investigation Report* ([https://chfs.ky.gov/agencies/dms/MAPForms/new1915ccriticalincidentreportingform.pdf](https://chfs.ky.gov/agencies/dms/MAPForms/new1915ccriticalincidentreportingform.pdf)) to the appropriate regulating agency within ten (10) business days of the incident. If the investigation is incomplete at the time of submission within ten business days, the direct service provider or case manager may provide additional documents as an addendum.

DMS tracks incident material submission timeframes internally; noncompliance with timeframes may result in technical assistance or other follow-up actions as determined by DMS.

**Q154: For SCL, is three medication errors at the same location referring to three medication errors per agency or three medication errors per participant’s physical home setting?**

**Date Added/Revised: 10/10/19**

This question appears to be referencing the incident type “Three or More Non-Critical Incidents of the Same Incident Type in a 90 Calendar Day Period." This is an occurrence in which a waiver participant has experienced three or more of the same type of non-critical incidents (e.g., medication error without serious outcome) within a 90-calendar day period. This includes non-critical incidents that occur at any location.

If a waiver provider is aware that the waiver participant has experienced three or more of the same type of non-critical incidents within the 90-calendar day period, the waiver provider is responsible for reporting accordingly. However, the waiver provider is only responsible for tracking incident reports that he or she completes. The waiver provider is not required to track incident reports submitted by other parties.
Section 13: Participant Safeguards

Q156: Are there assurances in place so that a participant’s voice and wishes are really being heard when the case manager approves services in Medicaid Waiver Management Application (MWMA)?

DMS is conducting reviews of participant-centered service plans regularly by reviewing a random sampling of plans. During these reviews, Cabinet staff will look at the documentation entered in MWMA to ensure the participant’s wishes are included within the plan and case managers are authorizing services based on DMS requirements and guidelines.

Section 14: Appeals and Grievances

Q157: What is an “acceptable response” timeframe for a grievance or complaint?

The Department’s response to a grievance or complaint is determined by the nature of the complaint or grievance. The Department defines a complaint and a grievance as follows:

A complaint is an expression of dissatisfaction from the participant regarding some aspect of their 1915(c) HCBS waiver service delivery or experience that does not require follow up by the Department.

A grievance is an expression of dissatisfaction from the participant due, in part or in full, to the failure of the Department, or a provider to adhere to established operating procedures, regulations, and waiver requirements. **Grievances may require the Department or its designee to follow up and resolve the issue.**

Upon receiving a complaint or grievance, the Department will immediately assess and categorize the gravity of the grievance or complaint and determine if an immediate response, timely response or acknowledgement of the grievance or complaint is required.

1. **The Department will provide an immediate response** if a participant’s health, safety, or welfare are jeopardized.
2. The Department will provide a **timely response** if a grievance requires action to be taken but does not put the health, safety, or welfare of the participant in jeopardy. Some action, including opening an investigation and notifying the appropriate parties, must be taken within seven (7) calendar days of receiving the grievance. Resolution of the grievance is dependent on the nature of the grievance and resolution is not required to occur within seven (7) calendar
days. The Department will contact the participant via his/her preferred method of 
communication once the grievance is resolved.

3. If no action is necessary, the Department will document the complaint within the DMS 
approved system but not provide an official response to the participant or his/her 
representative.

Q158: What is the procedure for filing a complaint about a case manager?

Date Added/Revised: 1/14/2020

A grievance can be filed by filling out the “1915(c) Waiver Grievance Form” and emailing it to 1915cwaiverhelpdesk@ky.gov or by mailing it to:

Department for Medicaid Services
Division of Community Alternatives
275 E. Main St., 6W-B
Frankfort, Kentucky 40621

A complaint or grievance can also be filed by calling the 1915(c) Waiver Help Desk at 844-784-5614. More information on filing a grievance is available at https://chfs.ky.gov/agencies/dms/dca/Documents/whatdoesthismeantomeAG.pdf.

Q159: What are the anticipated timeframes for an administrative hearing?

Date Added/Revised: 1/8/2020

The Department is not making any changes to the administrative hearing timeline. In accordance with 907 KAR 1:563, a recommended order shall be issued within fifteen (15) days of the administrative hearing date for 1915(c) HCBS waiver services.

Q160: Can a recipient or applicant file a grievance and/or complaint while simultaneously pursuing an administrative hearing? If the grievance resolves the issue, how will DMS communicate that to the hearings branch?

Date Added/Revised: 1/14/2020

Yes, a grievance or complaint regarding waiver services or service providers can be filed while simultaneously pursuing an administrative hearing. If the grievance or complaint is resolved before the administrative hearing occurs, the administrative hearing will be cancelled. More information about filing an appeal or grievance is available at https://chfs.ky.gov/agencies/dms/dca/Documents/whatdoesthismeantomeAG.pdf.

Q161: Can a waiver participant or applicant skip the reconsideration step and directly request an administrative hearing? Can a participant or applicant request an administrative hearing if he or she misses the 14-day deadline for reconsideration but postmarks a request for an administrative hearing within 30 calendar days of the notice of adverse action?

Date Added/Revised: 1/8/2020
Yes, in accordance with 907 KAR 1:563, a waiver applicant, recipient or authorized representative may request an administrative hearing by filing a written request with the Department. The hearing request must be in writing and clearly specify the reason for the request, the date of service or type of service for which payments may be denied and be postmarked within thirty (30) calendar days of the Department’s written notice of adverse action. More information about filing a reconsideration or an appeal is available at https://chfs.ky.gov/agencies/dms/dca/Documents/whatdoesthismeantomeAG.pdf.

Section 15: Stakeholder Engagement

Q162: How can stakeholders provide input?

Date Added/Revised: 1/8/2020

There are multiple ways for stakeholders to provide their input, ask questions, and provide suggestions throughout the redesign process:

1. **Stakeholder Advisory Panels:** The Department has formed a Home and Community-Based Services Advisory Panel (HCBS-AP) and three (3) subpanels to address specific 1915(c) HCBS topics and better include stakeholders in the decision-making process.

   a. **The HCBS-AP** provides subject matter expertise to advise the Department on 1915(c) HCBS waiver redesign and changes to the 1915(c) HCBS system in Kentucky. The HCBS-AP engages multiple stakeholder types, including panelists representing all waivers. Panelists collectively consider 1915(c) HCBS waiver policy and operational changes proposed by the Department and the impacts those changes may have on all stakeholders, especially participants.

   b. **Three (3) subpanels** focused on specific 1915(c) HCBS topics support the HCBS-AP’s work. The subpanels focus on the following areas:

      • **Subpanel 1: Participant-Directed Services (PDS) Advisory Subpanel**
        The PDS Advisory Subpanel provides input and offers firsthand examples and perspectives related to 1915(c) HCBS, PDS, and Fiscal Management Agency (FMA) policies and operations. The PDS Advisory Subpanel will
        o Discuss clarifying the PDS policies and adjust the process for approving all workers;
        o Developing a PDS self-assessment tool; and,
        o Identifying standardized FMA performance standards.

      • **Subpanel 2: Centralized Quality Management Advisory Subpanel**
        The Centralized Quality Management Advisory Subpanel offers the Department stakeholders’ input and perspective related to
        o Assessing the Commonwealth’s management of critical incidents;
        o Considering a web-based system that will track and trend critical incidents;
        o Streamlining provider certification across waivers; and,
        o Issuing and monitoring provider corrective action plans.
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- **Subpanel 3: Case Management Advisory Subpanel**
  The Case Management Advisory Subpanel provides input and offers firsthand examples and perspectives related to case management processes, support, and training needs. The Case Management Advisory Subpanel will discuss:
  - Streamlining service authorizations;
  - Developing standards for person-centered service planning;
  - Designing case manager training; and,
  - Implementing a case manager help desk.

2. **Rate Study Workgroup:** The rate study workgroup met regularly from November 2018 until September 2019 to provide feedback on key rate components and assumptions on the 1915(c) HCBS Rate Study. The group consisted of participants, providers, and provider association representatives covering a wide range of services and populations included in the 1915(c) HCBS waiver programs.

3. **Ongoing Stakeholder Engagement:** The established email address is open and staff from the Department is monitoring it for your comments and questions. Your feedback is critically important for this redesign to succeed. Please share your feedback at any time by:
   - Emailing MedicaidPublicComment@ky.gov,
   - Calling the Division of Community Alternatives (DCA) at (502) 564-7540, or
   - Sending a letter to the following address:
     Department for Medicaid Services  
     Division of Community Alternatives  
     275 E. Main Street 6W-B  
     Frankfort, Kentucky 40621

| Q163: What are the stakeholder advisory panels and how will they impact redesign? |
| Date Added/Revised: 4/12/18 |

The Department has selected four (4) advisory panels comprised of 1915(c) HCBS stakeholders as described in the question and answer above. These panels are made up of stakeholders (panelists), who will provide subject matter expertise and input throughout the 1915(c) HCBS waiver redesign process. Feedback received from the panelists will be helpful as the Department considers ways to improve HCBS in Kentucky. The advisory panels include multiple stakeholder types and panelists represent all waivers.

Although the panels’ input will be used to inform the Department’s decision-making, the Department, as the single State Medicaid Agency, will remain the final decision-maker throughout redesign of Kentucky’s 1915(c) HCBS waiver programs.

The public can review the panels’ meeting minutes on the Division of Community Alternatives website at: [https://chfs.ky.gov/agencies/dms/dca/Pages/default.aspx](https://chfs.ky.gov/agencies/dms/dca/Pages/default.aspx).
Q164: What are the public comment webinars? How do I access them?

Webinars are an efficient way to communicate detailed information to a wide audience in an efficient manner. The Department has used webinar platforms throughout the 1915(c) HCBS waiver redesign process. The Department continues to build its informational webinar library. All current webinars can be found on the Department’s Trainings and Webinars page at https://chfs.ky.gov/agencies/dms/Pages/training.aspx. This link is also found on the DCA website at https://chfs.ky.gov/agencies/dms/dca/Pages/default.aspx by clicking “View 1915(c) HCBS Waiver Webinars.”

Q165: Why did the Department pause the original public comment period in January 2019?

The Department started a formal public comment period on Monday, January 7, 2019 and paused the public comment period on Friday, January 18, 2019. During that period, the Department received valuable comments from stakeholders and identified a need to pause public comment in order to revise the waivers further. When the revisions were complete, the Department restarted the public comment period for a full thirty (30) days. It was held from March 15, 2019 to April 15, 2019.

Q166: What has changed since the original release of the waivers in January 2019?

In addition to the proposed changes included in the January 7, 2019 release of the waivers, the Department has made the following additional changes in the March 15, 2019 release of the waivers:

- Based on stakeholder feedback from summer 2018, the Department updated the way it calculates patient liability. This should reduce or eliminate patient liability for waiver participants.
- The Department clarified PDS policies, including the criteria for hiring legally responsible individuals, background check and training requirements for PDS employees, and which services can be delivered by a legally responsible person, a legal guardian and/or a relative via the PDS service delivery option.
- The Department plans to transition Occupational, Physical and Speech Therapy from MPW to the Medicaid State Plan based on guidance received from CMS.
- The Department updated text to ensure easier readability and understanding.
- The Department double checked each waiver to ensure program and population-specific notations were correct and updated those notations as needed.
- Based on the updated 1915(c) waiver application released by CMS in January 2019, the Department added Appendix H-2 regarding the use of participant experience surveys.

On November 8, 2019, the Department released appendices C, I, and J of the amended 1915(c) HCBS waivers for another round of formal public comment. These appendices were updated based on the outcome of the 1915(c) HCBS Rate Study, which concluded in September 2019.
Q167: If I submitted a comment during the original comment period (January 7, 2019 through February 6, 2019), do I have to resubmit my comment for it to be counted as part of public comment?

Date Added/Revised: 3/15/19

No, you do not need to resubmit your comment. The Department counted, reviewed, and considered all comments submitted beginning with the original formal public comment period that began January 7, 2019 through the end the new formal public comment period that runs from March 15, 2019 to April 15, 2019, as part of the public comment process with CMS. Comments submitted outside of this timeframe will be addressed through either a regularly updated Frequently Asked Questions (FAQs) document or Department staff interaction.

Q168: What is a formal public comment period? How do I submit an official public comment?

Date Added/Revised: 1/8/2020

CMS requires a 30-day formal public comment period prior to the Department submitting updated waiver applications or substantive amendments for approval. The Department initially held a formal public comment period for the amended 1915(c) HCBS waiver applications from March 15, 2019, until April 15, 2019. The Department held a second formal public comment period from November 8, 2019, until December 10, 2019 for updates to appendices C, I and J of the amended 1915(c) HCBS waiver applications.

During the formal comment period, submitted comments are considered an “official public comment.” These comments are not responded to individually. They are publicized and responded to through the public comment process with CMS.

The Department is dedicated to continuously recognizing and considering stakeholder input. Comments can be submitted outside of formal public comment periods; however, those comments will not be part of what the Department submits to CMS. Those comments will be addressed through either a regularly updated Frequently Asked Questions (FAQs) document or Department staff interaction.

You can submit a comment to DMS in one of three ways:

1. **Email:** Send an email to medicaidpubliccomment@ky.gov
2. **Phone:** Call (502) 564-7540
3. **Mail:** Send a letter to:
   
   Department for Medicaid Services
   
   275 E. Main St. 6W-B
   
   Frankfort, Kentucky 40621

Q169: I submitted a comment during the public comment period. How will my comment impact the 1915(c) HCBS waiver amendments?

Date Added/Revised: 1/8/2020
Throughout the public comment period held from March 15, 2019, to April 15, 2019, Department staff reviewed and categorized the comments. After the public comment period closed on April 15, 2019, the Department began the process of determining which recommendations submitted during public comment would be adopted.

As required by CMS, the Department provided a public response to all comments submitted between March 15, 2019 and April 15, 2019. The public response summarizes all the comments submitted during public comment and provides the Department’s rationale for adopting or not adopting the recommendation. The Department’s formal response to public comment from March 15, 2019, to April 15, 2019, can be found on the DCA website at: https://chfs.ky.gov/agencies/dms/dca/Documents/dmsofficialpubliccommentresponse.pdf

DMS will follow the same process for public comments submitted during the official public comment period from November 8, 2019, until December 10, 2019.

### Q170: Will there be more town halls in 2020? When will they be held?

**Date Added/Revised:** 7/25/19

The Department held in-person Town Hall Meetings in various regions of the Commonwealth to further discuss the Department’s changes to the 1915(c) HCBS waiver applications and update stakeholders on 1915(c) HCBS waiver redesign.

These meetings took place between June 11, 2019 and June 24, 2019. There are no additional town halls scheduled at this time. The Department will announce any future town halls through the Department list-serve and on the DCA website.

### Q171: Why was I not selected for the stakeholder advisory panel?

**Date Added/Revised:** 12/14/18

Due to the enthusiastic response from stakeholders, we were unable to accommodate everyone who applied to be a panelist. The Department chose panelists for their unique point of view and perspective. Individuals were appointed based on representation of stakeholder types, waiver representation, geographical location, and expertise in the panel subject manner.

### Q172: If I was not selected to serve on the stakeholder advisory panel, am I still able to offer input? Is there time to have my voice heard?

**Date Added/Revised:** 1/8/2020

Yes, the Department welcomes feedback from all stakeholders. Anyone is welcome to ask questions and make comments regarding 1915(c) HCBS waiver programs at any time.

Note: Please share your feedback at any time by:

- Emailing MedicaidPublicComment@ky.gov,
- Calling the Division of Community Alternatives (DCA) at (502) 564-7540, or
- Sending a letter to the following address:

  Department for Medicaid Services  
  Division of Community Alternatives
Please note: During the formal comment period, submitted comments are considered an “official public comment.” DMS held formal public comment periods during the following time periods:

- March 15, 2019 to April 15, 2019
- November 8, 2019 to December 10, 2019

Comments made during formal public comment are not responded to individually. These comments are publicized and responded to through the public comment process with CMS. Comments submitted outside of these timeframes are addressed through either a regularly updated Frequently Asked Questions (FAQs) document or Department staff interaction.

Q173: What if I have a case-specific question about a HCBS topic?

Date Added/Revised: 1/8/2020

In November 2019, the Department opened the 1915(c) Waiver Help Desk to answer case-specific questions. The help desk can be contacted by phone at 844-784-5614 or by email at 1915cwaiverhelpdesk@ky.gov.

Q174: How has the Cabinet informed legislators of the project?

Date Added/Revised: 5/31/18

Briefings and updates on the 1915(c) HCBS waiver assessment are available to legislators upon request. DMS and Navigant provided a formal update to the Medicaid Advisory and Oversight Committee regarding our progress. The Cabinet welcomes future engagement of legislators and their staff and is actively seeking ways to better educate and inform them on this project.

Q175: I emailed my comments to the public comment email box. Who is reviewing them and how are they used?

Date Added/Revised: 5/31/18

The Department welcomes public comment. The public comment email box is available for those who may not be able to, or be comfortable with, sharing their thoughts in a public meeting. You can provide comments about any 1915(c) HCBS waiver related topic. All submissions to the public comment inbox are forwarded to Navigant, who reviews feedback, and catalogues the comment for tracking purposes. The Department also reviews all comments and utilizes the input to help guide the decisions made within this process.

Q176: How do I join a Technical Advisory Committee (TAC)?

Date Added/Revised: 5/31/18

Each TAC is governed by regulations that designate appointment positions for each TAC. To determine if there is an opening on a TAC, an individual would need to reach out to the chairperson.
of the TAC to discuss if they can be nominated. For information on the TACs, please visit https://chfs.ky.gov/agencies/dms/tac/Pages/default.aspx.

Q177: How can I receive further updates and/or notification about any future meetings related to the 1915(c) HCBS assessment or waiver changes?

Date Added/Revised: 5/31/18

Please send your request to MedicaidPublicComment@ky.gov to be added to a list-serve. You do not have to attend a meeting to have your name added to this list.

Q178: In addition to this FAQs document, are there any recently published documents regarding 1915(c) HCBS redesign?

Date Added/Revised: 1/8/2020

The Department regularly publishes stakeholder handouts for individuals using the waivers and for waiver providers to help educate the public on the future of 1915(c) HCBS waiver redesign. These materials, along with other educational documents regarding 1915(c) HCBS waivers, are available on the DMS Division of Community Alternatives website at https://chfs.ky.gov/agencies/dms/dca/Pages/default.aspx.

Q179: When will the 1915(c) HCBS waiver amendment webinars be posted to the Department website?

Date Added/Revised: 1/8/2020

The Department posted an updated webinar about waiver amendments on November 22, 2019. The webinar is a recording that can be viewed at any time. It can be accessed through the following link: https://chfs.adobeconnect.com/_a1154899231/poq1j03e5ryv/.

Section 15: Provider Access

Q180: The Supports for Community Living (SCL) waiver states that Community Guide agencies cannot provide case management services. Can you provide clarification on this?

Date Added/Revised: 10/10/19

The services for case management and community guides must be separate and conflict-free. If an organization provides both case management services and community guide services, the organization cannot provide both services to the same participant, in accordance with federal rules.

Q181: Are Community Mental Health Centers (CMHC) and Area Agencies on Aging and Independent Living (AAA) the only IRS-approved Fiscal / Employer Agents? Are there plans to open this service up to all providers?

Date Added/Revised: 10/10/19
DMS plans to continue the existing provider arrangement with financial management agencies (FMAs), such as CMHCs and AAAs, after waiver redesign. DMS is evaluating expansion of this service to other providers in the future.

Q182: How can the State ensure that the pool of workers will be available when legal guardians are eliminated?

Date Added/Revised: 10/10/19

A participant’s ability to employ legally responsible individuals is not being eliminated. The PDS redesign provides participants with more flexibility than current processes when hiring PDS employees. A participant can still employ an LRI as a PDS employee if certain conditions are met. See this reference document for more information: https://chfs.ky.gov/agencies/dms/dca/Documents/pdsonepager.pdf

Also, please refer to the webinar on Legally Responsible Individuals for additional information. The LRI webinar can be accessed at the following link: http://chfs.adobeconnect.com/pav6itvhqtg/

Section 16: General Information Regarding Waiver Redesign

Q183: When will changes to the waiver start?

Date Added/Revised: 1/8/2020

Any changes will take effect after the waivers have been reviewed and approved by CMS. The Department anticipates this to occur in mid-2020. DMS will notify the public of the confirmed effective date of 1915(c) HCBS waiver applications and the associated Kentucky Administrative Regulations (KAR) once they have been approved.

Q184: Will the Department write new waiver regulations to accompany the waiver changes?

Date Added/Revised: 1/8/2020

Yes, to reflect the updates made to the waiver applications and streamline regulations across waivers, the Department plans to revise existing waiver regulations. The public will have an opportunity to comment on the waiver regulations after they are drafted and released. The Department anticipates releasing the regulations for public comment in early 2020.

Q185: How do the changes to the waivers promote independence for participants while delivering high quality and more cost-effective care?

Date Added/Revised: 7/25/19

The Department began the waiver redesign process in 2017 with the goal of improving the safety and quality of services the Department provides to waiver participants and promote participant’s freedom to choose their providers and the autonomy to make their own decisions. In the waiver amendments released in March 2019, the Department proposed the following changes to promote independence of participants:
1. **Decrease or eliminate the amount of money waiver participants contribute** to the cost of services, also called patient liability. By decreasing patient liability, participants may have more income to spend as they choose.

2. Transition responsibility for **service authorization of some services to case managers** or participant-directed case managers (PDCMs) so participants can receive services more quickly. The Department also proposed additional guidance and training for case managers and participant-directed case managers, so the **person-centered planning process includes the participant’s choices, circumstances, and preferences**. These changes are intended to promote independence and choice of participants while eliminating the additional time of contracting with a quality improvement organization (QIO) for service authorizations.

3. **Continue to allow participants to hire legally responsible individuals** to deliver some participant-directed services to promote participant choice.

4. **Update and clarify the critical incident reporting**, investigation, and resolution process across all 1915(c) HCBS waivers to improve the health, safety, and welfare of participants.

**Section 17: Other Medicaid Topics**

**Q186:** Can waiver participants work for an employer in their community?

Date Added/Revised: 5/17/19

Yes, the Department supports any participant’s desire to enter or remain part of the Commonwealth’s workforce. The Department offers supported employment services through the ABI, ABI-LTC, Michelle P. and SCL waivers. The Department also encourages participants to assess additional employment resources by contacting their case manager or the Kentucky Office of Vocational Rehabilitation.

**Q187:** Do 1915(c) HCBS waiver participants have to pay a co-payment for State Plan Services?

Date Added/Revised: 1/8/2020

No, 1915(c) HCBS waiver participants will no longer pay a co-payment for State Plan services, such as pharmacy and hospital stays. The Department will send additional information about this update soon.

**Q188:** Governor Andy Beshear announced the end of the Kentucky HEALTH 1115 demonstration waiver on December 16, 2019. What impact does this decision have on the 1915(c) HCBS waivers?

Date Added/Revised: 1/8/2020

Individuals who get 1915(c) HCBS waiver benefits were not included in Kentucky HEALTH and should experience no change in benefits due to the end of the program.

**Q189:** What is the difference between an 1115 waiver and a 1915(c) HCBS waiver?

Date Added/Revised: 1/8/2020
1915(c) HCBS waivers are for home and community based services. These waivers let the state pay for services that are not normally covered by Medicaid. The services are designed to allow individuals to keep living at home in the community and getting services instead of going to an institution like a nursing home.

1115 waivers are usually for people who do not have serious health issues. These waivers let states test new ways to improve health for people on Medicaid and lower Medicaid program costs. Kentucky does not have any 1115 waivers approved at this time.