Kentucky Department for Medicaid Services
Supports for Community Living Renewal
Official Response to Formal Public Comment from June 24, 2022 – July 24, 2022

Between June 24, 2022, and July 24, 2022, the Department for Medicaid Services (DMS) received formal public comments regarding the renewal of Kentucky's Supports for Community Living (SCL) waiver. SCL is a 1915(c) Home and Community Based Services (HCBS) waiver that provides services to individuals who have an intellectual or developmental disability.

To continue offering SCL services, DMS must renew the waiver with the Centers for Medicare and Medicaid Services (CMS). DMS held the formal public comment period to allow stakeholders to provide feedback on updates proposed in the SCL renewal application. This document provides the DMS response to all stakeholder comments submitted during the formal public comment period.

Below you will find a few definitions to help you understand the DMS Response. If you have questions about this response, please email MedicaidPublicComment@ky.gov.

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
DMS assigned a number to each set of comments to help us track them. Please note the reference # sometimes goes out of numerical order to allow for grouping of similar comments.	**This section identifies the type of stakeholder(s) who made the comments (providers, caregivers, etc.)**	**This is where you will find the public comments. DMS grouped and summarized comments.**	**This is where you will find the DMS response to each set of comments.**	**This section lists any changes DMS made to the amended SCL application based on the comments received.**

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
Covered Services				
CS1	Provider Participant Other Stakeholder	**Unbundling of Consultative Clinical and Therapeutic Services** Commenters support the unbundling of Consultative Clinical and Therapeutic Services (CCT) into three separate services.	Thank you for your feedback.	
CS2 CS20	Provider	**Consultative Clinical and Therapeutic Services – Limit** Commenter suggests increasing the limit of CCT. "3 hours/month for such critical services is inadequate... I strongly encourage allowing the waiver to cover at least one hour per week of each service to adequately support the real impact these services have the potential to make."	Thank you for the suggestion. Changing a service limit requires amending the SCL Kentucky Administrative Regulation (KAR). DMS is not amending 907 KAR 12:010 for this renewal. Kentucky's full 1915(c) HCBS waiver service menu, including service limits, will be reviewed following the completion of the 1915(c) HCBS waiver rate study which is currently underway. Any updates to service limits will be completed through a future KAR change accompanied by a waiver amendment. The public will have an opportunity to review and comment on future KAR and waiver amendments before they are final.	
CS4	Provider	**Consultative Clinical and Therapeutic Services – Limit** Commenters noted the unbundling of CCT appears to	DMS acknowledges that commenters indicated a limit of 160 units per year is needed for each service, however, the limit cannot be increased at this time. In the current SCL waiver application,	DMS will update the waiver application to indicate the limit for CCT – Positive Behavior Supports, CCT-Psychological Services, and CCT –

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		give participants 160 units of each service per year: CCT - Positive Behavior Supports, CCT - Psychological Services, and CCT - Nutritional Services.	the limit for Consultative Clinical and Therapeutic Services is 160 units per year. When the waiver renewal takes effect, CCT - Positive Behavior Supports, CCT - Psychological Services, and CCT - Nutritional Services will have a limit of 160 units per year **combined**, which will make the limit the same as what is currently allowed under the bundled version of the service. Changing a service limit requires amending the SCL KAR. DMS is not amending 907 KAR 12:010 for this renewal. Kentucky's full 1915(c) HCBS waiver service menu, including service limits, will be reviewed following the completion of the 1915(c) HCBS waiver rate study, which is currently underway. Any updates to service limits will be completed through a future KAR change accompanied by a waiver amendment. The public will have an opportunity to review and comment on future KAR and waiver amendments before they are final.	Nutritional Services is 160 units per year combined.
CS27	Other Stakeholder Provider	**Consultative Clinical and Therapeutic Services – Usage** Commenters request participants be allowed to roll	Thank you for the suggestion. This would require changing the service limit specifications. Changing a service limit requires amending the SCL KAR. DMS is not amending 907 KAR 12:010 for this renewal. Kentucky's full 1915(c) HCBS waiver service menu,	

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		over unused units of CCT from month to month. Commenters say “this ensures that: i. Medicaid dollars are used only when needed (i.e. Prevents the “use it or lose it mentality”); and ii. Ensures that participants can access services when they truly need them most."	including service limits, will be reviewed following the completion of the 1915(c) HCBS waiver rate study, which is currently underway. Any updates to service limits will be completed through a future KAR change accompanied by a waiver amendment. The public will have an opportunity to review and comment on future KAR and waiver amendments before they are final.	
CS7	Provider	**Consultative Clinical and Therapeutic Services – Positive Behavior Supports and Positive Behavior Supports** Commenter say it appears the services CCT - Positive Behavior Supports and Positive Behavior Supports overlap and requested clarification on the difference between the services. "CCT-Positive Behavior Supports includes 'a professional may…develop a positive behavior support plan'. This appears to duplicate Positive Behavior Supports which is a fixed rate for …'development of a positive behavior support plan'.”	CCT-Positive Behavior Supports does not include development of the positive behavior support plan. Plan development will continue to be covered by the standalone Positive Behavior Supports service.	The definition of CCT – Positive Behavior Supports will be updated to clarify it does not cover the development of the positive behavior support plan.

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CS8	Provider	**Consultative Clinical and Therapeutic Services and Person-Centered Coach** Commenter asked how unbundling CCT will impact usage alongside Person Centered Coach. "Will Person Centered Coaching supports continue to be available in conjunction with Psychological and Nutritional services...? Supervision of the Person Centered Coach is referenced under CCT-Positive Behavior Supports but not under CCT-Psychological Services or CCT-Nutritional Services."	The role of the Person-Centered Coach is not changing with the waiver renewal. The service can still be used with CCT – Nutritional Services and CCT – Psychological Services as it is today.	The definitions of CCT – Nutritional Services and CCT-Psychological Services will be edited to clarify the role of the Person-Centered Coach.
CS19	Provider Other Stakeholder	**Consultative Clinical and Therapeutic Services and Person-Centered Coach** Commenters request the following language be added to the definition of CCT - Psychological Services to allow for use of the Person-Centered Coach: "*This service may also include direct monitoring of implementation of the home treatment/support plan and/or*	The role of the Person-Centered Coach is not changing with the waiver renewal. The service can still be used with CCT – Nutritional Services and CCT – Psychological Services as it is today.	The definitions of CCT – Nutritional Services and CCT-Psychological Services will be edited to clarify the role of the Person-Centered Coach.

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		the person-centered service plan as well as direct supervision of the Person Centered Coach by the supervising licensed or certified professional." Commenters say "Both Positive Behavior Supports and Nutrition Services can utilize Person Centered Coaches (PCCs) to assist with monitoring, implementation, and training under their respective plans, but this language was removed from the description of Psychological Services. We have found PCCs to be helpful across all three of the CCTS services including Psychological Services where PCCs are able to continue training participant's and their teams on needed therapeutic interventions including the use of coping skills."		
CS17	Provider Other Stakeholder	**Consultative Clinical and Therapeutic Services – Exceptional Supports** Commenters are concerned the unbundling of CCT eliminates the ability to request Exceptional Supports for SCL waiver participants.	DMS is not eliminating or changing the Exceptional Supports process with the SCL waiver renewal.	

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		"We respectfully request that an exceptional supports protocol be retained that allows for additional PBS or Psychological Services for clients at risk of harm to self or others." "We believe that continued use of exceptional supports for this high acuity population will reduce the need for acute psychiatric hospital admissions as well as ICF/ID admissions."		
CS18	Provider Other Stakeholder	**Consultative Clinical and Therapeutic Services – Psychological Services** Commenters request clarification on the provider types allowed to provide CCT - Psychological Services, citing a discrepancy between the proposed provider qualification and the current waiver provider qualification. "The current SCL waiver program allows for multiple licensed mental health provider types to provide Psychological Services to participants under the waiver including Licensed Clinical Social Workers, Licensed Marriage and Family Therapists, Licensed	DMS did not intend to exclude providers for CCT – Psychological Services from the renewal SCL waiver application. The provider qualifications for CCT – Psychological Services as defined in the current approved SCL waiver application will apply to the renewal SCL application as well.	The provider qualification for CCT – Psychological Services will be updated to include the following professionals: Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Professional Clinical Counselor, and Licensed Psychological Associate. Licensed Psychologists and Licensed Psychological Practitioners were already listed in the renewal waiver application.

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		Professional Clinical Counselors, Licensed Psychological Associates, Licensed Psychologists, and Licensed Psychological Practitioners."		
CS25	Caregiver	**Consultative Clinical and Therapeutic Services and Music Therapy** Commenter requests music therapy be included in Consultative Clinical and Therapeutic Services - Positive Behavior Supports.	Thank you for the suggestion. Changing a service definition requires amending the SCL KAR. DMS is not amending 907 KAR 12:010 for this renewal. Kentucky's full 1915(c) HCBS waiver service menu, including the potential expansion of current services, will be reviewed following the completion of the 1915(c) HCBS waiver rate study, which is currently underway. Any updates to the service menu will be completed through future KAR changes accompanied by a waiver amendment. The public will have an opportunity to review and comment on future KAR and waiver amendments before they are final.	
CS3	Provider	**Proposed Service Menu Addition – Money Management** Commenter recommends creating a money management service for participants in Residential to learn how to handle their finances and avoid the need for a third-party payee.	Thank you for the suggestion. Adding a service requires amending the SCL KAR. DMS is not amending 907 KAR 12:010 for this renewal. Kentucky's full 1915(c) HCBS waiver service menu, including the potential addition or expansion of current services, will be reviewed following the completion of the 1915(c) HCBS waiver rate study, which is currently underway. Any updates to the service menu will be	

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		"In recent years we have seen many residential providers decline to apply as payee for many understandable reasons. This has forced our clients to rely on non-waiver companies who we have seen make late payments which result in unnecessary late fees, eviction notices, and even terminated services."	completed through future KAR changes accompanied by a waiver amendment. The public will have an opportunity to review and comment on future KAR and waiver amendments before they are final.	
CS5	Provider Other Stakeholder	**Behavior Support Plan – Revisions** Commenters said revisions to a participant's person-centered service plan should not be required annually. "If… the plan… is working… there should not be a requirement to make any changes. It is not necessary… from a clinical standpoint. It would then also have to go through the BIC." "We... suggest that rather than the Cabinet paying for annual revisions of plans, the Cabinet simply add to the Annual Plan of Care meeting the requirement that the Behavior Support Specialist review the existing	While DMS expects positive behavior support plans to be **reviewed** annually, there is no requirement these plans be **revised** annually.	The definition of Positive Behavior Supports will be edited to say "The need for the plan shall be evaluated at least annually and revisions made as needed" to clarify the expectations of the service.

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		plan with the team and gather team input on whether the plan needs to be revised. This will guarantee that the plan is reviewed by the entire team at least annually without the expense of unnecessary revisions."		
CS6	Provider	**Case Manager Network Adequacy** Commenter says they have observed a shortage of SCL case managers and attributes it to high caseloads and low compensation.	DMS recognizes the need for a larger provider network for all waivers. DMS is taking steps to help grow the case management network for all 1915(c) HCBS waivers. 1. The 1915(c) HCBS Rate Study: The 1915(c) HCBS Rate Study currently underway aims to develop a sound payment and rate-setting methodology for all HCBS in Kentucky. The findings of this study will allow DMS to update rates for all HCBS services, including case management, to reflect provider costs more accurately. 2. Temporary Case Manager Qualification Changes: In March 2022, DMS temporarily expanded provider qualifications for case managers through Appendix K of the 1915(c) HCBS waiver application to address staffing shortages caused by the COVID-19 pandemic. Appendix K will remain in place up to six months after	

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			the end of the federal public health emergency due to COVID-19. Rate adjustments and any temporary waiver changes DMS decides to make permanent will be added to the waiver programs through future waiver and KAR amendments following the completion of the rate study. The public will have an opportunity to review and comment on any rate adjustments or waiver application and KAR updates before they are final.	
CS9	Provider	**Residential Support Level II and Personal Assistance** Commenter requests that participants using Residential Support Level II continue to have access to Personal Assistance, which is currently allowed under Kentucky's COVID-19 Appendix K amendment.	Thank you for the suggestion. Making Appendix K changes permanent requires amending the SCL KAR. DMS is not amending 907 KAR 12:010 for this renewal. Kentucky's full 1915(c) HCBS waiver service menu, including the addition of Appendix K allowances, will be reviewed following the completion of the 1915(c) HCBS waiver rate study, which is currently underway. Any updates to the service menu will be completed through future KAR changes accompanied by a waiver amendment. The public will have an opportunity to review and comment on future KAR and waiver amendments before they are final.	

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CS31	Provider	**Residential Support Level I and Level II – Personal Assistance** Commenter recommends allowing participants in Residential to receive a limited amount of Personal Assistance as an alternative to Day Training or Community Access. "One of the biggest barriers to honoring participant preference for their schedules is that both residential and day training are group settings and reimbursement rates do not support 1:1 staffing ratios. Even 20 hours per week would make a significant difference in the quality of life of participants and compliance with Final Rule."	Thank you for your suggestion. Kentucky's COVID-19 Appendix K amendment temporarily allows participants receiving Residential Support Level II to also receive Personal Assistance and/or Respite. Making Appendix K changes permanent and/or expanding current services requires amending the SCL KAR. DMS is not amending 907 KAR 12:010 for this renewal. Kentucky's full 1915(c) HCBS waiver service menu, including the addition of Appendix K allowances or expanded services, will be reviewed following the completion of the 1915(c) HCBS waiver rate study, which is currently underway. Any updates to the service menu will be completed through future KAR changes accompanied by a waiver amendment. The public will have an opportunity to review and comment on future KAR and waiver amendments before they are final.	
CS10	Provider	**Residential Support Level I – Number of Individuals Served** Commenter requests clarification on the rate for Residential Support Level I based on the number of individuals served in a residence.	The number of participants who can be served in a staffed residence is not changing. The language is intended to note that the reimbursement rate varies based on the number of individuals served in a staffed residence or group home.	

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		"The waiver document includes the following language: '…variable rates based on three or fewer persons in the residence vs. four or more persons in the residence…'. Please clarify if this is a reference to Residential Level I supports provided in a licensed group home or if the intent is to allow more than three participants to reside in a staffed residence."		
CS23	Other Stakeholder	**Residential Support Level I – Group Homes** Commenter asked if waiver services will continue to be provided in group homes.	Yes. DMS did not change any settings where waiver services can be provided in the proposed SCL waiver renewal.	
CS28	Provider Other Stakeholder	**Residential Support Level I – Internet Access in Residence** Commenters have concerns about the cost of requiring internet access in provider-owned or leased Residential Support Level I homes. Commenters recommend: 1. Including the cost of internet access in the rate model being developed as part of	1915(c) HCBS waiver participants receiving Residential services have the freedom to control their activities, which can include accessing the internet. After another review of the service definition, DMS will not require Residential providers to have internet access in Residential Support – Level I homes. While not a requirement, DMS expects participants to have the freedom to choose if they want internet access and for providers to work with those who do to determine how to best meet this request. Keep in mind	The waiver application will be edited to remove the requirement for internet access in Residential Support – Level I homes.

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		Kentucky's 1915(c) HCBS Rate Study. 2. Cost caps to prevent providers from having to purchase "unreasonably expensive internet access." 3. That providers be allowed to purchase hotspots, tablets with data plans, and other options that fulfill the requirement. 4. That internet access not be required in a residence if no participants in that residence desire having it.	participants may qualify for programs that make internet more accessible, such as the Affordable Connectivity Program.	
CS15	Participant	**Residential Provider Network Adequacy** Commenter describes difficulty in finding a suitable residential living situation while receiving SCL waiver supports. The challenges include having to move multiple times within a short time, living situations where fellow residents are not a good fit, and spending years searching for a new place to live.	Thank you for sharing your story with us. DMS is taking steps to grow the provider network, including the 1915(c) HCBS Rate Study currently underway. The rate study aims to develop a rate-setting methodology that reflects provider costs more accurately for all HCBS to attract and retain Residential providers. The SCL waiver also offers the following additional Residential	

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		"There is a shortage of accessible homes for someone in my situation... which is impacting far too many people who are often overlooked."	options, which are historically underutilized: 1. Technology Assisted Residential - This service allows a participant who needs up to 24-hour support to increase their independence by using technology to monitor health, safety, and welfare and reduce the need for Residential staff. 2. Shared Living - This service is designed as an alternative to Residential services and allows a participant to live in their own home with a housemate/live-in caregiver to provide some of their supports. If a participant desires to use one of the above Residential options, they should talk to their case manager.	
CS11	Provider Caregiver	**Waiver Services and Acute Hospital Settings** Commenters request clarification regarding receipt of waiver services for participants in acute hospital settings. "The language included in Additional Requirements B. (page 8) notes '*….waiver services are not furnished to individuals who are inpatients in*	Section 1902(h) of the Social Security Act allows HCBS to be provided to individuals in acute care hospital settings who are receiving inpatient care for acute medical conditions, injuries, or surgery. It does not apply to individuals receiving long-term care in facility-based settings including, but not limited to, nursing homes, rehabilitation centers, and/or treatment facilities.	

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		a hospital…'. This appears to contradict the Major Changes #7 (pages 1-2) which outlines circumstances which would permit the provision of waiver services in an inpatient setting." "What is the difference and how do we know if the participant is considered inpatient or acute?"		
CS12	Caregiver	**Waiver Services and Acute Hospital Settings** Commenter requests the language regarding receipt of waiver services for participants in acute hospital settings be clarified after experiencing an inability to access this provision under Appendix K. "Personal Assistance was not allowed to be provided while in the hospital for over 4 days. The parent was the sole provider and became exhausted because the hospital had no one to stay with the individual and no relief was available."	Thank you for your comment. It is important to note not all SCL services can be provided in an acute hospital setting. Waiver services provided in an acute hospital setting must: • Be needed to meet emergent, non-medical needs or risks when there is not a family member or natural support available to assist. • Not duplicate services the hospital is required to provide, such as bathing or feeding. • This policy is not intended for continuing the participant's full person-centered service plan while they are hospitalized. When participants and/or their caregivers encounter a situation where receiving waiver services in an acute hospital may be appropriate, they or	

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			their case manager should contact DMS for further guidance.	
CS13	Provider Participant Other Stakeholder	**Waiver Services and Acute Hospital Settings – Services Allowed** Comment applauds the allowance of waiver services in an acute hospital setting. "Keeping these participants safe in the community is a challenge and historically acute psychiatric facilities have been reluctant to take individuals with intellectual disabilities... We anticipate that the proposed change... will allow for Positive Behavior Supports Specialists and the Person Centered Coaches working under them to provide the training and support needed to participants in acute psychiatric hospital settings thus allowing these participants to have longer in-patient stays until their psychiatric issues and resulting behaviors are under control and they can be safely reintegrated into the community."	Thank you for your feedback. This provision only applies to participants receiving inpatient care for acute medical conditions, injuries, or surgery. Waiver services cannot be provided in acute psychiatric facilities as these settings have the capability to meet a participant's behavioral and mental health needs while hospitalized.	

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CS16	Provider	**Waiver Services and Acute Hospital Settings** Commenter requests that language regarding the allowance of waiver services in an acute hospital setting be added to the waiver application.	The policy regarding waiver services provided in acute hospital settings was included in the proposed SCL waiver application released publicly from June 24 to July 24, 2022. It was found in the Major Changes section at the beginning of the waiver application.	
CS22	Other Stakeholder	**Waiver Services and Acute Hospital Settings** Commenter appreciates the addition of language in the SCL waiver allowing waiver services to be provided in acute hospital settings when the hospital cannot meet the participant's health, safety, and welfare needs. Commenter has the following question: "Please confirm that communication and behavior needs are not an exhaustive list."	Thank you for your comment. Waiver services provided in an acute hospital setting must: • Be needed to meet emergent, non-medical needs or risks when there is not a family member or natural support available to assist. • Not duplicate services the hospital is required to provide, such as bathing or feeding. • This policy is not intended for continuing the participant's full person-centered service plan while they are hospitalized. When participants and/or their caregivers encounter a situation where receiving waiver services in an acute hospital may be appropriate, they or their case manager should contact DMS for further guidance.	

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CS21	Provider	**Telehealth Services** Commenter requests telehealth, which is currently allowed under Appendix K, become a permanent option for some services including Positive Behavior Supports, Adult Day Health Care, and Adult Day Training. "COVID-19 is never going away and after the state of emergency ends, providers need the ability to keep our participants safe while they receive services."	While waiver services are community-based, DMS recognizes allowing participants to interact with health care professionals and providers via telehealth can be both beneficial and person-centered. Any permanent telehealth policy updates will be made through future waiver and KAR amendments. DMS is not amending 907 KAR 12:010 for this renewal. Kentucky's 1915(c) HCBS waivers, including whether to make telehealth permanent, will be reviewed following the completion of the 1915(c) HCBS waiver rate study, which is currently underway. The public will have an opportunity to review and comment on future KAR and waiver amendments before they are final. DMS acknowledges face-to-face visits increase the risk to participants and case managers during the ongoing COVID-19 pandemic. The temporary waiver changes made through Appendix K of the 1915(c) HCBS waiver application allow case managers to conduct all visits via phone or using remote options (such as FaceTime, Skype, etc.), so long as the method used allows for direct interaction between the waiver participant and the case manager (email or leaving a message is not considered interactive). This temporary	

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			policy update will remain until Appendix K expires or is discontinued at which time providers will receive at least 48 hours' notice.	
CS24	Caregiver	**Service Limits – Units vs. Hours** Commenter requests service limits be converted from units to hours in the waiver application. "It is annoying to have to do the math to determine how many hours are allotted."	Thank you for your comment. Services limits are listed in units in the waiver application to make it consistent with the both the SCL KAR and the system providers use to bill waiver services.	
CS26	Caregiver	**Supported Employment and Job Fading** Commenter disagrees with the part of the Supported Employment definition that states *"The expectation is for systemic fading of the Employment Specialist to begin as soon as possible without jeopardizing the job."* "There needs to be the ability for the Employment Specialist to continue as long as he/she is needed."	This statement is found in the "Job Acquisition" phase of the Supported Employment definition. The expectation of the service is that the Employment Specialist will fade after helping the participant develop natural supports on the job and become substantially responsible for their performance in the workplace, however, there is no specific time limit for when this must occur. As the definition states *"…before successful employment can be determined there must be confirmation that the employee is functioning well at the job."* Once the person is successful in the job with minimal assistance, they can continue to access the service as	

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			outlined in the "Long-Term Follow-Up" phase of the service definition which allows for the Employment Specialist to provide support with maintaining the job or desired job changes.	
CS29	Provider Other Stakeholder	**Community Access – Provider Qualification** Commenters note the provider specification for Community Access Specialist requires that individuals complete *"a department-approved credential within three (3) months of application while providing Community Access services under the direct supervision of a qualified community access specialist"* and that this is not required in the SCL KAR. Commenters request the provider qualification be changed to match 907 KAR 12:010.	After a review of 907 KAR 12:010, the deadline to complete a department-approved credential within three (3) months will be changed to one (1) year.	The provider qualifications for Community Access will be edited to match 907 KAR 12:010, which allows one (1) year to complete a department-approved credential.
CS30	Provider	**Specialized Medical Equipment** Commenter says providing Specialized Medical Equipment	DMS recognizes a rate adjustment is necessary for all 1915(c) HCBS waivers, however, rates are not being changed with this renewal. DMS is currently conducting a rate study of all 1915(c) HCBS waiver services to develop a sound payment and rate-	

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		is costly and burdensome for providers. "The responsible provider must pay the funds in advance for purchases and often incur interest charges on credit cards and then is not reimbursed for any of these costs or the administrative costs of managing the purchase and reimbursement process. If this is expected of providers, they should receive some kind of reimbursement for the work and cost of providing the service."	setting methodology, informed by analyzing the reasonable and necessary costs incurred by providers who service waiver services. Any rate adjustments will be made through future waiver and KAR amendments. The public will have an opportunity to review and comment on any rate adjustments before they are final.	
CS32	Provider	**Community Guide** Commenter says the definition of Community Guide in the SCL KAR may be preventing more agencies from providing the Community Guide service. "...The current regulations state that a community guide cannot provide other direct waiver services to ANY waiver participant. It is the biggest reason that there is currently only 1 agency in the state of Kentucky attempting to provide CG services (based on my recent statewide search	Thank you for the suggestion. Changing a service definition requires amending the SCL KAR. DMS is not amending 907 KAR 12:010 for this renewal. Kentucky's full 1915(c) HCBS waiver service menu, including the potential expansion of current services, will be reviewed following the completion of the 1915(c) HCBS waiver rate study, which is currently underway. Any updates to the service menu will be completed through future KAR changes accompanied by a waiver amendment. The public will have an opportunity to review and comment on future KAR and waiver amendments.	

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		reaching out to all CG providers in the provider directory). I recommend that regulations be updated to match the language in this application to increase the number of qualified community guides."		
Eligibility and Enrollment				
EE1	Provider Other Stakeholder	**Patient Liability** Commenters applaud the increase in financial eligibility from 100% of the Federal Benefit Rate (FBR) to 300% of the FBR, which reduces or eliminates patient liability payments for most waiver participants.	Thank you for your feedback.	
EE4	Other Stakeholder	**Financial Eligibility** Commenter applauds the selection of 'Yes' under *4. Waiver(s) Requested, B. Income and Resources for the Medically Needy* at the beginning of the waiver application.	Thank you for your feedback.	

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EE6	Other Stakeholder	**Financial Eligibility** Commenter applauds selection of 'No Cost Limit' under *Individual Cost Limit* in Appendix B.	Thank you for your feedback. It is important to note "No Cost Limit" does not refer the amount of services a participant receives. The CMS' Technical Application for a §1915(c) Home and Community-Based Waiver [Version 3.6, January 2019] Instructions, Technical Guide and Review Criteria says No Cost Limit means *"When an individual cost limit is not imposed, this means that no otherwise eligible individual will be denied entrance to the waiver solely based on the anticipated costs of the home and community-based services that the person may require. Again, this does not mean that the person is entitled to unlimited home and community-based services once enrolled in the waiver program. The amount of services that will be furnished to an individual is determined based on assessed needs and as specified during the development of the service plan and is subject to any other limitations specified in Appendix C."*	
EE8	Caregiver	**Waiver Target Groups – Selection** Commenter asked why autism is not checked in *Appendix B-1: Specification of the Waiver*	The Intellectual Disability or Developmental Disability, or Both category in *Appendix B-1-a: Target Group(s)* is a preset option in the 1915(c) waiver application developed by CMS. The Intellectual Disability or	

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		Target Group(s) since SCL supports individuals with autism.	Developmental Disability, or Both is the most inclusive of the options provided by CMS and is composed of all individuals, including those with autism, who otherwise would require the level of care furnished in an intermediate care facility for individuals with intellectual disability (ICF/IID).	
EE2	Provider Other Stakeholder	**Waiver Target Groups – Definition of Intellectual Disability** Commenters request revisions to the definition of intellectual disability in the waiver application. Commenters say the definition does not align with the Diagnostic and Statistical Manual of Mental Disorders (DSM) definition nor the definition in 907 KAR 12:010. "...in requiring an IQ cut off of 70 or below, the SCL renewal application is thus not taking into account that an individual can test above 70 but still be so limited in their adaptive functioning that they in fact have an intellectual disability." "…the SCL regulation currently defines intellectual disability in	After reviewing 907 KAR 12:010, the waiver application will be edited to clarify IQ requirements.	B-1-b. of the waiver application will be edited to state "significantly sub-average intellectual functioning confirmed by both clinical assessment and individualized standardized intelligence testing resulting in an IQ score of seventy (70) or below that includes a margin for measurement error of plus or minus five (5) points."

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		part as "significantly sub-average intellectual functioning and an intelligence quotient (IQ) of seventy (70) plus or minus five (5)… DMS should not make an IQ score above 69 a hard cut off for SCL eligibility... We suggest that DMS follow the current DSM and eliminate any fixed number from the definition of intellectual disability."		
EE9	Caregiver	**Waiver Target Groups – Related Conditions** Commenter asked why "Related Condition" is defined in *Appendix B-2: Additional Criteria.*	"Related Condition" is defined in *Appendix B: Additional Criteria* to make the waiver more inclusive of individuals who meet ICF/IID level of care. ICF/IID level of care and "Related Condition" are also defined in 907 KAR 1:022. Per CMS' Technical Application for a §1915(c) Home and Community-Based Waiver [Version 3.6, January 2019] Instructions, Technical Guide and Review Criteria, *"States are advised that the ICF/IID level of care is reserved for persons with intellectual disability or a related condition, as defined in 42 CFR §435.1009. Participants in a waiver linked to the ICF/IID level of care must meet the 'related condition' definition when they are not diagnosed as having an*	

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			intellectual disability (e.g., persons with autism).”	
EE5	Other Stakeholder	**Waiver Target Groups – Definition of Related Condition** Commenter applauds the definition of ‘Related Condition’ in Appendix B. "…we welcome the language used to describe a related condition (developmental disability) as it includes an impairment of general intellectual functioning or adaptive behavior and follows 907 KAR 1:022 § 4(5)"	Thank you for your feedback.	
EE3	Other Stakeholder	**SCL Participants and Psychiatric Hospital Admissions** Commenter says they are aware of instances of SCL participants being involuntarily disenrolled from the waiver after admission to a psychiatric hospital.	Participants should not be involuntarily terminated because of admission to a psychiatric hospital. Per 907 KAR 12:010, a participant can only be involuntarily terminated for the following reasons: • An applicant fails to access services within sixty (60) days of receiving a notice of potential funding and does not receive an extension based on demonstration of good cause. Good cause is defined in 907 KAR 12:010.	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
			• A participant fails to access any of the services outlined in their person-centered service plan for sixty (60) days and does not receive an extension based on demonstration of good cause. Good cause is defined in 907 KAR 12:010. • A participant moves to a residence outside of Kentucky. • Does not meet ICF/IID patient status criteria as outlined in 907 KAR 1:022. A participant admitted to a psychiatric hospital is most at risk of termination due to failure to access services during the specific time period. If a participant is in this situation, their case manager should contact the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID), Division of Developmental and Intellectual Disabilities (DDID) or DMS to discuss their options. If the commenter is aware of specific instances of SCL participants being involuntarily terminated because of psychiatric hospital admission, please contact DDID or DMS to allow us to evaluate the situation and potential resolutions.	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
EE7	Other Stakeholder Caregiver	**Reserved Waiver Capacity Numbers** Commenters note a reduction in the number of Reserved Waiver Capacity slots in waiver years 4 and 5 from 228 to 178 and asked how the numbers are determined. "The currently approved waiver reserves 278 slots. Having 100 less reserved emergency SCL slots will not be sufficient to cover the need."	Reserved Waiver Capacity slots were calculated based on historic allocations for emergencies and the number of participants leaving the SCL waiver each year. Fewer participants have been transitioning off the SCL waiver in recent years, resulting in an estimated reduction in the number of slots available for emergency allocations.	
EE10	Caregiver	**Waiver Slots** Commenter asked why there is no increase in the number of persons served in Appendix B.	4,941 was the maximum number of slots available in the waiver at the time the application was released for public comment. Slots can only be increased when the Kentucky legislature approves additional funding for the waiver program during the state's biennial budget process. During the 2022-2024 budgeting process, the Kentucky legislature approved a total of 100 additional slots for the SCL waiver. 50 slots will be added in the 2022-2023 fiscal year and another 50 in the 2023-2024 fiscal year, pending CMS approval. This means the maximum number of slots available in the waiver will become	The waiver application will be updated to reflect the additional of 100 slots approved in Kentucky's 2022-2024 state budget.

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
			4,991 in 2022-2023 and 5,041 in 2023-2024.	
Case Management				
CM1	Provider	**Face-to-Face Case Management Visits – Residential** Commenters request that DMS continue to require quarterly visits face-to-face visits in the participant's home for those receiving Residential services saying this requirement will "increase the quality of service delivery and care for SCL participants."	Thank you for your feedback. DMS is not changing the requirement for case managers to visit participants who receive Residential services in their homes once per quarter with this waiver renewal.	
CM16	Provider	**Face-to-Face Case Management Visits – Residential** Commenter requests changing the requirement to visit participants who receive Residential services in their home from quarterly to bi-annually. "We understand the importance of monitoring participants in their homes, especially since the national health pandemic has	Thank you for your feedback. DMS is not changing the requirement for case managers to visit participants who receive Residential services in their homes once per quarter with this waiver renewal.	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
		forced us to perform this task virtually. However, going from doing this annually to doing this quarterly is a radical change."		
CM21	Provider	**Monthly Case Management Visits – Location** Commenter requests case managers be allowed to conduct the monthly face-to-face visit with the participant in settings other than covered sites. "It is understandable all services need to be monitored, but by specifying at a service site, that takes out observing those doing PA, or PDS services in the community- which could give the CM more knowledge and insight on how person is doing on goals than simply discussing at a home visit."	Per 907 KAR 12:010, case managers can conduct the monthly face-to-face visit at "a location where the participant is engaged in services." This means visits can occur anywhere the participant is receiving services such as at home, out in the community, or at a facility like the adult day health care center.	D-2-a. of the waiver application will be edited from "The CM shall conduct one face-to-face visit with a participant at a covered site…" to "The CM shall conduct one face-to-face visit with a participant at a location where the participant is engaged in services."
CM23	Provider	**Monthly Case Management Visits – Attendees** Commenter states that currently PDS representatives are only required to attend the monthly face-to-face visit once per quarter. Commenter asks if the requirement has been changed	The requirement for a monthly face-to-face contact between the case manager, the participant, and the participant's representative (if applicable) is included in the currently approved SCL waiver. DMS did not change the requirement in the renewal SCL waiver as this is considered a best practice.	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
		to monthly with the SCL waiver renewal.		
CM6	Provider	**Monthly Case Management Visits – Telehealth** Commenters note the waiver application did not include telehealth as a method for case managers to conduct monthly face-to-face visits, which is currently allowed under Appendix K. "Offering this option to participants and their families has proven to actually decrease the number of cancelled face-to-face visits, allowing Case Managers and Support Brokers to monitor service delivery more consistently."	Making Appendix K changes permanent requires amending the SCL KAR. DMS is not 907 KAR 12:010 for this renewal. Kentucky's 1915(c) HCBS waivers, including whether to make Appendix K changes permanent, will be reviewed following the completion of the 1915(c) HCBS waiver rate study, which is currently underway. Any updates will be completed through future KAR changes accompanied by a waiver amendment. The public will have an opportunity to review and comment on future KAR and waiver amendments before they are final. DMS acknowledges face-to-face visits increase the risk to participants and case managers during the ongoing COVID-19 pandemic. The temporary waiver changes made through Appendix K of the 1915(c) HCBS waiver application allow case managers to conduct all visits via phone or using remote options (such as FaceTime, Skype, etc.), so long as the method used allows for direct interaction between the waiver participant and the case manager (email or leaving a message is not considered interactive). This temporary	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
			policy update will remain until Appendix K expires or is discontinued at which time providers will receive at least 48 hours' notice.	
CM2	Provider Other Stakeholder	**Timely Submission of Person-Centered Service Plans** Commenters have concerns about the deadline to submit the annual person-centered service plan (PCSP) seven (7) days prior to the end of the participant's level of care (LOC) year as outlined in Appendix D. Concerns include: • Delays caused by unforeseen circumstances, gathering documentation, and obtaining signatures. • That the deadline, coupled with the requirement to gather signatures, will prevent timely changes to the PCSP for participants experiencing a crisis or needs immediate changes to the PCSP. • The deadline creates an additional hurdle for case managers and will	Thank you for sharing your concerns. The completed and signed PCSP must be uploaded to the Medicaid Waiver Management Application (MWMA) seven (7) calendar days before the end of the participant's current LOC period to prevent any gaps in service for the participant. As outlined in Appendix D, the person-centered service planning process can begin forty-five (45) calendar days before the end of the LOC period to give the person-centered planning team sufficient time to complete the plan, gather the required documentation, and obtain signatures. The seven (7) calendar day deadline is for PCSP renewals only. If a participant experiences a change in their condition or service needs, a PCSP modification can be completed at any time as outlined in *Appendix D-1-d. under "C. Event-Based Modification of the Person-Centered Service Plan*." This policy allows the person-centered planning team to	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
		not solve the issue of late PCSP submissions. • The deadline creates a discrepancy across other 1915(c) HCBS waiver programs. Commenters recommend instances of case managers submitting late PCSPs should be addressed directly by DMS or DBHDID rather than thorough general waiver policy.	follow an expedited process and adjust the PCSP as quickly as possible. This deadline was incorporated into the HCB and Model II waivers when they were renewed in 2020 and is being incorporated into the ABI waiver renewal in progress. To ensure alignment among all 1915(c) HCBS waivers, the deadline will also be included in the upcoming ABI LTC and MPW renewals.	
CM4	Provider	**Timely Submission of Person – Centered Service Plans** Commenter appreciates the deadline to have the PCSP completed and uploaded to MWMA seven (7) days before the end of the participant's LOC year. "…It is not uncommon for us to have to contend with expired PAs resulting in a gap in provision of needed services. This new language should reduce the number of expired PAs."	Thank you for your feedback.	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
CM19	Provider	**Timely Submission of Person-Centered Service Plans – Start of Person-Centered Planning** Commenter suggests increasing the proposed timeframe to begin the person-centered planning process for PCSP renewals. "Can we make this similar to the other waivers and use 60 days prior to LOC expiring, to allow CM time to have the meetings and get all paperwork put into MWMA?"	The forty-five (45) day timeframe to begin person-centered service planning is consistent with current policy and has been included in previous waiver renewals and reflects best practices. Level of care recertifications begin 60 (sixty) days before the end of the level of care year.	
CM13	Provider	**Timely Submission of Person-Centered Service Plans – Approval** Commenter requests clarification on the deadline to submit the annual PCSP seven (7) calendar days before the end of the participant's current LOC period. "Does this mean that if the PCSP is uploaded 6 days prior to the end of the LOC, it will be denied?"	Late submissions may not be fully approved before the start of the new LOC period if there are services that require Cabinet-level review. This increases the risk that participants may experience a gap in services or that providers may not receive payment for services rendered. The seven (7) calendar day deadline assures there is adequate time for review of the PCSP to occur before the start of the new LOC period.	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
CM5	Provider Other Stakeholder	**Submission of Person-Centered Service Plans – Signatures** Commenters request clarification on language regarding the requirement to have all signatures of the person-centered team before initiating services. "The way that we read this provision, it appears that any service provided prior to all members of the treatment team signing off will not be reimbursed and thus this language appears to say that PAs for services cannot be backdated... We therefore request that the above language either be clarified such that it is clear that PAs can be backdated or the language be deleted so that services are not delayed nor is payment for necessary services denied due to a provider agency who is slow at responding to requests for signature."	Signatures from all service providers are only required for the initial and annual PCSPs. Event-based modifications only require signatures from the providers affected by any event-based modifications. PCSPs that are missing the required signatures will not be denied, however, the services without a signature may not be prior authorized until a signature is obtained. Providers may not receive reimbursement for services rendered before they are prior authorized.	
CM14	Provider	**Submission of Person-Centered Service Plans – Signatures**	This is correct. The signature sheet should be signed by all members of the person-centered planning team	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
		Commenter requests clarification on obtaining signatures on the PCSP. "(Is)...the signature sheet… signed at the PCSP meeting and submitted with MWMA when the plan is submitted."	after the development of the initial PCSP and the annual PCSP renewal. For event-based modifications, signatures should be obtained from the participant, the case manager, and any new service providers for whom the scope, amount, or duration of service has changed.	
CM11	Provider	**Event-Based Modifications to the Person-Centered Service Plan – Signatures** Commenters request clarification on the requirement to obtain all signatures when completing an event based PCSP modification. "How does this apply to people who need emergency services? Right now case managers sometimes get requests after someone has been started in residential due to an emergency and asked to 'back date' residential or behavioral services. "	Signatures from all service providers are only required for the initial and annual PCSPs. Event-based modifications only require signatures from any new service providers or from current providers for whom the scope, amount, or duration of service has changed. For event-based modifications made due to an emergent situation, it is possible for PCSPs to be backdated. Emergency requests should be made as quickly as feasible and include documentation reflecting the reason for the delay.	
CM7	Provider	**Participant Corrective Action Plans**	Corrective action plans have been added for participants to give them an opportunity to correct issues that are interfering with the delivery of PDS	

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		Commenters request clarification on corrective action plans. "What does it mean by CAP for participants?" "Only PDS participants/representatives have CAPs (not the PDS employees)… these mentions are confusing and may need clarification."	services. DMS added this option after observing a growing number of participants being terminated from PDS without being given the opportunity to correct the issue(s).	
CM12	Provider	**Implementation of the Person-Centered Service Plan** Commenter requests a definition for 'home' as referenced in *Appendix D-1-d.* under '*Initial Development of the Person-Centered Service Plan.'* The language says, *"Upon acceptance of a new participant, the CM must conduct an initial home visit to begin the person-centered planning process."*	Case managers are expected to conduct an initial in-person visit with the participant; however, it does not have to occur in the participant's home.	D-1-d. of the waiver application will be edited from "…the CM must conduct an initial home visit" to "…the CM must conduct an initial in-person visit."
CM15	Provider	**Development of the Person-Centered Service Plan – Assessment** Commenter asked for clarification on which tool is used for SCL assessment.	This is correct. The Supports Intensity Scale (SIS) is used as the functional assessment for SCL participants.	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
		"Is the “assessment” referring to the Supports Intensity Scale (SIS) assessment?"		
CM9	Provider	**Development of the Person-Centered Service Plan – Role of Supports Intensity Scale and Health Risk Screening Tool** Commenters request clarification on the role of the SIS and the Health Risk Screening Tool (HRST) in the service planning development process. "During this time, goals are not required since there is no assessment. Will this be changed? Will participants now receive their SIS assessment after allocation but prior to LOC?" "How will the initial PCSP be developed when the SIS assessment and HRST are not available until after someone has begun receiving waiver services?"	The role of the SIS and the HRST in the service planning development process is not being changed in the waiver renewal. The initial 120-day service plan remains in place.	
CM10	Provider	**Development of the Person-Centered Service Plan – SMART Goals**	Thank you for your feedback.	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
		Commenters thank DMS for including SMART goals as a requirement in the person-centered planning process and requested that: • Training be provided to all case managers, providers, and participants. • The use of SMART goals to be communicated to all regulatory agencies for consistency in reviews and audits.		
CM25	Provider Other Stakeholder	**Development of the Person-Centered Service Plan – Questions about Process** Commenters say the service plan development process described in Appendix D does not accurately describe the current process. "Currently, for any new SCL allocation, case managers are directed to request one hundred and twenty (120) days of service. This request generally occurs before the SIS assessment can be scheduled, especially for emergency	The current process is not changing in the waiver renewal. The initial 120-day service plan remains in place.	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
		allocation... clarify if the current practice of implementing a one hundred and twenty (120) day initial service period is being revised."		
CM28	Provider	**Development of the Person-Centered Service Plan – Participant Engagement** Commenter asked the following regarding participant engagement in the person-centered planning process. "How should the team address when the SIS and/or HRST identify areas where a participant needs to develop additional skills to ensure health, safety, and welfare or to meet other participant-desired outcomes, but the participant doesn't see a need for these goals to be on the PCSP and doesn't want to work on these goals?"	It is the responsibility of members of the person-centered planning team, including the case manager, to educate the participant on his or her identified risks and the potential consequences of not addressing risk. D-1-e. of the waiver application addresses the rights of the participant and the role of the person-centered team and case manager in risk assessment and mitigation saying *"Participants with legal decision-making authority have the right to accept risks. The participant's CM is responsible to discuss risks with the participant and the participant's legal guardian or authorized representative, if applicable, and make sufficient efforts to engage the participant and the participant's person-centered team to develop risk mitigation strategies that reduce risks, particularly those adversely impacting health, safety, or welfare of the participant, individuals with whom the participant resides, and those who interact with the participant in order to deliver the PCSP.*	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
			A participant's CM must document the outcomes of risk mitigation strategies. Documentation must demonstrate due diligence in addressing risks with the participant and members of the person-centered team. If a participant refuses to engage in risk mitigation strategies and accepts risks, the CM is responsible to assess the participant's understanding of risks and potential consequences. The CM is responsible to educate the participant when risks impede the ability of providers to deliver services safely and effectively, which is a violation of a participant's signed rights and responsibilities form, and must make participants aware of disruption or loss of services due to ongoing risks that are not mitigated. The CM must proceed in this manner with any participants with an appointed legal guardian or authorized representative with decision-making authority. *If concern exists that a participant may not demonstrate understanding of risk and consequence, the CM is expected to refer participants to child or adult protective services to address any possible self-neglect, caregiver neglect, or other abuse/neglect/exploitation issues that may exist. The CM and all Medicaid-funded providers are required to cooperate with protective service*	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
			investigations. Findings of an investigation may prompt necessary adjustment to the PCSP, in which case the CM should proceed with adjustment to the PCSP in accordance with the process outlined to make an event-based modification to the PCSP as established in Section D-1."	
CM17	Caregiver	**Service Authorization** Commenter appreciates the person-centeredness of the waiver renewal application and case management standards. "…like the fact that the Case Manager can approve service authorizations, as I believe that will streamline the process."	Thank you for your feedback.	
CM24	Provider Other Stakeholder	**Service Authorization** Commenters note service authorization is not included in the definition of the Case Management service.	The service authorization process is not being changed in the renewal. The Case Management service definition states that *"Activities are documented, and plans for supports and services are reviewed by the case manager at least annually and more often as needed using the person-centered planning processes described in Appendix D."* Service authorization is outlined in the person-centered planning process in Appendix D.	

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CM18	Caregiver	**Conflict-Free Case Management** Commenter noted in Appendix D that entities and/or individuals that have a responsibility to monitor service plan implementation and may provide other direct waiver services to the participant. The commenter asked whether this is a conflict of interest.	DMS allows case management entities to also provide direct services, however, it must establish safeguards to make sure monitoring is conducted in the best interest of the participant. DMS has established the following safeguards as outlined in Appendix D of the waiver application. *"Providers for the participant, or those who have an interest in or are employed by a provider for the participant, must not provide case management or develop the PCSP. For participants who request an exception to this, the Department will require the CM to provide the following to ensure the participant is free from undue influence:* 1. *Documentation showing that there are no willing CM within thirty (30) miles of the participant's home;* 2. *Documentation of conflict of interest protections;* 3. *An explanation of how CM functions are separated within the same entity; and* 4. *Demonstration of the availability of a clear and accessible dispute resolution process that advocates for*	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
			participants within service or case management entity. *Exemptions for conflict free case management shall be requested initially and, upon reassessment or at least annually."*	
CM26	Provider	**Conflict-Free Case Management** Commenter requests additional exceptions to the Conflict-Free Case Management requirement beyond the lack of available providers in a specific geographic region. "Not considering other valid reasons for an exemption puts unnecessary limitations on a participant's freedom of choice. As long as the steps required for other exemptions are followed, there should be effective safeguards in place to ensure appropriate service delivery."	DMS does not limit a participant's choice of case managers in situations beyond those related to Conflict Free Case Management as required by CMS' 2014 Federal Final Rule for HCBS. The Federal Final Rule only addresses the lack of available providers in a specific geographic region stating, *"a provider who renders case management to the participant must not also provide another waiver service to that same participant, unless the case manager/support broker is the only willing and qualified provider in the geographical area thirty (30) miles from the participant's residence."*	
CM20	Provider	**Notification of Person-Centered Service Plan Changes** Commenter asked for clarification on how service providers are notified of changes	Service providers receive notifications of changes to the PCSP via MWMA and can check the system for updates. Case managers are responsible to collaborate with service providers to ensure requests are made in a timely manner and to assure services are	D-1-g. will be edited to clarify the case manager's role in notifying providers of changes to the PCSP.

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
		to the person-centered service plan. "On page 140, it states all providers delivering services will be notified via MWMA when a participants PCSP has changed and will be responsible to review changes… on page 142 it states The CM is responsible for notifying providers of approval or denial of the completed PCSP. These two sentences seem to be conflicting. If MWMA system is alerting providers, why would the CM be responsible for alerting providers?"	being delivered according to the PCSP.	
CM22	Provider	**Risk Assessment and Mitigation** Commenter asked if emergency backup plans are required for traditional participants as well as those who use PDS.	Traditional provider agencies must have an agency plan to address emergencies and are not required to have an individual emergency plan for each participant. An individual emergency plan is required for participants using the PDS delivery option.	
CM27	Provider	**Freedom of Choice** Commenter asked how informed choice as outlined in Appendix D will be operationalized. "A number of case managers have historically aligned	DMS discourages case managers from asserting undue influence on a participant's freedom to choose service providers. Case managers are expected to educate participants on freedom of choice and assist the participant in choosing from any available provider by helping them	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
		themselves with specific direct service providers they prefer to work with and do not always offer unbiased information about available providers, as well as only tend to make referrals to certain agencies...How will the Department work to prevent this practice and ensure that case managers do not unduly influence the choice of other service providers?"	access a list of available providers, answering questions about providers, and informing them of web-based provider profiles. DMS plans to also increase the number of participant surveys to monitor the quality of services, including how well-informed they are regarding freedom of choice.	
CM29	Provider	**Standard Documentation – Case Management** Commenter requests DMS develop a standardized template case managers can use to inventory the participant's person preferences, their individual considerations for service delivery, and their needs, wants and future aspirations as outlined in Appendix D. "It would be very helpful to have a standardized format that is used by all providers."	Thank you for your comment. DMS does not develop standard templates for case management activities to give case management providers flexibility in how they conduct person-centered planning activities.	
CM31	Provider	**Standard Documentation – Service Notes** Commenter requests DDID develop a standardized format	Thank you for your comment. There is no standard template for monthly service notes to allow providers flexibility in their business practices. Providers can enter notes in MWMA,	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
		for providers to use for monthly service notes.	which provides a standard format for note keeping. Directions for using the Service Note module are available on TRIS.	
CM30	Provider	**Case Management and Conflicts of Interest** Commenter applauds DDID training for case managers on avoiding conflicts of interest or personal bias but says more action is needed. "...there is no safeguard to prevent this from happening, and it is something that is still happening with some case managers."	Thank you for your comment. Case managers are discouraged from asserting undue influence on participants and training will continue to be offered on preventing conflicts of interest or personal bias in the person-centered planning process.	
CM32	Provider	**Maintenance of Forms** Commenter requests case managers not be responsible to maintain service plan documentation separate from what is entered in MWMA. "Case managers spend many hours creating each service plan in MWMA and uploading all related service plan documents where they are then immediately accessible to all providers on the team as well as auditors and	Case management agencies must retain service plan records, however, using MWMA to enter the service plan and upload all related service plan documents meets this requirement. If a case management agency is using MWMA to retain records, it does not need to maintain a separate set of records outside MWMA.	D-1-h. will be edited to reflect records can be maintained in MWMA.

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
		those responsible for monitoring. It wastes significant time and resources for agencies to then download, file, and maintain a duplicate record of all these documents."		
Participant Safeguards				
PS1	Provider	**Incident Reporting – Types of Incidents** Commenter suggests a new incident type be added to MWMA called Restricted Access. The commenter says this category would include times when "...someone is being kept from accessing part of their home, or their belongings without the proper steps being taken to ensure that the person's rights aren't being violated."	Thank you for your suggestion. This would be considered an unauthorized rights restriction. These situations should be reported using the incident reporting process outlined in Appendix G. While there is no category specifically for unauthorized rights restrictions, a reporter can choose the most appropriate category. In the commenter's example, neglect would be one category it could be reported under. DMS and DDID continually monitor incident trends and patterns, which can be used to determine if additional incident types are needed in MWMA.	
PS2	Provider	**Incident Notifications – MWMA** Commenter suggests the MWMA be modified to automatically notify Adult Protective Services (APS) or	Thank you for your suggestion. DMS is continually evaluating ways to improve both MWMA and communication between state agencies that help assure participant health, safety, and welfare. DMS will investigate whether	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
		Child Protective Services (CPS) when incidents of abuse, neglect, or exploitation are reported in the system. "…it eliminates a step and takes away the opportunity for a gap in communication when a critical incident is reported. This would decrease the time it takes to complete a report and would also allow tracking by the state, and provide updates and feedback to the case manager through MWMA."	this is an option as part of our regular MWMA improvement process.	
PS9		**Incident Notifications – Reporting Abuse, Neglect or Exploitation** Commenter states reporting instances of abuse, neglect, or exploitation to the Department for Community Based Services (DCBS) on weekends, holidays or after hours is difficult. “It has not been uncommon to wait for 30 plus minutes for an operator to answer the after-hours number. There needs to be a way to make a report by fax, email, or online 24/7."	Appendix G outlines the options for reporting abuse, neglect, and/or exploitation of a waiver participant. If a child or adult is at immediate risk of abuse or neglect that could result in serious harm or death, it is considered an emergency and should be reported to local law enforcement or 911. There is an online system available for reporting non-emergency situations that do not require an urgent response. The website is monitored during regular business hours (8:00 a.m. to 4:30 p.m. EST, Monday through Friday). Reports are not reviewed on evenings, weekends, or State holidays. The system is available at	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
			https://prd.webapps.chfs.ky.gov/reportabuse/home.aspx. During regular business hours, reporters can also contact their local DCBS office to report suspected ANE. A list of local DCBS offices is available at https://prd.webapps.chfs.ky.gov/Office_Phone/index.aspx.	
PS5	Caregiver	**Incident Notifications – Investigation Results** Commenter says notifications to the participant or the participant's family/guardian should be made immediately upon the close of critical incident investigations, not within 30 days as outlined in the waiver application.	Thank you for your suggestion. DMS continuously evaluates incident investigation policies and procedures and will make any adjustments to notification timeframes as needed.	
PS3	Other Stakeholder	**Adverse Action Notices** Commenter requests DMS ensure adverse action notices clearly explain the dispute resolution process, how to respond to a request for an administrative hearing, and who can request an administrative hearing.	DMS is continually evaluating communications for clarity and readability. DMS will review all adverse action notices and make improvements that more clearly explain the dispute resolution and administrative hearing processes.	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
		"…a provider cannot request an administrative hearing without also being an authorized representative. When an unauthorized provider requests an administrative hearing, often a concerned, but ill-advised case manager, the Hearing and Appeals Branch will dismiss the appeal. This can be an incurable error resulting in no hearing at all."		
PS4	Participant	**Participant Protections** Commenter appreciates Appendix G and the protections it provides to participants.	Thank you for your feedback.	
PS6	Provider	**Risk Assessment and Mitigation – Participant Engagement** Commenter asked the following question about Risk Assessment and Mitigation as outlined in Appendix D. "How will providers accurately address safety risks when the SIS cannot contain any information that contradicts information provided by the participant? It is not rare for some participants to be unaware	The SIS assessment should not be the only source used for risk assessment. The person-centered planning team should identify and discuss risks during the person-centered planning process and the case manager should identify and discuss risks during the monthly face-to-face contact with the participant.	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
		or concerned about legitimate safety risks, despite receiving education about these risks. Will providers be held accountable for harm that comes to a participant for a safety risk that the participant doesn't feel should be included in any of the assessments?"		
PS7	Provider	**Risk Assessment and Mitigation – Emergency Backups** Commenter says critical staffing shortages make it difficult or impossible to identify emergency backups for a participant. "Waiver providers do not have access to special resources to circumvent the critical staffing shortages faced by most types of businesses in this current time, nor should they be expected to or penalized when they cannot do the impossible."	DMS recognizes the challenges staffing shortages have created for 1915(c) HCBS waiver providers, which makes it critical that providers have emergency backup plans in place. Paid support can be substituted with natural supports, family members, friends or other individuals who can assist the participant.	
PS8	Provider	**Risk Assessment and Mitigation - Implementation Challenges** Commenter says the requirement to make participants aware of potential disruption or	While DMS recognizes the involuntary discharge process has challenges for providers and continues to evaluate ways to improve it, participants still need education to understand the potential consequences of risks that go unmitigated. The person-centered	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
		loss of services when risks are not mitigated is unrealistic in some Residential situations. "The only recourse a residential provider has if all risk mitigation strategies and education have failed would be to issue a 30-day notice of involuntary termination of services. With the provider required to continue residential services past the 30-day notice until another provider has agreed to accept the person for services, the 30-day notice doesn't have much meaning to some participants. Meanwhile the provider is required to continue providing services in a situation where there is documented evidence of serious unmitigated risks that the provider is ultimately liable for."	planning team should work together to identify potential risks, educate the participant on the risks and potential outcomes, and look for mitigation strategies for all waiver services.	
PS10	Provider	**Abuse, Neglect, and Exploitation Training** Commenter requests that DDID develop abuse, neglect, and exploitation training materials for providers to use when training participants. "There should also be a specific provider type designated to be	It is the responsibility of the provider to educate participants at least annually regarding the recognition of abuse, neglect, and exploitation as well as how to report it. DMS and DDID leave it up to providers to develop any educational materials or methods for this process as training should be person-centered, tailored to each participant's learning style, and can be conducted using the best method for	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
		responsible for this training so there is not confusion and ambiguity over who should be providing the training."	that participant (for example, in writing, online, or face-to-face). Because providers and case managers work with each participant regularly, they are best equipped to know what methods of learning will be most helpful for that person.	
PS11	Provider	**Medication Administration Training** Commenter says the requirement to use a DDID-trained Registered Nurse (RN) to provide medication administration training to staff is difficult and costly. "The list of available RN trainers and those who are currently still providing the training continues to diminish. The remaining RN trainers are charging extremely high rates… It is often challenging to find an available RN trainer who has availability to train new staff as quickly as providers need them trained. This system creates very large barriers for providers who need to hire and train new staff to provide critical supports to participants."	Agencies have the option to contract with a DDID-trained RN or have their own RN trained by DDID. The requirement for non-licensed employees to receive medication administration training from a DDID-trained RN is included in the SCL KAR. 907 KAR 12:010 is not being amended with this waiver renewal. Changes to the SCL KAR will be considered after the conclusion of the 1915(c) HCBS waiver rate study, which is currently underway. Any updates will be completed through a future KAR change accompanied by a waiver amendment. The public will have an opportunity to review and comment on future KAR and waiver amendments before they are final.	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
Participant-Directed Services				
PDS1	Caregiver	**Legally Responsible Individuals as Participant-Directed Services (PDS) Employees** Commenter recommends amending 907 KAR 12:010 to allow legally responsible individuals, such as parents, to be hired as PDS employees. "The emergency order due to the national COVID pandemic has been a lifesaver… once the emergency is lifted then the parent is no longer eligible to provide the service."	907 KAR 12:010 currently allows legally responsible individuals, such as parents, to be hired as PDS employees for some services. This allowance was in place before the COVID-19 pandemic. Under normal waiver operations, legally responsible individuals must receive approval before being hired as PDS employees. Appendix K of the 1915(c) HCBS waiver application temporarily waives this process to give providers and participants more options to cover gaps in care resulting from COVID-19. The waived process will remain in place until Appendix K expires, which will occur up to six months after the end of the federal public health emergency. DMS will release more information on next steps for legally responsible individuals hired as PDS employees under Appendix K once the expiration date is known.	
PDS7	Provider	**Legally Responsible Individuals as PDS Employees – Provider Criteria**	DMS did not change the specifications for allowing a family member to be hired as a PDS provider as this is outlined in the SCL KAR. DMS is not amending 907 KAR 12:010 for this	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
		Commenter says the following statement *"Service must be one that the family member doesn't ordinarily provide"* in Appendix E of the waiver application could potentially exclude family members from becoming PDS employees. "...(It) could potentially exclude family members who have had no choice but to provide these services due to a shortage of providers or a client's preference for a family member to provide what is often very personal care."	renewal. Changes to the SCL KAR will be considered after the conclusion of the 1915(c) HCBS waiver rate study, which is currently underway. Any updates will be completed through a future KAR change accompanied by a waiver amendment. The public will have an opportunity to review and comment on future KAR and waiver amendments before they are final.	
PDS10	Caregiver	**Legally Responsible Individuals as PDS Employees – Provider Criteria** Commenter notes the policy for allowing legally responsible individuals to be hired as PDS employees states: *"The use of the family member must be age and developmentally appropriate"* and requested an explanation of what this means.	"Age and developmentally appropriate" means a family member can only be hired to provide care exceeding that necessary of an age-matched peer without a disability, whether an adult or a child. This refers to a participant who requires more support to complete activities of daily living, such as eating, dressing, and bathing, than someone of a similar age. Example: A father assists his 16-year-old daughter who has a disability with eating, bathing, and toileting. The father is providing extraordinary care	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
			not typically needed by others who are 16 years old.	
PDS11	Caregiver	**Legally Responsible Individuals as PDS Employees – Participant Criteria** Commenter notes the policy for allowing legally responsible individuals to be hired as PDS employees says: *"The participant must be learning skills for increased independence"'* and asked, "What if the participant will always need someone for support and is as independent as possible already?"	We recognize independence is person-centered and will look different for each participant. The expectation is for each participant to work on goals and objectives that either increase their level of independence or maintain their level of independence, if they have reached their maximum potential. If a participant's ability to reach a certain level of independence changes, so should the goals and objectives on which they are working.	C-2-d. will be edited from "The participant must be learning skills for increased independence" to "The participant must be working on goals and objectives that allow them to be as independent as possible." This language better reflects that independence is person-centered and different for each participant.
PDS2	Provider	**PDS Employee Timesheets and Electronic Visit Verification** Commenter notes Appendix C states, *"the Participant or PDS representative shall sign the employee's timesheet verifying the accuracy of the time reported"* and that this language is no longer correct due to the use of EVV.	EVV serves as the PDS employee's timesheet. The participant, if able, should verify the accuracy of the information entered in EVV, including the time reported, providing a signature in the EVV mobile app at the end of each service visit. If the participant is unable to sign, a guardian, legal representative, or the PDS representative (if present) can sign on his or her behalf. If no one is available to sign at the end of the visit, the PDS employee is given an option to indicate no signature was captured and the reason why.	C-2-c. will be edited from "The participant or PDS representative shall sign the employee's timesheet verifying the accuracy of the time reported" to "The participant or PDS representative shall verify the accuracy of the time reported" to reflect use of EVV instead of timesheet.

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
PDS3	Provider	**Background Screening – PDS Representatives** Commenters note Appendix E indicates PDS representatives must undergo the same background check as PDS employees and that this is new and burdensome requirement for PDS employers in the SCL waiver. "This is a new requirement that would result in increased cost to the employer of record." "Who will be responsible for the cost of the background check and what charges would prevent them from being a Representative? ... Representatives CANNOT be paid for their services so what is intent of requiring the background check? "	The requirement for a PDS representative to undergo a background screening is best practice and is included in the currently approved SCL waiver. The requirement is not changing with the SCL renewal waiver.	
PDS6	Other Stakeholder	**Background Screening – Costs** Commenter recommends the cost associated with securing	Thank you for your feedback. DMS understands the cost of employee background screenings is a challenge for participants using PDS and is evaluating different methods for	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
		PDS employees be included in the reimbursement rate to financial management services agencies or the participant's PDS budget.	covering PDS employee onboarding costs.	
PDS12	Provider	**Background Screening – Frequency** Commenter requests clarification on the statement *"PDS employees must undergo screenings at the time of hire and undergo recurring screenings per the PDS employer's policy."* "For the recurring, does this mean the participant/Representative (as employer) determines recurring screenings, since they are the employer?"	Yes, recurring screenings are at the discretion of the participant as the PDS employer.	
PDS4	Provider	**Rights, Risks and Responsibilities Form** Commenter asked about the Rights, Risks and Responsibilities form cited Appendix E of the waiver application. "...to which form this statement is referring – the DAIL-approved	The language in Appendix E refers to the Department for Aging and Independent Living (DAIL)-approved Employer Responsibilities and Expectations form.	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
		Employer Responsibilities and Expectations form, which is currently in use, or the SCL Rights, Responsibilities, and Risks form, which is no longer in use."		
PDS5	Other Stakeholder	**Financial Management Services – Provider Types** Commenter recommends financial management services be provided by a single entity rather than Area Development Districts (ADD) and Community Mental Health Centers (CMHC), as it is today. "The single FMS entity may be preferable as it would provide uniformity regarding labor and tax practices as well as untangle fiscal management from case management duties."	Thank you for your feedback. DMS recognizes the use of multiple FMS entities can create inconsistencies in the service. DMS is currently evaluating options for streamlining and simplifying FMS for participants using PDS.	
PDS14	Provider	**Financial Management Services – Network Adequacy** Commenter says several Community Mental Health Centers have lengthy wait lists for participants who wish to use PDS "…essentially making this an inaccessible service."	Thank you for your feedback. DMS will work with all CMHCs and ADDs to evaluate barriers to enrolling participants and provide technical assistance as needed.	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
PDS8	Provider	**Monthly Case Management Visits and PDS** Commenters asked for clarification on language in Appendix E that states *"A monthly face-to-face contact is required between the case manager and the participant and representative (if applicable) to ensure the needs are being met in an appropriate manner and monitor health, safety, and welfare…".* Commenters had the following questions and concerns: • "Is this state-appointed guardian, participant appointed authorized representative, PDS representative?" • "Participants may not want this "representative" to be present during the monthly visit and state-appointed guardians are not typically able to participate in monthly meetings. This could also hinder contacts with the participants in the community due to the	If the participant has a public or private guardian who is responsible to help with decisions regarding medical or other health, safety or, welfare-related issues, the guardian is expected to attend meetings and be available for discussions in order to fulfill their responsibilities on behalf of the individual. The requirement for a monthly face-to-face contact between the case manager, the participant, and the participant's PDS representative (if applicable) is included in the currently approved SCL waiver. DMS did not change the requirement in the renewal SCL waiver as this is considered a best practice. DMS agrees participants need the opportunity to see their case manager without other service providers present. Provider attendance is only required at person-centered team meetings and not the monthly face-to-face contact. This allows participants to have a candid conversation with their case manager about any concerns they have with their services or service providers. It is also important to note, person-centered team meetings are not a	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
		"representative's" availability. • "Participants need opportunities to meet with their case manager without other providers or representatives present. If a participant has a concern about their representative or a difference of opinion about how the services are directed, how can they report this to the case manager if the representative is always present…?" • "…Case managers would likely have to make 2 in person visits most months for PDS teams, and still receive no extra compensation for the extra visit or lengthy list of other PDS duties. This is yet another barrier to retaining a case management workforce that is both competent and willing to support participants with PDS and blended service plans."	substitute for the monthly face-to-face contact and vice versa.	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
PDS9	Provider	**Involuntary Termination of a Participant from PDS** Commenter asked for clarification on the term "findings packet" as it relates to involuntary termination of a participant in Appendix E. "Please clarify what is required to be in said findings packet."	There is no specific list of documents required in a findings packet. The expectation is for involuntary termination from PDS to occur only when all other options have been exhausted. When terminating a participant from PDS, the agency should be able to provide a detailed outline of the issues resulting in termination, the efforts to resolve the issues before pursuing termination, the outcome of those efforts, and any other documentation related to the case such as corrective action plans and/or incident reports. Agencies with questions about involuntary termination from PDS should contact DAIL at DAIL.pds@ky.gov.	
PDS13	Provider	**Misuse of Medicaid Funds** Commenter says more safeguards are needed to ensure waiver funds are not misused in PDS services.	Thank you for sharing your concerns. DMS continually monitors both traditional and PDS services for potential fraud, waste, and abuse and may adjust waiver policy as needed in future waiver and KAR amendments. All stakeholders play a role in identifying and reporting Medicaid fraud, waste, and abuse. If you suspect fraud, waste, or abuse of Medicaid funds, please contact the Cabinet for Health and Family Services, Office of the Inspector	

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			General, Division of Audits and Investigations by: • Phone (800) 372-2970 To leave a message, you can call anytime. To speak with a staff member, please call weekdays between 8 a.m. and 4:30 p.m. Eastern. • Email chfs.fraud@ky.gov • Mail Office of Inspector General Division of Audits and Investigations 275 E. Main St., 5E-D Frankfort, KY 40621 A person reporting suspected fraud and abuse is not required to give his/her name. Any information provided is kept confidential.	
Payment and Rate Setting				
PRS1	Provider Other Stakeholder	**Rate Increase for All Services** Commenters request increased reimbursement rates for SCL services citing the need to be able to offer higher wages to both Direct Support	DMS recognizes a rate adjustment is necessary for all 1915(c) HCBS waivers, however, rates are not being changed with this renewal. DMS is currently conducting a rate study of all 1915(c) HCBS waiver services to develop a sound payment and rate-setting methodology, informed by analyzing the reasonable and	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
		Professionals (DSP) and PDS employees. "We are recruiting employees in a marketplace where even entry level jobs are starting at $15/hour. While we can offer a very flexible schedule and a sense of purpose... DSP is a highly-skilled position that should be compensated as such, so that we can maintain and improve the quality of services as the cost of living rises."	necessary costs incurred by providers who service waiver services. Any rate adjustments will be made through future waiver and KAR amendments. The public will have an opportunity to review and comment on any rate adjustments before they are final.	
PRS2	Caregiver	**Agency Responsible for Establishment of Rates** Commenter noted under *b. Medicaid Agency Oversight of Operating Agency Performance* the application states DMS and DBHDID work together to establish a statewide rate methodology, however, under *6. Distribution of Waiver Operational and Administrative Functions* only *"Medicaid Agency"* is checked next to *"Establishment of a statewide rate methodology"*	Thank you for noting the discrepancy. DMS is solely responsible for establishing a statewide rate methodology.	The language under *b. Medicaid Agency Oversight of Operating Agency Performance* will be edited to accurately reflect DMS and DDID's joint functions.

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
PRS3	Caregiver	**Current Positive Behavior Supports Rate** Commenter notes that Positive Behavior Supports is paid using a standard fixed rate and requested the rate.	The current rate for Positive Behavior Supports is $731.50 per behavior support plan. Current base rates for most SCL services are available in Provider Letter #A-53. Rates for services listed in the letter were increased by 10% on July 1, 2018, per the 2018 budget passed by the Kentucky legislature. Rates for all other services are listed in 907 KAR 12:020.	
PRS4	Provider	**Recoupment** Commenter requested DMS and DDID adopt a standard of “substantial compliance" versus "strict compliance" when it comes to recoupments. "The current system is punitive and financially harmful to providers who are doing their best in a complicated system… providers who are making a good faith effort should not be in danger of having to close their doors because of recoupment for minor documentation errors that had no effect on the services provided… DMS/DDID should instead support providers	Providers must follow 907 KAR 12:010. DMS will evaluate the requirements included in each waiver-related KAR following the conclusion of the 1915(c) HCBS waiver rate study and make updates through future KAR amendments. The public will have an opportunity to review and comment on any updates before they are final.	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
		by providing effective and sufficient technical assistance."		
Provider Qualifications and Training				
PQT11	Provider	**Background Screening Registry Checks** Commenter notes a discrepancy between the number of registries required to be checked during background screenings for agency and PDS employees when KARES is not used and the list of required registries. "... 4 background checks are required if KARES is not used, but 5 are listed. Is the Sex Offender Registry maintained by KSP going to be required by regulations in addition to the 4 other background checks that are currently being run?"	Yes, the Kentucky State Police Sex Offender Registry is being added to the list of registries that must be checked when KARES is not used to conduct an agency or PDS employee background screening.	DMS will edit language in C-2-a. to state "If KARES is not used, pre-employment background investigations must be conducted using all five (5) of the following" followed by a list of the required registry checks.
PQT2	Provider Other Stakeholder	**Kentucky Sex Offender Registry Check** Commenter applauds the addition of the Kentucky State Policy Sex Offender registry to the list of required registry checks for direct service providers, PDS employees, and	Thank you for your comments. The Kentucky State Police Sex Offender Registry is a free registry that can be checked by any member of the public. The registry is available at http://kspsor.state.ky.us/ and can be searched by an individual's name.	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
		adult family members residing in a Residential Support Level II home. Commenters had a few questions about the addition: • What does this process look like? • Will we be using an online portal or a mail-in review with KSP? • Is there an associated cost to this new check?		
PQT12	Provider	**Kentucky Sex Offender Registry Check** Commenter asked why the Kentucky State Police Sex Offender Registry has been added to listed of required registry checks for background screenings when KARES is not used. "This seems redundant since someone must have a conviction to appear on the registry."	The Kentucky State Police Sex Offender Registry is a free registry that can be checked by any member of the public. The registry is available at http://kspsor.state.ky.us/ and can be searched by an individual's name. The search is quick and provides an extra layer of protection for waiver participants.	
PQT3	Other Stakeholder	**Options for Background Screenings** Commenter asked how participants using PDS can use KARES to conduct background	Participants are unable to use KARES to conduct background screenings on potential PDS employees at this time. No, the KARES system is an electronic background check process for providers who are licensed through the Cabinet. The participant's fiscal	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
		screenings for potential PDS employees.	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	
PQT10	Provider	**Out of State Background Screenings** Commenter says it is difficult to find the out of state equivalent to Kentucky's Administrative Office of the Courts background check when screening potential agency or PDS employees who have resided or worked outside Kentucky in the past 12 months. "As a suggestion, if the Department could combine a listing for each state, that would be most helpful. This would benefit traditional agencies and PDS employees when trying to obtain these required documents."	Thank you for your comment. DMS will examine options for making this information available to providers.	
PQT4	Provider Other Stakeholder	**Behavior Support Specialist – Continuing Education**	The provider requirements for Positive Behavior Supports in the current SCL waiver include six (6) hours of professional development or	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
		Commenters say six hours of continuing education for Behavior Support Specialists providing the Positive Behavior Supports service is unnecessary and burdensome. "They are professionals and often are licensed and that already requires continuing education." Another commenter asked DMS to clarify the rationale for requiring continuing education for this service. Another commenter recommends provider agencies be required to maintain documentation of active license and/or certification for behavior specialists and only be required to track continuing education hours for behavior specialists who are not licensed or certified.	continuing education. This requirement was not changed in the renewal SCL waiver application.	
PQT5	Provider	**Provider Qualifications – CCT Positive Behavior Supports and Positive Behavior Supports** Commenter note the provider qualifications for CCT-Positive Behavior Supports and Positive	The provider qualifications for CCT – Positive Behavior Supports and Positive Behavior Supports align with the qualifications listed in 907 KAR 12:010 for each service. Changing the provider qualifications for CCT – Positive	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
		Behavior Supports are not the same and recommended making them consistent.	Behavior Supports and Positive Behavior Supports requires amending the SCL KAR. DMS is not amending 907 KAR 12:010 for this renewal. Kentucky's full 1915(c) HCBS waiver service menu, including provider qualifications, will be reviewed following the completion of the 1915(c) HCBS waiver rate study, which is currently underway. Any updates to provider qualifications will be completed through a future KAR change accompanied by a waiver amendment. The public will have an opportunity to review and comment on future KAR and waiver amendments before they are final.	
PQT4.1	Provider	**Residential Support Level II – Provider Training** Commenter applauds the new requirement for adult family members in a Residential Support Level II household to complete a training course. The commenter also asked a question about training for Residential Level II providers. "Will adult family members living in a Residential Level II home still be required to complete training on the individualized needs/person centered plan of a	Thank you for your feedback. DMS did not change the PCSP training requirements for Residential Support Level II. Any individual living in the home and caring for the participant needs to have training on the PCSP.	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
		waver participant prior to being alone with the participant? This is a current requirement but is not listed with the training requirements in the waiver document."		
PQT6	Provider	**Provider Qualifications – Supported Employment** Commenter says the waiver renewal increased the qualifications for a Supported Employment Specialist and requested a rationale for the change.	The SCL waiver renewal application stated a Supported Employment Specialist "Be previously qualified or credentialed to provide supported employment services or have at least a bachelor's degree from an accredited college or university and one (1) year of experience in the field of developmental disabilities." Per 907 KAR 12:010, there is no requirement for the Supported Employment Specialist to have a bachelor's degree.	The waiver application will be edited to remove the requirement of a bachelor's degree for Supported Employment Specialists.
PQT7	Provider Other Stakeholder	**Provider Qualifications – Case Management** Commenters request revisions to the list of individuals who can be hired as case managers and/or case manager supervisors to include Licensed Behavior Analysts and Certified Social Workers.	Thank you for the suggestion. Changing the provider qualifications for case management requires amending the SCL KAR. DMS is not amending 907 KAR 12:010 for this renewal. Kentucky's full 1915(c) HCBS waiver service menu, including provider qualifications, will be reviewed following the completion of the 1915(c) HCBS waiver rate study, which is currently underway. Any updates to provider qualifications will be completed through a future KAR change accompanied by a waiver amendment. The public will have an	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
			opportunity to review and comment on future KAR and waiver amendments before they are final.	
PQT8	Provider Other Stakeholder	**Provider Qualifications – Case Management** Commenters note temporary changes included in Appendix K of the 1915(c) HCBS waiver application regarding case manager qualifications were not added to the SCL waiver and recommended the application be edited to include them.	Thank you for the suggestion. Changing the provider qualifications for case management requires amending the SCL KAR. DMS is not amending 907 KAR 12:010 for this renewal. Kentucky's full 1915(c) HCBS waiver service menu, including provider qualifications, will be reviewed following the completion of the 1915(c) HCBS waiver rate study, which is currently underway. Any updates to provider qualifications will be completed through a future KAR change accompanied by a waiver amendment. The public will have an opportunity to review and comment on future KAR and waiver amendments before they are final.	
PQT9	Caregiver	**Provider Qualifications – Case Management** Commenter asked for the definition of an SCL intellectual disability professional listed in the Provider Specification for Case Management.	SCL intellectual disability professionals are one of the provider types that can supervise case managers. Per 907 KAR 12:010, an SCL intellectual disability professional is a Doctor of Medicine or Osteopathy, registered nurse, or an individual who holds at least a bachelor's degree in a human services field. SCL intellectual disability professionals must also have at least one year of experience working with persons with an	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
			intellectual or developmental disability and must meet the personnel and training requirements in Section 3 of 907 KAR 12:010.	
Other				
O1	Provider	**Appendix K Changes** Commenter applauds the continuation of some options initiated in Appendix K.	Thank you for your feedback.	
O2	Provider	**Provider Involvement at Medical Appointments** Commenter requests the SCL regulation, 907 KAR 12:010, be more detailed about the involvement of Residential providers in medical appointments. "Some residential providers do not even participate in appointments and leave it up to family to do this, if family is willing. This also includes relaying information from the family member who attended the appointment to the residential provider. As a case manager, I do have family who interprets things differently and sometimes	Thank you for the suggestion. DMS is not amending 907 KAR 12:010 for this renewal. Kentucky's full 1915(c) HCBS waiver service menu, including updating provider requirements, will be reviewed following the completion of the 1915(c) HCBS waiver rate study, which is currently underway. Any updates will be completed through future KAR changes accompanied by a waiver amendment. The public will have an opportunity to review and comment on future KAR and waiver amendments before they are final.	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
		who only convey what they want. This just alarms me for continuity of care of the member. "		
O3	Provider	**MWMA Functions** Commenter requests case managers be given the ability to change a participant's address in MWMA. "It is a lengthy process and takes time with the guardian or client to be able to do with DCBS."	Thank you for your suggestion. DMS is evaluating ways to allow case managers to update this information, however, the address entered by DCBS will always be considered the address of record for the participant.	
O4	Provider	**Provider Healthcare** Commenter requests the state create a health care co-op for provider agencies. "This could potentially reduce health care costs for employees and companies and could possibly be done with minimal costs for the state."	Thank you for your suggestion. While DMS is unable to offer such an option to providers, the 1915(c) HCBS rate study aims to develop a sound payment and rate-setting methodology informed by analyzing the reasonable and necessary costs incurred by providers who serve waiver participants. This includes considering the cost of benefits for employees, such as health, vision, and dental. Information about the costs of these benefits for providers were collected in the cost and wage survey that DMS asked providers to complete in spring 2022. Rate adjustments will be made through future waiver and KAR amendments following the completion of the rate	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
			study. The public will have an opportunity to review and comment on any rate adjustments or waiver application and KAR updates before they are final.	
O5	Provider	**Provider Training Platforms** Commenter says recent changes to TRIS and the College of Direct Supports (CDS) have made it more difficult for train case managers to pass post-training tests and quizzes. "During a staffing crisis, there should be a balance between testing competence and realistic expectations."	Thank you for your comment. DMS and DDID are evaluating the requirements of both systems and the need for potential changes.	
O6	Other Stakeholder	**Waiver Manuals and Standard Operating Procedures** Commenter notes the waiver application says DMS will develop manuals and standard operating procedures for both internal Department use and to provide technical assistance and training to providers. "In doing so, please be mindful of KRS 13A.130, which prohibits an administrative body from modifying, expanding, or limiting	Thank you for your comment. DMS carefully cross-references Kentucky Administrative Regulations when developing waiver applications, manuals, standard operating procedures, and other technical assistance to ensure it aligns with the waiver specific KARs.	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
		an administrative regulation by internal policy, memorandum, or other form of action."		
O10	Other Stakeholder	**Waiver Manuals and Standard Operating Procedures** Commenter asked if participants have access to manuals and standard operating procedures developed for internal Department use and for providers.	All publicly available documents can be found on the DMS Division of Long-Term Services and Supports website and individual waiver websites. The Division of LTSS site is available at https://chfs.ky.gov/agencies/dms/dca/Pages/default.aspx and includes links to all waiver-related websites.	
O7	Caregiver	**Participant Surveys** Commenter appreciates the following: "I like the requirement that participant satisfaction surveys of the Financial Management agencies be conducted at a minimum annually."	Thank you for your feedback.	
O9	Caregiver	**Waiver Contact Person(s)** Commenter notes no contact person is listed in the *7. Contact Person(s)* section of the waiver application.	Contact persons from DMS and DDID will be listed on the application when it is submitted to CMS.	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
O11		**Responsibility for Development of Waiver Rules, Policies and Procedures** Commenter notes under *b. Medicaid Agency Oversight of Operating Agency Performance* it says both DMS and DBHDID develop rules, policies, procedures, and information governing the waiver program, however, under *6.Distribution of Waiver Operational and Administrative Functions* only "Medicaid Agency" is checked next to "Rules, policies, procedures and information development governing the waiver program."	Thank you for noting this discrepancy. DMS and DDID work in partnership to develop rules, policies, procedures, and information governing the SCL waiver program.	*6. Distribution of Waiver Operational and Administrative Functions* will be updated to indicate both DMS and DDID develop rules, policies, procedures, and information governing the SCL waiver program.
O12	Provider Other Stakeholder	**Kentucky Administrative Regulations and Updated Waiver Processes** Commenter says changes to service authorization practices and incident reporting were made without the approval of CMS and were not added to 907 KAR 12:010 and in violation of KRS Chapter 13A. "While we do not take issue with the changes made to the service authorization or incident	DMS recognizes the shift to service authorization and electronic incident reporting created a change in workflow for both providers and case managers, however, both were done in alignment with current waiver-related Kentucky Administrative Regulations. Per 907 KAR 12:010, an SCL service shall be prior authorized by the Department. The Department means the Department or its designee. DMS used a designee before making service authorization an in-house process in	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
		reporting processes, we maintain that the Cabinet is required to promulgate new regulations when it proposes a change to long standing policy."	November 2019, as allowed by 907 KAR 12:010. The primary shift in incident reporting is the change from paper incident reporting to electronic incident reporting via MWMA, which is outlined in 907 KAR 12:010, section 11, and states both incidents and critical incidents shall be reported via MWMA. The incident reporting policy, including types of incidents that require reporting, reporting requirements, and timeframes, were clarified and developed based on 907 KAR 12:010.	
O13	Provider	**Provider Administrative Tasks** Commenter requests DMS seek ways to reduce excessive administrative burden placed on waiver providers. "Our concern throughout the Waiver Renewal Application is such that at no point does it appear that consideration was given to minimizing the administrative burden on a provider."	Thank you for your comment. SCL policies and procedures are outlined in 907 KAR 12:010, which is not being amended with this waiver renewal. DMS will evaluate ways to reduce administrative burden through policy and procedure changes following the completion of the 1915(c) HCBS rate study currently underway. Any updates to policies and procedures will be added to the waiver programs through future waiver and KAR amendments following the completion of the rate study. The public will have an opportunity to review and comment on any rate adjustments or waiver application and KAR updates before they are final.	