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

## PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in ◆1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver◆s target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

## Request for a Renewal to a ◆1915(c) Home and Community-Based Services Waiver

### 1. Major Changes

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

No changes have been made to the waiver, however the state will be amending the waiver in the future.

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

### 1. Request Information (1 of 3)

**A.** The **State** of **Kentucky** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of ◆1915(c) of the Social Security Act (the Act).

**B. Program Title** (*optional - this title will be used to locate this waiver in the finder*):

Acquired Brain Injury Waiver

**C. Type of Request: renewal**

**Requested Approval Period:***(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ⦿ **5 years**

**Original Base Waiver Number: KY.0333**
**Waiver Number:KY.0333.R04.00**
**Draft ID: KY.012.04.00**

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

Regular Waiver

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

01/01/17

**Approved Effective Date: 01/01/17**

### 1. Request Information (2 of 3)

**F. Level(s) of Care**. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**
If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☑ **Nursing Facility**
Select applicable level of care

◉ **Nursing Facility as defined in 42 CFR ►►440.40 and 42 CFR ►►440.155**
If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☐ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**
If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

## 1. Request Information (3 of 3)

**G. Concurrent Operation with Other Programs.** This waiver operates concurrently with another program (or programs) approved under the following authorities
Select one:

◉ **Not applicable**

○ **Applicable**
Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**
Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

**Specify the §1915(b) authorities under which this program operates** *(check each that applies):*

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**
Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**
Specify the program:

**H. Dual Eligiblity for Medicaid and Medicare.**
Check if applicable:

☑ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

## 2. Brief Waiver Description

**Brief Waiver Description.** *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Acquired Brain Injury (ABI) waiver program was developed as an alternative to institutional care for Kentucky residents with acquired brain injuries. The ABI waiver focuses on intensive rehabilitation and retraining to assist individuals with acquired brain injury to reenter and function independently within a community given the community's existing resources.

ABI Waiver participants must be 18 years or older, meet the level of care criteria for placement in a nursing facility, and their services in a nursing facility would qualify for payment under the State Plan for Medical Assistance. ABI Waiver services are designed to allow participants to remain in or return to the community in the least restrictive setting. These services are not available to individuals while inpatient in a hospital, nursing facility, or ICF/MR/DD.

## 3. Components of the Waiver Request

**The waiver application consists of the following components.** *Note: Item 3-E must be completed.*

**A. Waiver Administration and Operation. Appendix A** specifies the administrative and operational structure of this waiver.

**B. Participant Access and Eligibility. Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

**C. Participant Services. Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

**D. Participant-Centered Service Planning and Delivery. Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

**E. Participant-Direction of Services.** When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

**F. Participant Rights. Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

**G. Participant Safeguards. Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

**H. Quality Improvement Strategy. Appendix H** contains the Quality Improvement Strategy for this waiver.

**I. Financial Accountability. Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

**J. Cost-Neutrality Demonstration. Appendix J** contains the State's demonstration that the waiver is cost-neutral.

## 4. Waiver(s) Requested

**A. Comparability.** The State requests a waiver of the requirements contained in ◆1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

**B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of ◆1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ( ) **Not Applicable**
- (●) **No**
- ( ) **Yes**

**C. Statewideness.** Indicate whether the State requests a waiver of the statewideness requirements in ◆1902(a)(1) of the Act *(select one)*:

- (●) **No**
- ( ) **Yes**

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

- [ ] **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.
  *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
*Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:*

## 5. Assurances

**In accordance with 42 CFR ⍰441.302, the State provides the following assurances to CMS:**

**A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to ⍰1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

**B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

**C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

**D.** Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

**E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

**F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

**G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

**H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. **Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. **Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR ◆440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR ◆ 440.160.

## 6. Additional Requirements

***Note: Item 6-I must be completed.***

A. **Service Plan**. In accordance with 42 CFR ◆441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. **Inpatients**. In accordance with 42 CFR ◆441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. **Room and Board**. In accordance with 42 CFR ◆441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. **Access to Services**. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. **Free Choice of Provider**. In accordance with 42 CFR ◆431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of ◆1915(b) or another provision of the Act.

F. **FFP Limitation**. In accordance with 42 CFR ◆433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. **Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR ◆431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR ◆431.210.

H. **Quality Improvement**. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. **Public Input.** Describe how the State secures public input into the development of the waiver:

The State secures public awareness by announcing public meetings and notifications to advocate groups, as well as providers, for input on changes to the waiver. All comments and concerns voiced or submitted through public meetings, provider meetings or public comment are considered and incorporated as possible by the writing team into the waiver document. Progress towards incorporating public and provider suggestions are reported through provider meetings and meetings with advocates on a regular basis.

**J. Notice to Tribal Governments**. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

**K. Limited English Proficient Persons**. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

## 7. Contact Person(s)

**A.** The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

**Last Name:**

Gresham

**First Name:**

Earl

**Title:**

Assistant Director, Division of Community Alternatives

**Agency:**

The Department for Medicaid Services

**Address:**

275 East Main Street

**Address 2:**

6W-B

**City:**

Frankfort

**State:**

**Kentucky**

**Zip:**

40621

**Phone:**

(502) 564-7540 **Ext:** 2021 ☐ **TTY**

**Fax:**

(502) 564-0249

**E-mail:**

EarlW.Gresham@ky. gov

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

**Last Name:**

**First Name:**

**Title:**

**Agency:**

**Address:**

**Address 2:**

**City:**

**State:**
**Kentucky**

**Zip:**

**Phone:**

**Ext:** **TTY**

**Fax:**

**E-mail:**

## 8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

**Signature:**

Alisha Clark

State Medicaid Director or Designee

**Submission Date:**

Dec 1, 2017

**Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.**

**Last Name:**

Gresham

**First Name:**

Earl

**Title:**

Assistant Director, Division of Community Alternatives

**Agency:**

Department for Medicaid Services

**Address:**

275 East Main Street

**Address 2:**

6W-B

**City:**

Frankfort

**State:**

**Kentucky**

**Zip:**

40621

**Phone:**

(502) 564-7540 **Ext:** 2021 ☐ **TTY**

**Fax:**

(502) 564-0249

**E-mail:**

EarlW.Gresham@ky.gov

## Attachments

**Attachment #1: Transition Plan**

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**

- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

**Attachment #2: Home and Community-Based Settings Waiver Transition Plan**
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
*Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.*
*To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.*
*Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.*
*Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.*

Kentucky assures that the settings transition plan included with this waiver renewal will be subject to any provisions or requirements included in Kentucky's approved Statewide Transition Plan. Kentucky will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

Kentucky 1915 (c) ABI Waiver Statewide Transition Plan
I. Background

## Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

## Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   ⦿ **The waiver is operated by the State Medicaid agency.**

   Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

   ⦿ **The Medical Assistance Unit.**

   Specify the unit name:

   Department for Medicaid Services

   *(Do not complete item A-2)*

   ○ **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

   Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

   *(Complete item A-2-a).*

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

Specify the division/unit name:

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

## Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
   **As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.**

   b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
   **As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.**

## Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

   ◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
   Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

   DMS contracts with a non-governmental agency to provide services as a Quality Improvement Organization (QIO). The QIO determines level of care, eligibiity determinations, prior authorizes requests for services and approves the Plan of Care. Fiscal agent services are also contracted with a non-governmental agency. The fiscal agent provides processing and payment of provider claims. Financial Management services for waiver members utilizing the participant directed opportunities are monitored through a governmental agency, the Commonwealth of Kentucky's Department for Aging and Independent Living (DAIL). DAIL's responsibilities include providing supports for members choosing to participate in non-medical waiver services.

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

## Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

   ◉ **Not applicable**

   ○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
   Check each that applies:

   ☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth

responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

*Specify the nature of these agencies and complete items A-5 and A-6:*

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

*Specify the nature of these entities and complete items A-5 and A-6:*

## Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

The Department for Medicaid Services (DMS) is responsible for assessing the performance of all contracted entities providing Quality Improvement Organization functions and the fiscal agent.

## Appendix A: Waiver Administration and Operation

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

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

## Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR ◆431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

| Function | Medicaid Agency | Contracted Entity |
|---|---|---|
| **Participant waiver enrollment** | ☑ | ☑ |
| **Waiver enrollment managed against approved limits** | ☑ | ☐ |
| **Waiver expenditures managed against approved levels** | ☑ | ☐ |
| **Level of care evaluation** | ☑ | ☑ |
| **Review of Participant service plans** | ☑ | ☑ |
| **Prior authorization of waiver services** | ☑ | ☑ |
| **Utilization management** | ☑ | ☑ |
| **Qualified provider enrollment** | ☑ | ☐ |
| **Execution of Medicaid provider agreements** | ☑ | ☐ |
| **Establishment of a statewide rate methodology** | ☑ | ☐ |

| | | |
|---|---|---|
| **Rules, policies, procedures and information development governing the waiver program** | ☑ | ☐ |
| **Quality assurance and quality improvement activities** | ☑ | ☑ |

## Appendix A: Waiver Administration and Operation

### Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. **Methods for Discovery: Administrative Authority**
***The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.***

i. **Performance Measures**

***For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application.*** *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

***Where possible, include numerator/denominator.***

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

**Performance Measure:**
**Number and percentage of Utilization Management Reports completed in a timely manner by the Fiscal Agent.**

**Data Source** (Select one):
**Reports to State Medicaid Agency on delegated**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☑ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☑ **Other**<br>Specify:<br>Fiscal agent, QIO | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |

| | | |
|---|---|---|
| | | |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>Fiscal agent, QIO | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The DMS contracts with the fiscal agent who in turn contracts with the QIO for medical necessity review. DMS and the fiscal agent meet on a weekly basis to review and identify issues/problems related to the level of care, plan of care and prior authorization of services. Should problems be identifed, then a collaborative plan is developed to resolve the issue/problem.

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

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

Identified problems are researched and addressed by the DMS and the Fiscal Agent through the use of Utilization Management Reports that are generated on a monthly basis. DMS monitors the Fiscal Agent to ensure that contract objectives and goals for LOC are met as appropriate. Should the Fiscal Agent not meet the requirements then a corrective action plan is required and/or a recoupment of funds could occur.

**ii. Remediation Data Aggregation**

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

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>Fiscal agent, QIO | ☐ **Annually** |
| | |

| | |
|---|---|
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**
○ **Yes**
Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix B: Participant Access and Eligibility

### B-1: Specification of the Waiver Target Group(s)

**a. Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR ⬚441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

| Target Group | Included | Target SubGroup | Minimum Age | Maximum Age | |
|---|---|---|---|---|---|
| | | | | Maximum Age Limit | No Maximum Age Limit |
| ☐ **Aged or Disabled, or Both - General** | | | | | |
| | ☐ | **Aged** | | | ☐ |
| | ☐ | **Disabled (Physical)** | | | |
| | ☐ | **Disabled (Other)** | | | |
| ☑ **Aged or Disabled, or Both - Specific Recognized Subgroups** | | | | | |
| | ☑ | **Brain Injury** | 18 | | ☑ |
| | ☐ | **HIV/AIDS** | | | ☐ |
| | ☐ | **Medically Fragile** | | | ☐ |
| | ☐ | **Technology Dependent** | | | ☐ |
| ☐ **Intellectual Disability or Developmental Disability, or Both** | | | | | |
| | ☐ | **Autism** | | | ☐ |
| | ☐ | **Developmental Disability** | | | ☐ |
| | ☐ | **Intellectual Disability** | | | ☐ |
| ☐ **Mental Illness** | | | | | |
| | ☐ | **Mental Illness** | | | |
| | ☐ | **Serious Emotional Disturbance** | | | |

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

Individuals served through the ABI Waiver are those individuals with acquired brain injury who can benefit from intensive rehabilitation services. The ABI waiver focuses on intensive rehabilitation and retraining to assist individuals with acquired brain injury to reenter and function independently within a community.

An acquired brain injury is an injury to the brain which is not hereditary, congenital or degenerative. Acquired brain injury includes central nervous system injury from physical trauma, anoxia or hypoxic episodes and allergic conditions, toxic substances and other acute medical/clinical incidents. Acquired brain injury does not include strokes treatable in nursing facilities providing routine rehabilitative services, spinal cord injuries in which there are not known or obvious injuries to the intracranial central nervous system, progressive dementia, depression and psychiatric disorders, intellectual disability, and other birth defect-related disorders. Individuals who exhibit aggressive behavior that poses an imminent threat of serious injury or loss of life to staff, co-participants, and/or members of the community may not be served through the ABI Waiver.

**c. Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may

be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

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

*Specify:*

## Appendix B: Participant Access and Eligibility

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

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

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

  **The limit specified by the State is** *(select one)*

  - ( ) **A level higher than 100% of the institutional average.**

    Specify the percentage:

  - ( ) **Other**

    *Specify:*

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

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

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

  - ( ) **The following dollar amount:**

    Specify dollar amount:

    **The dollar amount** *(select one)*

    -

**Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

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

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

Specify percent:

○ **Other:**

*Specify:*

## Appendix B: Participant Access and Eligibility

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

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

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

**c. Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

☐ **Other safeguard(s)**

Specify:

## Appendix B: Participant Access and Eligibility

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

**a. Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

**Table: B-3-a**

| Waiver Year | Unduplicated Number of Participants |
|---|---|

| | |
|---|---|
| **Year 1** | 383 |
| **Year 2** | 383 |
| **Year 3** | 383 |
| **Year 4** | 383 |
| **Year 5** | 383 |

**b. Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

- (●) **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- ( ) **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

**Table: B-3-b**

| Waiver Year | Maximum Number of Participants Served At Any Point During the Year |
|---|---|
| **Year 1** | |
| **Year 2** | |
| **Year 3** | |
| **Year 4** | |
| **Year 5** | |

## Appendix B: Participant Access and Eligibility

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

**c. Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- (●) **Not applicable. The state does not reserve capacity.**
- ( ) **The State reserves capacity for the following purpose(s).**

## Appendix B: Participant Access and Eligibility

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

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

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

**e. Allocation of Waiver Capacity.**

*Select one*:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**

○ **Waiver capacity is allocated to local/regional non-state entities.**

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

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

Eligible applicants will be selected for waiver entrance based on the date of their waiver application. If waiver capacity is not adequate for all eligible applicants, individuals will be selected for waiver entrance based on the date of their waiver application and their category of need, with individuals requiring emergency services receiving preference over individuals who require non-emergency services.

## Appendix B: Participant Access and Eligibility

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

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

## Appendix B: Participant Access and Eligibility

### B-4: Eligibility Groups Served in the Waiver

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

- ◉ **§1634 State**
- ○ **SSI Criteria State**
- ○ **209(b) State**

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

- ○ **No**
- ◉ **Yes**

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

***Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR ⊘435.217)***

- ☐ **Low income families with children as provided in §1931 of the Act**
- ☑ **SSI recipients**
- ☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- ☐ **Optional State supplement recipients**
- ☐ **Optional categorically needy aged and/or disabled individuals who have income at:**

*Select one*:

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

Specify percentage:

- ☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- ☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**

- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [ ] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [x] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

*Specify:*

The federal regulatory criteria for eligibility groups that are covered under the State Medicaid Plan that the state proposes to include under this waiver renewal includes:

42 CFR 435:110 Parents and other caregiver relatives
42 CFR 435:116 Pregnant Women; and
42 CFR 435:118 Children

***Special home and community-based waiver group under 42 CFR ⁄435.217)*** *Note: When the special home and community-based waiver group under 42 CFR ⁄435.217 is included, Appendix B-5 must be completed*

- ( ) **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR ⁄435.217.** *Appendix B-5 is not submitted.*
- (•) **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR ⁄435.217.**

*Select one and complete Appendix B-5.*

- (•) **All individuals in the special home and community-based waiver group under 42 CFR §435.217**
- ( ) **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

*Check each that applies*:

- [ ] **A special income level equal to:**

*Select one*:

- ( ) **300% of the SSI Federal Benefit Rate (FBR)**
- ( ) **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage: [ ]

- ( ) **A dollar amount which is lower than 300%.**

Specify dollar amount: [ ]

- [ ] **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- [ ] **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- [ ] **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- [ ] **Aged and disabled individuals who have income at:**

*Select one*:

- ( ) **100% of FPL**
- ( ) **% of FPL, which is lower than 100%.**

Specify percentage amount: [ ]

- [ ] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

*Specify:*

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (1 of 7)

*In accordance with 42 CFR ◆441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR ◆435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR ◆435.217 group.*

**a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR ◆435.217:

*Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.*

☑ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act.**
*Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.*

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (select one).*

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the State elects to (*select one*):

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
*(Complete Item B-5-b (SSI State) and Item B-5-d)*

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
*(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)*

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
*(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)*

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (2 of 7)

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.*

**b. Regular Post-Eligibility Treatment of Income: SSI State.**

The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in ◆1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

**i. Allowance for the needs of the waiver participant** (*select one*):

○ **The following standard included under the State plan**

*Select one*:

○ **SSI standard**
○ **Optional State supplement standard**
○ **Medically needy income standard**
○ **The special income level for institutionalized persons**

(*select one*):

○ **300% of the SSI Federal Benefit Rate (FBR)**
○

**A percentage of the FBR, which is less than 300%**

Specify the percentage:

**A dollar amount which is less than 300%.**

Specify dollar amount:

**A percentage of the Federal poverty level**

Specify percentage:

**Other standard included under the State Plan**

*Specify:*

**The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

**The following formula is used to determine the needs allowance:**

*Specify:*

SSI standard plus $20 general exclusion

**Other**

*Specify:*

**ii. Allowance for the spouse only** (*select one*):

**Not Applicable**

**The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

*Specify:*

**Specify the amount of the allowance** (*select one*):

**SSI standard**

**Optional State supplement standard**

**Medically needy income standard**

**The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

**The amount is determined using the following formula:**

*Specify:*

**iii. Allowance for the family** (*select one*):

- ○ **Not Applicable (see instructions)**
- ○ **AFDC need standard**
- ◉ **Medically needy income standard**
- ○ **The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR ◆435.811 for a family of the same size. If this amount changes, this item will be revised.

- ○ **The amount is determined using the following formula:**

*Specify:*

- ○ **Other**

*Specify:*

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

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- ○ **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- ◉ **The State does not establish reasonable limits.**
- ○ **The State establishes the following reasonable limits**

*Specify:*

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (3 of 7)

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.*

**c. Regular Post-Eligibility Treatment of Income: 209(B) State.**

**Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.**

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (4 of 7)

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.*

**d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules**

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

**i. Allowance for the personal needs of the waiver participant**

(*select one*):

- ○ **SSI standard**
- ○ **Optional State supplement standard**
- ○ **Medically needy income standard**
- ○ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

  Specify percentage:

- ○ **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised

- ◉ **The following formula is used to determine the needs allowance:**

  *Specify formula:*

  SSI Standard plus the $20 General Exclusion

- ○ **Other**

  *Specify:*

**ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR ⁄435.726 or 42 CFR ⁄435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.**

Select one:

- ◉ **Allowance is the same**
- ○ **Allowance is different.**

*Explanation of difference:*

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

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- ○ **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- ◉ **The State does not establish reasonable limits.**
- ○ **The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (5 of 7)

*Note: The following selections apply for the five-year period beginning January 1, 2014.*

**e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.**

**Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.**

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (6 of 7)

*Note: The following selections apply for the five-year period beginning January 1, 2014.*

**f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.**

**Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.**

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (7 of 7)

*Note: The following selections apply for the five-year period beginning January 1, 2014.*

**g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.**

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

**Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.**

## Appendix B: Participant Access and Eligibility

### B-6: Evaluation/Reevaluation of Level of Care

*As specified in 42 CFR ⧫441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.*

**a. Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

**i. Minimum number of services.**

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

**ii. Frequency of services.** The State requires (select one):

- ◉ **The provision of waiver services at least monthly**
- ○ **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

*If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:*

**b. Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (*select one*):

- ○ **Directly by the Medicaid agency**
- ○ **By the operating agency specified in Appendix A**
- ○ **By an entity under contract with the Medicaid agency.**

*Specify the entity:*

- ◉ **Other**

*Specify:*

Independent case manager

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

The individual who performs the initial evaluation of level of care for waiver applicants must be a registered nurse, a licensed practical nurse, or have a bachelorŁs or masterŁs degree in a human services field and meet all applicable requirements of his or her particular field including a degree in psychology, sociology, social work, rehabilitation counseling, or occupational therapy;
In addition, the individual performing this evaluation must be an independent case manager or be employed by a free-standing case management agency, and must have completed case management training that is consistent with the curriculum that has been approved by the department prior to providing case management services.

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

A patient status decision shall be based on medical diagnosis, care needs, services and health personnel required to meet these needs and the feasibility of meeting the needs through alternative institutional or non-institutional services.
(1) For an admission and continued stay, an individual shall qualify under the preadmission screening and resident review criteria specified in 42 U.S.C. 1396r and 907 KAR 1:755.
(2) An individual shall qualify for high-intensity nursing care if:
(a) On a daily basis:
1. The individual's needs mandate:

**e. Level of Care Instrument(s).** Per 42 CFR ◆441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- ○ **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ◉ **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

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

The tool used for institutional care does not reflect the personŁs community, home or environmental support systems. The MAP-351 reflects all criteria for Level of Care determination, but also reflects the supports needed to stay in their home.

**f. Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

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

**g. Reevaluation Schedule.** Per 42 CFR ◆441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**

*Specify the other schedule:*

h. **Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations *(select one)*:

- (●) **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ( ) **The qualifications are different.**

*Specify the qualifications:*

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

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

j. **Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

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

## Appendix B: Evaluation/Reevaluation of Level of Care

### Quality Improvement: Level of Care

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

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

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

i. **Sub-Assurances:**

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

**Performance Measures**

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

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

**Performance Measure:**
**Number and percent of new enrollees who had a level of care evaluation indicating need for insititutional level of care prior to receipt of services. N= Number of new enrollees who had a level of care indicating need for institutional level of care prior to receipt of services. D= Number of new waiver participants**

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

| **Responsible Party for data collection/generation***(check* | **Frequency of data collection/generation***(check* | **Sampling Approach***(check each that applies):* |
|---|---|---|

| *each that applies):* | *each that applies):* | |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☑ **Other**<br>Specify:<br>QIO | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>QIO | ☑ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**b.** ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

**Performance Measures**

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

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess*

*progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Number and percent of waiver participants who received a redetermination of level of care within 12 months of their initial or last level of care determination. N= Number of LOC determinations with 351 forms on file. D= Number of waiver participants.**

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

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☑ **Other**<br>Specify:<br>QIO | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>QIO | ☑ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other** |

| | |
|---|---|
| | Specify: |

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

**Performance Measures**

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

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

**Performance Measure:**
**Number and percent of level of care determinations with completed 351 assessment forms on file. N= Number of LOCs with completed 351 forms on file. D=Number of waiver participants.**

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

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☑ **Other**<br>Specify:<br>QIO | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| | |

| | |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify: | ☑ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Assessment services include a comprehensive initial assessment which shall be conducted by the case manager within 7 days of receipt of the request. Once a person meets the LOC criteria, those dates are entered into the MMIS with a 12 month span. The date begins with the date the MAP-351A is signed and must be updated in order for the person to continue to receive services and the provider to receive payment for those services that are provided. The state contracts for the implementation of the LOC process,to ensure that all forms are completed appropriately and accordingly using the 907 KAR 1:022 Nursing Facility Level of Care regulation. Contracts are evaluated and monitored by DMS on a yearly basis to ensure the process is carried out according to DMS rules and regulations.

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

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

DMS addresses problems as discovered through the use of utilization management reports which are generated by the fiscal agent and the QIO for evaluation/reevaluation. These reports show number of new participants who received LOC prior to services being provided, shows number of timely reevaluations, and forms/instruments completed as required by the state. DMS will meet with the contractors in order to identify and remediate the problem.
ABI members are provided written appeal rights anytime there is an adverse action initiated. These appeals are held timely and fair hearing procedures are exercised through the Administrative Hearings Branch.

**ii. Remediation Data Aggregation**

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

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>QIO | ☑ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties

responsible for its operation.

## Appendix B: Participant Access and Eligibility

### B-7: Freedom of Choice

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

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

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

All waiver members are informed of their choice of institutional care or waiver programs and available services, including all available waiver providers by participating Case Management waiver providers. This information is provided at the initial evaluation and at each reevaluation and documented on the MAP-350, LLong Term Care Facilities and Home and Community Based Program Certification FormL. Written copies of this signed form are retained in the persons chart and maintained by the Case Management provider. Electronic copies are maintained by the QIO.

**b. Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Written copies of this signed form are retained in the persons chart and maintained by the Case Management provider. Electronic copies are maintained by the QIO.

## Appendix B: Participant Access and Eligibility

### B-8: Access to Services by Limited English Proficiency Persons

**Access to Services by Limited English Proficient Persons.** Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

All Kentucky Medicaid providers are required to provide effective language access services to Medicaid members who are limited in their English proficiency (LEP). Specific procedures for assuring LEP access may vary by provider, but are required to address assessment of the language needs of members served by the provider, provision of interpreter services at no cost to the member, and staff training. Provider procedures for assuring LEP access are ensured through routine interaction and monitoring. When the State learns of an individual needing assistance, staff consult with the individual, case manager and the service provider to determine the type of assistance needed and may require additional activities on the part of the provider to ensure the appropriate translation services are available to the individual.

As indicated in Appendix A, Waiver Administration and Operation, of this application, the Department for Medicaid Services (DMS) contracts with several outside entities to perform waiver administrative functions, including level of care determination and prior authorization of services, processing and payment of provider claims and fiscal

## Appendix C: Participant Services

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

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

| Service Type | Service | | |
|---|---|---|---|
| **Statutory Service** | **Adult Day Training** | | |
| **Statutory Service** | **Case Management** | | |
| **Statutory Service** | **Respite** | | |
| **Statutory Service** | **Supported Employment** | | |
| **Extended State Plan Service** | **Behavioral Services** | | |
| **Extended State Plan Service** | **Counseling** | | |
| **Extended State Plan Service** | **Group Counseling** | | |
| **Extended State Plan Service** | **Occupational Therapy** | | |
| **Extended State Plan Service** | **Specialized Medical Equipment** | | |
| **Extended State Plan Service** | **Speech Therapy** | | |
| **Supports for Participant Direction** | **Community Guide** | | |
| **Supports for Participant Direction** | **Financial Management Services** | | |

| | | | |
|---|---|---|---|
| **Supports for Participant Direction** | **Goods and Services** | | |
| **Other Service** | **Assessment/reassessment** | | |
| **Other Service** | **Community Living Supports** | | |
| **Other Service** | **Environmental and minor home modifications** | | |
| **Other Service** | **Supervised Residential Care Level I** | | |
| **Other Service** | **Supervised Residential Care Level II** | | |
| **Other Service** | **Supervised Residential Care Level III** | | |

## Appendix C: Participant Services

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

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

**Service Type:**

Statutory Service

**Service:**

Day Habilitation

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

Adult Day Training

**HCBS Taxonomy:**

**Category 1:**

04 Day Services
05 Nursing

**Sub-Category 1:**

04060 adult day services (social model)
04070 community integration

**Category 2:**

17 Other Services

**Sub-Category 2:**

**Category 3:**

17 Other Services

**Sub-Category 3:**

**Category 4:**

17 Other Services

**Sub-Category 4:**

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

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

**Service Definition** *(Scope):*

Adult day training services provide assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the individual resides. Adult day training services shall focus on enabling the individual to attain or maintain his or her maximum functional level and shall be coordinated with any occupational or speech therapies listed in the plan of care. In addition, adult day training services may serve to reinforce skills or lessons taught in school, therapy, or other settings. All adult day training services must be prior authorized.

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

Limited to 160 15 minute units per calendar week, alone or in combination with Supported Employment Services

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

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

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Community mental health centers |
| Agency | Adult Day Health Care |
| Individual | Qualified ADT Staff |
| Agency | Approved waiver providers |

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Adult Day Training**

**Provider Category:**

Agency

**Provider Type:**

Community mental health centers

**Provider Qualifications**

**License** *(specify):*

902 KAR 20:091

**Certificate** *(specify):*

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

All standards identified in program regulations and services manual.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Office of Inspector General

**Frequency of Verification:**

Annually (more frequently if necessary)

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Adult Day Training**

**Provider Category:**

Agency

**Provider Type:**

Adult Day Health Care

**Provider Qualifications**

**License** *(specify):*

902 KAR 20:066

**Certificate** *(specify):*

Certified, at least annually, by DMS

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

All standards identified in program regulations and services manual.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Office of Inspector General
Department for Medicaid Services

**Frequency of Verification:**

Annually (more frequent if necessary)

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Adult Day Training**

**Provider Category:**

Individual

**Provider Type:**

Qualified ADT Staff

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

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

1.Is eighteen (18) years or older; and Has a high school diploma or GED; is or is at least twenty-one (21) years old; and
2.Meets all applicable personnel and training requirements as stated in ABI regulation;
3.Has a valid Social Security number or a valid work permit if not a citizen of the U.S.; and
4.Has the ability to: a) communicate effectively with the person/family; b) understand and carry out instructions; c) perform required documentation.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Community Guide or Case Manager if Community Guide service is not utilized.

**Frequency of Verification:**

Prior to service delivery.

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Adult Day Training**

**Provider Category:**

Agency

**Provider Type:**

Approved waiver providers

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

Certified at least annually by DMS

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

An approved waiver provider shall:
a) Be enrolled as a Kentucky Medicaid provider in accordance with Kentucky regulation;
b) Be certified by the department, and recertified at least annually;
c) Have an office within the Commonwealth of Kentucky;
d) Have a governing body that shall be: 1) a legally-constituted entity within the Commonwealth of Kentucky; and 2) responsible for the overall operation of the organization including establishing policy that complies with the Kentucky administrative regulation

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Department for Medicaid Services

**Frequency of Verification:**

Annually or more frequently if necessary.

## Appendix C: Participant Services

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

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid

agency or the operating agency (if applicable).

**Service Type:**

Statutory Service

**Service:**

Case Management

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

**HCBS Taxonomy:**

**Category 1:**

01 Case Management
02 Round-the-Clock Services

**Sub-Category 1:**

01010 case management

**Category 2:**

17 Other Services

**Sub-Category 2:**

**Category 3:**

17 Other Services

**Sub-Category 3:**

**Category 4:**

17 Other Services

**Sub-Category 4:**

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

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

**Service Definition** *(Scope):*

Case Management Services assist individuals who receive waiver services in gaining access to needed waiver and other State plan services. Case managers shall be responsible for monitoring the services included in the individual's plan of care and shall initiate the assessment and reassessment process for the Level of Care determination.

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

This service is limited to one unit per member, per month, (one unit of service is defined as one calendar month).

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

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

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Approved waiver providers |

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Case Management**

**Provider Category:**

Agency

**Provider Type:**

Approved waiver providers

**Provider Qualifications**

**License** *(specify)*:

Registered nurse, a licensed practical nurse, psychologist, social worker, rehabilitation counselor or occupational therapist.

**Certificate** *(specify)*:

Certified at least annually by DMS.

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

An approved waiver provider shall:
a) Be enrolled as a Kentucky Medicaid provider in accordance with Kentucky regulation;
b) Be certified by the department, and recertified at least annually;
c) Have an office within the Commonwealth of Kentucky;
d) Have a governing body that shall be: 1) a legally-constituted entity within the Commonwealth of Kentucky; and 2) responsible for the overall operation of the organization including establishing policy that complies with the Kentucky administrative regulation

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Department for Medicaid Services

**Frequency of Verification:**

Annually or more frequently if necessary.

## Appendix C: Participant Services

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

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

**Service Type:**

Statutory Service

**Service:**

Respite

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

**HCBS Taxonomy:**

**Category 1:**

09 Caregiver Support
10 Other Mental Health and Behavioral Services

**Sub-Category 1:**

09011 respite, out-of-home
09012 respite, in-home

**Category 2:**

09 Caregiver Support
10 Other Mental Health and Behavioral Services

**Sub-Category 2:**

09011 respite, out-of-home
09012 respite, in-home

**Category 3:**

17 Other Services

**Sub-Category 3:**

**Category 4:**

17 Other Services

**Sub-Category 4:**

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

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

**Service Definition** *(Scope):*

Respite care service is defined as short term care which is provided to a waiver recipient due to absence or need for relief of the primary caregiver, or provided to an individual who is unable to care for himself during transition from a residential facility. Respite care services must be provided at a level to appropriately and safely meet the medical needs of the waiver recipient. Respite is considered an essential service to assist the recipient and family to prevent institutionalization. The Case Manager or Community Guide shall be responsible for assisting individuals to access other supports or supports available through other available funding streams if their needs exceed the limit. Respite services shall be prior authorized.

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

Reimbursement for respite care services shall be limited to no more than 5760 fifteen minute units per recipient per calendar year. The limit is based on past maximum historical utilization amounts.

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

**Participant-directed as specified in Appendix E**

☑
☑ **Provider managed**

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

☑ **Legally Responsible Person**
☑ **Relative**
☑ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Qualified Respite Staff |
| Agency | Approved waiver providers |
| Agency | Home Health Agency |
| Agency | Adult Day Health Care |

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Respite**

**Provider Category:**

Individual

**Provider Type:**

Qualified Respite Staff

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

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

1.Is eighteen (18) years or older; and has a high school diploma or GED; or
Is at least twenty-one (21) years old; and
2.Meets all applicable DMS personnel and training requirements;
3.Has a valid Social Security number or a valid work permit if not a citizen of the U.S.;
4.Has the ability to: a) communicate effectively with the person/family; b) understand and carry out instructions;c) perform required documentation

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Community Guide or Case Manager if Community Guide service is not utilized.

**Frequency of Verification:**

Prior to service delivery

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Approved waiver providers

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

Certified, at least annually by DMS

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

An approved waiver provider shall:
a) Be enrolled as a Kentucky Medicaid provider in accordance with Kentucky regulation;
b) Be certified by the department, and recertified at least annually;
c) Have an office within the Commonwealth of Kentucky;
d) Have a governing body that shall be: 1) a legally-constituted entity within the Commonwealth of Kentucky; and 2) responsible for the overall operation of the organization including establishing policy that complies with the Kentucky administrative regulation

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Department for Medicaid Services

**Frequency of Verification:**

Annually (more frequent if necessary

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Home Health Agency

**Provider Qualifications**

**License** *(specify):*

902 KAR 20:081

**Certificate** *(specify):*

Certified, at least annually by DMS

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

All standards identified in program regulations and services manual.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Office of Inspector General
Department for Medicaid Services

**Frequency of Verification:**

Annually (more frequent if necessary)

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Adult Day Health Care

**Provider Qualifications**

**License** *(specify):*

902 KAR 20:066

**Certificate** *(specify):*

Certified at least annually by DMS

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

All standards identified in program regulations and services manual.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Office of Inspector General
Department for Medicaid Services

**Frequency of Verification:**

Annually (more frequent if necessary)

## Appendix C: Participant Services

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

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

**Service Type:**

Statutory Service

**Service:**

Supported Employment

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

**HCBS Taxonomy:**

**Category 1:**

03 Supported Employment
04 Day Services

**Sub-Category 1:**

03010 job development
03021 ongoing supported employment, individual

**Category 2:**

17 Other Services

**Sub-Category 2:**

**Category 3:**

17 Other Services

**Sub-Category 3:**

**Category 4:**

17 Other Services

**Sub-Category 4:**

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

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

**Service Definition** *(Scope):*

Supported employment services consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting. Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

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

Limited to 160 fifteen minute units per calendar week, alone or in combination with adult day training services.

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

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

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Supported Employment Specialist |
| Agency | Approved waiver providers |

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Supported Employment**

**Provider Category:**

Individual

**Provider Type:**

Supported Employment Specialist

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

Completion of the UK HDI KY Supported Employment Training Project within 6 months of the date the specialist begins providing ABI participant directed SE services.

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

DMS standards for SE Specialist are:
a.Minimum of bachelor1.s degree and one year of experience providing a service to an individual with a disability.
b.Relevant experience and/or credentialing will substitute for education on a year for year basis; AND
c.Meets all applicable ABI personnel and training requirements.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Community Guide or Case Manager if Community Guide service is not utilized.

**Frequency of Verification:**

Prior to service delivery

# Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Supported Employment**

**Provider Category:**

Agency

**Provider Type:**

Approved waiver providers

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

Certified, at least annually, by DMS

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

An approved waiver provider shall:
a) Be enrolled as a Kentucky Medicaid provider in accordance with Kentucky regulation;
b) Be certified by the department, and recertified at least annually;
c) Have an office within the Commonwealth of Kentucky;
d) Have a governing body that shall be: 1) a legally-constituted entity within the Commonwealth of Kentucky; and 2) responsible for the overall operation of the organization including establishing policy that complies with the Kentucky administrative regulation

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Department for Medicaid Services

**Frequency of Verification:**

Annually (more frequently if necessary)

## Appendix C: Participant Services

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

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

**Service Type:**

Extended State Plan Service

**Service Title:**

Behavioral Services

**HCBS Taxonomy:**

**Category 1:**

10 Other Mental Health and Behavioral Services
11 Other Health and Therapeutic Services

**Sub-Category 1:**

10040 behavior support
10050 peer specialist

**Category 2:**

17 Other Services

**Sub-Category 2:**

**Category 3:**

17 Other Services

**Sub-Category 3:**

**Category 4:**

17 Other Services

**Sub-Category 4:**

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

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

**Service Definition** *(Scope):*

Behavioral services include the design and evaluation of systematic interventions intended to produce socially significant improvements in the memberĽs behavior and is based upon the principles of learning and applied behavior analysis. These services also include a functional analysis of the ABI recipientĽs behavior and the development of a behavioral support plan.

Behavioral services must be provided by a Certified Psychologist with autonomous functioning, Licensed Psychologist, Licensed Psychological Associate, Psychiatrist, LCSW, ARNP, Clinical Nurse Specialist with a masterĽs degree in psychiatric nursing, Board Certified Behavior Analyst or Licensed Professional Clinical Counselor.

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

Limited to 16 15-minute units per day.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

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

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Approved waiver providers |
| Agency | Community mental health centers |

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**
**Service Name: Behavioral Services**

**Provider Category:**

Agency

**Provider Type:**

Approved waiver providers

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

Certified, at least annually, by DMS

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

An approved waiver provider shall:
a) Be enrolled as a Kentucky Medicaid provider in accordance with Kentucky regulation;
b) Be certified by the department, and recertified at least annually;
c) Have an office within the Commonwealth of Kentucky;
d) Have a governing body that shall be: 1) a legally-constituted entity within the Commonwealth of Kentucky; and 2) responsible for the overall operation of the organization including establishing policy that complies with the Kentucky administrative regulation

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Department for Medicaid Services

**Frequency of Verification:**

Department for Medicaid Services

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**
**Service Name: Behavioral Services**

**Provider Category:**

Agency

**Provider Type:**

Community mental health centers

**Provider Qualifications**

**License** *(specify):*

902 KAR 20:091

**Certificate** *(specify):*

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

All standards identified in program regulations and services manual.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Office of Inspector General

**Frequency of Verification:**

Annually (more frequently if necessary)

## Appendix C: Participant Services

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

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

**Service Type:**

Extended State Plan Service

**Service Title:**

Counseling

**HCBS Taxonomy:**

**Category 1:**

10 Other Mental Health and Behavioral Services
11 Other Health and Therapeutic Services

**Sub-Category 1:**

10060 counseling
10070 psychosocial rehabilitation
10080 clinic services

**Category 2:**

17 Other Services

**Sub-Category 2:**

**Category 3:**

17 Other Services

**Sub-Category 3:**

**Category 4:**

17 Other Services

**Sub-Category 4:**

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

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

**Service Definition** *(Scope):*

Counseling services are designed to help a member resolve personal issues or interpersonal problems resulting from his or her acquired brain injury and assist a family member in implementing a member's approved assessment of needs and plan of care. May be provided to a family member individually as relates to the psychological services of the waiver participant.

This service must be provided by a Certified Psychologist with autonomous functioning, Licensed Psychologist, Licensed Psychological Associate, Psychiatrist, LCSW, ARNP, Clinical Nurse Specialist with a master's degree in psychiatric nursing, Certified Alcohol and Drug Counselor, Licensed Marriage and Family Therapist, or Licensed Professional Clinical Counselor.

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

Limited to 16 15-minute units per day.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

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

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Community mental health centers |
| Agency | Approved waiver providers |

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**
**Service Name: Counseling**

**Provider Category:**

Agency

**Provider Type:**

Community mental health centers

**Provider Qualifications**

**License** *(specify):*

902 KAR 20:091

**Certificate** *(specify):*

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

All standards identified in program regulations and services manual.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Office of Inspector General

**Frequency of Verification:**

Annually (more frequently if necessary)

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**
**Service Name: Counseling**

**Provider Category:**

Agency

**Provider Type:**

Approved waiver providers

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

Certified, at least annually, by DMS

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

An approved waiver provider shall:
a) Be enrolled as a Kentucky Medicaid provider in accordance with Kentucky regulation;
b) Be certified by the department, and recertified at least annually;
c) Have an office within the Commonwealth of Kentucky;
d) Have a governing body that shall be: 1) a legally-constituted entity within the Commonwealth of Kentucky; and 2) responsible for the overall operation of the organization including establishing policy that complies with the Kentucky administrative regulation

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Department for Medicaid Services

**Frequency of Verification:**

Annually (more frequently if necessary)

## Appendix C: Participant Services

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

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

**Service Type:**

Extended State Plan Service

**Service Title:**

Group Counseling

**HCBS Taxonomy:**

**Category 1:**

10 Other Mental Health and Behavioral Services
11 Other Health and Therapeutic Services

**Sub-Category 1:**

10060 counseling
10070 psychosocial rehabilitation

**Category 2:**

17 Other Services

**Sub-Category 2:**

**Category 3:**

17 Other Services

**Sub-Category 3:**

**Category 4:**

17 Other Services

**Sub-Category 4:**

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

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

**Service Definition** *(Scope):*

Group counseling is designed to help a member resolve personal issues or interpersonal problems resulting from his or her acquired brain injury and assist a family member in implementing a member's approved assessment of needs and plan of care. Provided to two to eight members.

This service must be provided by a Certified Psychologist with autonomous functioning, Licensed Psychologist, Licensed Psychological Associate, Psychiatrist, LCSW, ARNP, Clinical Nurse Specialist with a master's degree in psychiatric nursing, Certified Alcohol and Drug Counselor, Licensed Marriage and Family Therapist, or Licensed Professional Clinical Counselor.

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

2-8 people in a group settig. Maximum of 48 fifteen minute units per member per month.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

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

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Approved waiver providers |
| Agency | Community mental health centers |

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**
**Service Name: Group Counseling**

**Provider Category:**

Agency

**Provider Type:**

Approved waiver providers

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

Certified, at least annually, by DMS

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

An approved waiver provider shall:
a) Be enrolled as a Kentucky Medicaid provider in accordance with Kentucky regulation;
b) Be certified by the department, and recertified at least annually;
c) Have an office within the Commonwealth of Kentucky;
d) Have a governing body that shall be: 1) a legally-constituted entity within the Commonwealth of Kentucky; and 2) responsible for the overall operation of the organization including establishing policy that complies with the Kentucky administrative regulation

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Department for Medicaid Services

**Frequency of Verification:**

Annually (more frequently if necessary)

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**
**Service Name: Group Counseling**

**Provider Category:**

Agency

**Provider Type:**

Community mental health centers

**Provider Qualifications**

**License** *(specify):*

902 KAR 20:091

**Certificate** *(specify):*

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

All standards identified in program regulations and services manual.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Office of Inspector General

**Frequency of Verification:**

Annually (more frequently if necessary)

## Appendix C: Participant Services

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

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

**Service Type:**

Extended State Plan Service

**Service Title:**

Occupational Therapy

**HCBS Taxonomy:**

**Category 1:**

11 Other Health and Therapeutic Services
12 Services Supporting Self-Direction

**Sub-Category 1:**

11080 occupational therapy
11090 physical therapy

**Category 2:**

17 Other Services

**Sub-Category 2:**

**Category 3:**

17 Other Services

**Sub-Category 3:**

**Category 4:**

17 Other Services

**Sub-Category 4:**

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

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

**Service Definition** *(Scope):*

Occupational therapy shall be:
1. A physician-ordered evaluation of a memberLs level of functioning by applying diagnostic and prognostic tests;
2. Physician ordered services in a specified amount and duration to guide a member in the use of therapeutic, curative, and self-care activities to assist a member in obtaining the highest possible level of functioning;
3. Training of other providers to improve the level of functioning;
4. Exclusive of maintenance or the prevention of regression; Shall demonstrate progress toward goal and objectives identified in the approved assessment of needs and plan of care;

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

Limited to 16 fifteen minute units per day.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

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

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Adult Day Health Care agencies |

| | |
|---|---|
| **Individual** | **Approved waiver providers** |
| **Agency** | **Home Health agencies** |

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**
**Service Name: Occupational Therapy**

**Provider Category:**

Agency

**Provider Type:**

Adult Day Health Care agencies

**Provider Qualifications**

**License** *(specify):*

902 KAR 20:081

**Certificate** *(specify):*

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

All standards identified in program regulations and services manual.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Office of Inspector General

**Frequency of Verification:**

Annually (more frequent if necessary)

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**
**Service Name: Occupational Therapy**

**Provider Category:**

Individual

**Provider Type:**

Approved waiver providers

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

Certified, at least annually, by DMS

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

An approved waiver provider shall:
a) Be enrolled as a Kentucky Medicaid provider in accordance with Kentucky regulation;
b) Be certified by the department, and recertified at least annually;
c) Have an office within the Commonwealth of Kentucky;
d) Have a governing body that shall be: 1) a legally-constituted entity within the Commonwealth of Kentucky; and 2) responsible for the overall operation of the organization including establishing policy that complies with the Kentucky administrative regulation.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Department for Medicaid Services

**Frequency of Verification:**

Annually (more frequent if necessary

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**
**Service Name: Occupational Therapy**

**Provider Category:**

Agency

**Provider Type:**

Home Health agencies

**Provider Qualifications**

**License** *(specify):*

902 KAR 20:066

**Certificate** *(specify):*

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

All standards identified in program regulations and services manual.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Office of Inspector General

**Frequency of Verification:**

Annually (more frequent if necessary)

## Appendix C: Participant Services

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

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

**Service Type:**

Extended State Plan Service

**Service Title:**

# Specialized Medical Equipment

**HCBS Taxonomy:**

**Category 1:**

14 Equipment, Technology, and Modifications
15 Non-Medical Transportation
16 Community Transition Services

**Sub-Category 1:**

14031 equipment and technology
14032 supplies

**Category 2:**

17 Other Services

**Sub-Category 2:**

**Category 3:**

17 Other Services

**Sub-Category 3:**

**Category 4:**

17 Other Services

**Sub-Category 4:**

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

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

**Service Definition** *(Scope):*

Specialized medical equipment and supplies include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, devices which enable individuals at high risk of institutionalization to secure help in an emergency, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

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

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

**Legally Responsible Person**

- ☐
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Certified Case Management Waiver Provider |

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**
**Service Name: Specialized Medical Equipment**

**Provider Category:**

Agency

**Provider Type:**

Certified Case Management Waiver Provider

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

Certified by Department for Medicaid Services

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Department for Medicaid Services

**Frequency of Verification:**

At least annually

## Appendix C: Participant Services

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

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

**Service Type:**

Extended State Plan Service

**Service Title:**

Speech Therapy

**HCBS Taxonomy:**

**Category 1:**

11 Other Health and Therapeutic Services
12 Services Supporting Self-Direction
13 Participant Training

**Sub-Category 1:**

11100 speech, hearing, and language therapy
11110 respitory therapy
11120 cognitive rehabilitative therapy

**Category 2:**

17 Other Services

**Sub-Category 2:**

**Category 3:**

17 Other Services

**Sub-Category 3:**

**Category 4:**

17 Other Services

**Sub-Category 4:**

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

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

**Service Definition** *(Scope):*

Speech therapy shall be:
1. A physician ordered evaluation of a member with a speech or language disorder.
2. A physician ordered habilitative service in a specified amount and duration to assist a member with a speech and language disability in obtaining the highest possible level of functioning;
3. Training of other providers to improve the level of functioning;
4. Exclusive of maintenance or the prevention of regression; Shall demonstrate progress toward goal and objectives identified in the approved assessment of needs and plan of care.

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

Limited to 16 15-minute units per day.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

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

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|

| | |
|---|---|
| **Agency** | **Home Health agencies** |
| **Agency** | **Adult Day Health Care** |
| **Agency** | **Approved waiver providers** |

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**
**Service Name: Speech Therapy**

**Provider Category:**

Agency

**Provider Type:**

Home Health agencies

**Provider Qualifications**

**License** *(specify):*

902 KAR 20:066

**Certificate** *(specify):*

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

All standards identified in program regulations and services manual.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Office of Inspector General

**Frequency of Verification:**

Annually (more frequent if necessary)

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**
**Service Name: Speech Therapy**

**Provider Category:**

Agency

**Provider Type:**

Adult Day Health Care

**Provider Qualifications**

**License** *(specify):*

902 KAR 20:081

**Certificate** *(specify):*

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

All standards identified in program regulations and services manual.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Office of Inspector General

**Frequency of Verification:**

Annually (more frequent if necessary)

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**
**Service Name: Speech Therapy**

**Provider Category:**

Agency

**Provider Type:**

Approved waiver providers

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

Certified, at least annually, by DMS

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

An approved waiver provider shall:
a) Be enrolled as a Kentucky Medicaid provider in accordance with Kentucky regulation;
b) Be certified by the department, and recertified at least annually;
c) Have an office within the Commonwealth of Kentucky;
d) Have a governing body that shall be: 1) a legally-constituted entity within the Commonwealth of Kentucky; and 2) responsible for the overall operation of the organization including establishing policy that complies with the Kentucky administrative regulation

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Department for Medicaid Services

**Frequency of Verification:**

Annually (more frequent if necessary

## Appendix C: Participant Services

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

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

**Service Type:**

Supports for Participant Direction

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

**Support for Participant Direction:**

Information and Assistance in Support of Participant Direction

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

Community Guide

**HCBS Taxonomy:**

**Category 1:**

12 Services Supporting Self-Direction
13 Participant Training

**Sub-Category 1:**

12010 financial management services in support of self-direction
12020 information and assistance in support of self-direction

**Category 2:**

17 Other Services

**Sub-Category 2:**

**Category 3:**

17 Other Services

**Sub-Category 3:**

**Category 4:**

17 Other Services

**Sub-Category 4:**

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

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

**Service Definition** *(Scope):*

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

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

Unit of service: 15 minutes  Limit: 576 units per year

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

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

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Qualified Community Guide |
| Agency | Approved waiver providers |

## Appendix C: Participant Services

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

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

**Provider Category:**

Individual

**Provider Type:**

Qualified Community Guide

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

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

Standards for Community Guides are:
a.Minimum of bachelorL.s degree and one year of experience in the field of brain injury.
b. Relevant experience and/or credentialing will substitute for education on a year for year basis;
c.Has a valid Social Security number or a valid work permit if not a citizen of the U.S.; and
d.Meets all applicable personnel and training requirements as stated in ABI program regulation

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Case Manager

**Frequency of Verification:**

Prior to Service Delivery

## Appendix C: Participant Services

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

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

**Provider Category:**

Agency

**Provider Type:**

Approved waiver providers

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

Certified at least annually by DMS.

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

An approved waiver provider shall:
a) Be enrolled as a Kentucky Medicaid provider in accordance with Kentucky regulation;
b) Be certified by the department, and recertified at least annually;
c) Have an office within the Commonwealth of Kentucky;
d) Have a governing body that shall be: 1) a legally-constituted entity within the Commonwealth of Kentucky; and 2) responsible for the overall operation of the organization including establishing policy that complies with the Kentucky administrative regulation

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Department for Medicaid Services

**Frequency of Verification:**

Annually or more frequently if necessary.

## Appendix C: Participant Services

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

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

**Service Type:**

Supports for Participant Direction

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

**Support for Participant Direction:**

Financial Management Services

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

**HCBS Taxonomy:**

**Category 1:**

12 Services Supporting Self-Direction
13 Participant Training

**Sub-Category 1:**

12010 financial management services in support of self-direction
12020 information and assistance in support of self-direction

**Category 2:**

17 Other Services

**Sub-Category 2:**

**Category 3:**

17 Other Services

**Sub-Category 3:**

**Category 4:**

17 Other Services

**Sub-Category 4:**

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

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

**Service Definition** *(Scope):*

Management and direction of funds in the memberLs approved participant-directed budget. The provider shall perform the employer responsibilities of payroll processing which shall include: issuance of paychecks; withholding federal, state and local tax and making tax payments to the appropriate tax authorities; and, issuance of W-2 forms. The provider shall be responsible for performing all fiscal accounting procedures including issuance of expenditure reports to the member, their representative, the case manager and the Department for Medicaid Services. The provider shall maintain a separate account for each member while continually tracking and reporting funds, disbursements and the balance of the memberLs budget. The provider shall process and pay invoices for goods and services approved in the memberLs plan of care. FMS is required for participants that elect the consumer directed option.

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

Financial management is defined as a fifteen (15) minute unit. Financial management services are limited to eight (8) units per member, per calendar month. Financial management services are limited to members opting to participant direct some or all of their non-medical services and only apply to participant-directed services.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

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

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Quasi-Governmental Agency |

## Appendix C: Participant Services

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

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

**Provider Category:**

Agency

**Provider Type:**

Quasi-Governmental Agency

**Provider Qualifications**

**License** *(specify):*

902 KAR 20:091
Licensed by the Office of Inspector General

**Certificate** *(specify):*

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

Community Mental Health Centers and Area Development Districts are quasi-governmental agencies operating throughout the Commonwealth of Kentucky. Both organizations were established by state law, specifying the manner of governance, organization, staffing and areas of responsibility (KRS 210.370 to 210.480 ł. CMHCs; and KRS 147A.050 to 147A.110 ł. Area Development Districts.) Both CMHCs and Area Development Districts have a designated region within the state to which their services are mandated and limited.

To provide Medicaid waiver services, quasi-governmental agencies must be enrolled as a Kentucky Medicaid provider in accordance with Kentucky regulations, receive training approved by the Department for Medicaid Services on financial management responsibilities and be subject to regular oversight and monitoring, including on-site monitoring, by the Department for Medicaid Services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Office of Inspector General

**Frequency of Verification:**

Annually (more frequently if necessary)

## Appendix C: Participant Services

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

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

**Service Type:**

Supports for Participant Direction

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

**Support for Participant Direction:**

Other Supports for Participant Direction

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

Goods and Services

**HCBS Taxonomy:**

**Category 1:**

17 Other Services

**Sub-Category 1:**

17010 goods and services
17020 interpreter

**Category 2:**

17 Other Services

**Sub-Category 2:**

**Category 3:**

17 Other Services

**Sub-Category 3:**

**Category 4:**

17 Other Services

**Sub-Category 4:**

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

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

**Service Definition** *(Scope):*

The purchase of goods must be individualized and may be utilized to reduce the need for personal care or enhance the independence within the home or community of the program participant. All items purchsed within the individuals budget must be prior authorized and included in the paticipant directed support spending plan. As a Medicaid funded service this definition will not cover experimental goods and services inclusive of items which may be defined as restrictive under G.S. 122C-60.

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

Individuals shall not receive goods and services through both traditional and participant directed supports. A member may receive a combination of participant directed and traditional waiver services providing duplication of services does not occur. Goods and services shall be prior authorized and payment for these services shall not exceed the member's budget as established by DMS.

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

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

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Individual Vendor |
| Agency | Agency Vendor |

## Appendix C: Participant Services

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

**Service Type: Supports for Participant Direction**
**Service Name: Goods and Services**

**Provider Category:**

Individual

**Provider Type:**

Individual Vendor

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

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

Have an applicable business license for goods or services provided
Understands and agrees to comply with the self-directed services and goods delivery requirements

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Community Guide or Case Manager if Community Guide service is not utilized. Community Guide services are designed to empower individuals to define and direct their own services and supports. These services are only for persons who opt for self directed supports for either some or all of their support services. The person determines the amount of Community Guide services, if any, and the specific services that the Community Guide will provide. Community Guide services do not duplicate Case Management services. Community Guides may not provide other direct waiver services, including Case Management, to any waiver participant.

**Frequency of Verification:**

Prior to service delivery

## Appendix C: Participant Services

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

**Service Type: Supports for Participant Direction**
**Service Name: Goods and Services**

**Provider Category:**

Agency

**Provider Type:**

Agency Vendor

**Provider Qualifications**

**License** *(specify):*

Applicable business license as required by the local, city, or county government in which the service is provided.

**Certificate** *(specify):*

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

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Community Guide or Case Manager if Community Guide service is not utilized. Community Guide services are designed to empower individuals to define and direct their own services and supports. These services are only for persons who opt for self directed supports for either some or all of their support services. The person determines the amount of Community Guide services, if any, and the specific services that the Community Guide will provide. Community Guide services do not duplicate Case Management services. Community Guides may not provide other direct waiver services, including Case Management, to any waiver participant.

**Frequency of Verification:**

Prior to service delivery

# Appendix C: Participant Services

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

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

**Service Type:**

Other Service

As provided in 42 CFR ◆440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Assessment/reassessment

**HCBS Taxonomy:**

**Category 1:**

01 Case Management
02 Round-the-Clock Services

**Sub-Category 1:**

01010 case management

**Category 2:**

17 Other Services

**Sub-Category 2:**

**Category 3:**

17 Other Services

**Sub-Category 3:**

**Category 4:**

17 Other Services

**Sub-Category 4:**

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

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

**Service Definition** *(Scope):*

Assessment services evaluate the recipientŁs abilities, needs, physical and mental health, social supports and environment, and identify the services that the recipient or family cannot manage or arrange. Information obtained during the assessment process is utilized to make a level of care determination. The assessment must be conducted by an ABI waiver case manager and must include at least one contact with the recipient and, if appropriate, his family, in the recipientŁs home. The assessment/reassessment information will be utilized by the case manager to develop the recipientŁs plan of care. Reassessment will take place at least every twelve months, or more often if indicated. Reassessment services will be conducted using the same procedures as for an assessment service. Information included in the plan of care plan will be utilized during the reassessment process.

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

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

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

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Community Mental Health Centers |
| Agency | Approved waiver case management providers |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Assessment/reassessment**

**Provider Category:**

Agency

**Provider Type:**

Community Mental Health Centers

**Provider Qualifications**

**License** *(specify)*:

902 KAR 20:091

**Certificate** *(specify)*:

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

All standards identified in program regulations and services manual.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Office of the Inspector General

**Frequency of Verification:**

Annually (more frequently if necessary)

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Assessment/reassessment**

**Provider Category:**

Agency

**Provider Type:**

Approved waiver case management providers

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

Certified, at least annually, by DMS

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

An approved waiver provider shall:
a) Be enrolled as a Kentucky Medicaid provider in accordance with Kentucky regulation;
b) Be certified by the department, and recertified at least annually;
c) Have an office within the Commonwealth of Kentucky;
d) Have a governing body that shall be: 1) a legally-constituted entity within the Commonwealth of Kentucky; and 2) responsible for the overall operation of the organization including establishing policy that complies with the Kentucky administrative regulation

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Department for Medicaid Services

**Frequency of Verification:**

Annually (more frequently if necessary)

# Appendix C: Participant Services

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

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

**Service Type:**

Other Service

As provided in 42 CFR ◆440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Community Living Supports

**HCBS Taxonomy:**

**Category 1:**

08 Home-Based Services
09 Caregiver Support
10 Other Mental Health and Behavioral Services

**Sub-Category 1:**

08040 companion
08050 homemaker
08060 chore

**Category 2:**

17 Other Services

**Sub-Category 2:**

**Category 3:**

17 Other Services

**Sub-Category 3:**

**Category 4:**

17 Other Services

**Sub-Category 4:**

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

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

**Service Definition** *(Scope):*

Community Living Support services facilitate independence and promote integration into the community, for individuals residing in their own home.

Supports are provided one-to-one and include assistance, support (including reminding, observing, and/or guiding) and/or training in activities such as meal preparation; laundry; routine household care and maintenance; activities of daily living such as bathing, eating, dressing, personal hygiene; shopping; money management; reminding, observing and or monitoring of medications; non-medical care not requiring nurse or physician intervention.

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

Community Living Supports is limited to 160 fifteen minute units per week. The Case Manager will be responsible for assisting individuals to access other natural supports or supports available through other funding streams if their needs exceed this limit.

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

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

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Community Mental Health Centers |
| Agency | Home Health Agencies |
| Agency | Approved waiver providers |
| Individual | Qualified CLS Provider |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Community Living Supports**

**Provider Category:**

Agency

**Provider Type:**

Community Mental Health Centers

**Provider Qualifications**

**License** *(specify):*

902 KAR 20:091

**Certificate** *(specify):*

Certified, at least annually, by DMS

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

All standards identified in program regulations and services manual.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Office of Inspector General

**Frequency of Verification:**

Annually (more frequent if necessary)

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Community Living Supports**

**Provider Category:**

Agency

**Provider Type:**

Home Health Agencies

**Provider Qualifications**

**License** *(specify):*

902  KAR 20:081

**Certificate** *(specify):*

Certified, at least annually, by DMS

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

All standards identified in program regulations and services manual.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Office of Inspector General

**Frequency of Verification:**

Annually (more frequent if necessary)

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Community Living Supports**

**Provider Category:**

Agency

**Provider Type:**

Approved waiver providers

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

Certified, at least annually, by DMS

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

An approved waiver provider shall:
a) Be enrolled as a Kentucky Medicaid provider in accordance with Kentucky regulation;
b) Be certified by the department, and recertified at least annually;
c) Have an office within the Commonwealth of Kentucky;
d) Have a governing body that shall be: 1) a legally-constituted entity within the Commonwealth of Kentucky; and 2) responsible for the overall operation of the organization including establishing policy that complies with the Kentucky administrative regulation

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Department for Medicaid Services

**Frequency of Verification:**

Annually (more frequent if necessary)

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Community Living Supports**

**Provider Category:**

Individual

**Provider Type:**

Qualified CLS Provider

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

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

1.Is eighteen (18) years or older; and has a high school diploma or GED; or is at least twenty-one (21) years old; and
2.Meets all applicable ABI personnel and training requirements as stated in regulation;
3.Has a valid Social Security number or a valid work permit if not a citizen of the U.S.;
4.Has the ability to: a) communicate effectively with the person/family; b) understand and carry out instructions; c) perform required documentation.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Community Guide or Case Manager if Community Guide service is not utilized. Community Guide services are designed to empower individuals to define and direct their own services and supports. These services are only for persons who opt for self directed supports for either some or all of their support services. The person determines the amount of Community Guide services, if any, and the specific services that the Community Guide will provide. Community Guide services do not duplicate Case Management services. Community Guides may not provide other direct waiver services, including Case Management, to any waiver participant.

**Frequency of Verification:**

Prior to service delivery.

## Appendix C: Participant Services

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

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

**Service Type:**

Other Service

As provided in 42 CFR ◆440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Environmental and minor home modifications

**HCBS Taxonomy:**

**Category 1:**

14 Equipment, Technology, and Modifications
15 Non-Medical Transportation

**Sub-Category 1:**

14010 personal emergency response system (PERS)
14020 home and/or vehicle accessibility adaptations

**Category 2:**

17 Other Services

**Sub-Category 2:**

**Category 3:**

17 Other Services

**Sub-Category 3:**

**Category 4:**

17 Other Services

**Sub-Category 4:**

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

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

**Service Definition** *(Scope):*

Physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems, which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes. All environmental and minor home adaptations shall be prior authorized.

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

Reimbursement for environmental and minor home modifications shall be limited to $2000 per member, per calendar year. The Case Manager or Community Guide shall be responsible for assisting individuals to access other natural supports or supports available through other funding streams if their needs exceed the above limit.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

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

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Adult Day Health Care |
| Agency | Home Health agencies |
| Agency | Approved Waiver providers |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Environmental and minor home modifications**

**Provider Category:**

Agency

**Provider Type:**

Adult Day Health Care

**Provider Qualifications**

**License** *(specify):*

902 KAR 20:081

**Certificate** *(specify):*

Certified, at least annually, by DMS

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

All standards identified in program regulations and services manual.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Office of Inspector General
Department for Medicaid Services

**Frequency of Verification:**

Annually (more frequent if necessary)

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Environmental and minor home modifications**

**Provider Category:**

Agency

**Provider Type:**

Home Health agencies

**Provider Qualifications**

**License** *(specify):*

902 KAR 20:066

**Certificate** *(specify):*

Certified, at least annually, by DMS

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

All standards identified in program regulations and services manual.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Office of Inspector General
Department for Medicaid Services

**Frequency of Verification:**

Annually (more frequent if necessary)

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Environmental and minor home modifications**

**Provider Category:**

Agency

**Provider Type:**

Approved Waiver providers

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

Certified, at least annually, by DMS

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

An approved waiver provider shall:
a) Be enrolled as a Kentucky Medicaid provider in accordance with Kentucky regulation;
b) Be certified by the department, and recertified at least annually;
c) Have an office within the Commonwealth of Kentucky;
d) Have a governing body that shall be: 1) a legally-constituted entity within the Commonwealth of Kentucky; and 2) responsible for the overall operation of the organization including establishing policy that complies with the Kentucky administrative regulation

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Department for Medicaid Services

**Frequency of Verification:**

Annually (more frequent if necessary)

## Appendix C: Participant Services

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

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

**Service Type:**

Other Service

As provided in 42 CFR ⬩440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Supervised Residential Care Level I

**HCBS Taxonomy:**

**Category 1:**

01 Case Management
02 Round-the-Clock Services

**Sub-Category 1:**

02021 shared living, residential habilitation
02022 shared living, mental health services

**Category 2:**

17 Other Services

**Sub-Category 2:**

**Category 3:**

17 Other Services

**Sub-Category 3:**

**Category 4:**

17 Other Services

**Sub-Category 4:**

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

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

**Service Definition** *(Scope):*

Supervised Residential Care Level I shall not have greater than three (3) ABI recipients in a home rented or owned by the ABI provider. This setting provides nineteen (19) to twenty-four (24) hour supervision and assistance and training with daily living skills. Based on the individual needs of a recipient this setting may include periods of up to 5 hours per day for a member to work towards increased independence. If this option is utilized, an ABI provider shall develop an individualized plan for the recipient to work towards increased independence, which shall include:
(1.) necessary provisions to assure the recipient's health, safety and welfare;
(2.) documented approval by the recipient's treatment team; and
(3.) periodic review and updates, based on changes in the recipient's status.

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

Limited to one unit per member per calendar day.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Approved waiver providers |
| Agency | Community mental health centers |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Supervised Residential Care Level I**

**Provider Category:**

Agency

**Provider Type:**

Approved waiver providers

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

Certified, at least annually, by DMS

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

An approved waiver provider shall:
a) Be enrolled as a Kentucky Medicaid provider in accordance with Kentucky regulation;
b) Be certified by the department, and recertified at least annually;
c) Have an office within the Commonwealth of Kentucky;
d) Have a governing body that shall be: 1) a legally-constituted entity within the Commonwealth of Kentucky; and 2) responsible for the overall operation of the organization including establishing policy that complies with the Kentucky administrative regulation

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Department for Medicaid Services

**Frequency of Verification:**

Annually (more frequently if necessary)

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Supervised Residential Care Level I**

**Provider Category:**

Agency

**Provider Type:**

Community mental health centers

**Provider Qualifications**

**License** *(specify):*

902 KAR 20:091

**Certificate** *(specify):*

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

Community mental health centers are community-based, quasi-governmental agencies established by Kentucky law (KRS 210.370 - 210.480) to serve as the behavioral health public safety net. They are not inpatient facilities.

All standards identified in program regulations and services manual

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Office of Inspector General

**Frequency of Verification:**

Annually (more frequently if necessary)

# Appendix C: Participant Services

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

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

**Service Type:**

Other Service

As provided in 42 CFR ◆440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Supervised Residential Care Level II

**HCBS Taxonomy:**

**Category 1:**

01 Case Management
02 Round-the-Clock Services
03 Supported Employment

**Sub-Category 1:**

02021 shared living, residential habilitation
02022 shared living, mental health services
02023 shared living, other

**Category 2:**

17 Other Services

**Sub-Category 2:**

**Category 3:**

17 Other Services

**Sub-Category 3:**

**Category 4:**

17 Other Services

**Sub-Category 4:**

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

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

**Service Definition** *(Scope):*

Supervised Residential Care Level II - shall not have greater than three (3) ABI recipients in a home rented or owned by the ABI provider. Provides 12-18 hours supervision and 24 hour on call support.
Provides assistance and training with daily living skills which shall include activities such as: ambulation, dressing, grooming, eating, toileting, bathing, meal planning, grocery shopping and meal preparation, laundry, budgeting and financial matters, home care and cleaning, instruction in leisure skills, and instruction in self medication. In addition, social skills training including increasing positive behaviors and reduction or elimination of maladaptive behaviors per the plan of care. Provide or arrange transportation to services, activities, and medical appointments as needed; as well as accompanying and assisting an ABI recipient while utilizing transportation services. Participation in medical appointments and follow-up care as directed by the medical staff.

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

Limited to one unit per member per calendar day.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Approved waiver providers |
| Agency | Community Mental Health Centers |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Supervised Residential Care Level II**

**Provider Category:**

Agency

**Provider Type:**

Approved waiver providers

**Provider Qualifications**

**License** *(specify)*:

**Certificate** *(specify)*:

Certified, at least annually, by DMS

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

An approved waiver provider shall:
a) Be enrolled as a Kentucky Medicaid provider in accordance with Kentucky regulation;
b) Be certified by the department, and recertified at least annually;
c) Have an office within the Commonwealth of Kentucky;
d) Have a governing body that shall be: 1) a legally-constituted entity within the Commonwealth of Kentucky; and 2) responsible for the overall operation of the organization including establishing policy that complies with the Kentucky administrative regulation

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Department for Medicaid Services

**Frequency of Verification:**

Annually (more frequently if necessary)

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Supervised Residential Care Level II**

**Provider Category:**

Agency

**Provider Type:**

Community Mental Health Centers

**Provider Qualifications**

**License** *(specify):*

902 KAR 20:091

**Certificate** *(specify):*

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

Community mental health centers are community-based, quasi-governmental agencies established by Kentucky law (KRS 210-370-210.480) to serve as the behavioral health public safety net. They are not inpatient facilities.

All standards identified in program regulations and services manual

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Office of Inspector General

**Frequency of Verification:**

Annually (more frequently if necessary)

# Appendix C: Participant Services

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

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

**Service Type:**

Other Service

As provided in 42 CFR ⍰440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Supervised Residential Care Level III

**HCBS Taxonomy:**

**Category 1:**

01 Case Management
02 Round-the-Clock Services
03 Supported Employment

**Sub-Category 1:**

02031 in-home residential habilitation
02032 in-home round-the-clock mental health services
02033 in-home round-the-clock services, other

**Category 2:**

17 Other Services

**Sub-Category 2:**

**Category 3:**

17 Other Services

**Sub-Category 3:**

**Category 4:**

17 Other Services

**Sub-Category 4:**

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

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

**Service Definition** *(Scope):*

Supervised Residential Care Level III L (Independent Residential Support) L may be provided in a single family home, duplex or apartment building. No more than two waiver participants may be supported in one home or apartment
Provides support in the home of an ABI participant who lives alone or with an unrelated roommate, as needed with daily living skills which shall include: ambulating, dressing, grooming, eating, toileting, bathing, meal planning, grocery shopping and meal preparation, laundry, budgeting and financial matters, home care and cleaning, instruction in leisure skills, and instruction in self medication. In addition, social skills training including increasing positive behaviors and reduction or elimination of maladaptive behaviors per the plan of care.
Provide or arrange transportation to services, activities, and medical appointments as needed; as well as accompanying and assisting an ABI recipient while utilizing transportation services.
Participation in medical appointments and follow-up care as directed by the medical staff.

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

Limited to one unit per member per calendar day.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

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

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Community Mental Health Centers |
| Agency | Approved Waiver Providers |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Supervised Residential Care Level III**

**Provider Category:**

Agency

**Provider Type:**

Community Mental Health Centers

**Provider Qualifications**

**License** *(specify):*

902 KAR 20:091

**Certificate** *(specify):*

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

Community mental health centers are community-based, quasi-governmental agencies established by Kentucky law (KRS 210-370-210.480) to serve as the behavioral health public safety net. They are not inpatient facilities.

All standards identified in program regulations and services manual

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Office of Inspector General

**Frequency of Verification:**

Annually (more frequently if necessary)

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Supervised Residential Care Level III**

**Provider Category:**

Agency

**Provider Type:**

Approved Waiver Providers

**Provider Qualifications**

**License** *(specify):*

902 KAR 20:078

**Certificate** *(specify):*

Certified, at least annually, by DMS

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

An approved waiver provider shall:
a) Be enrolled as a Kentucky Medicaid provider in accordance with Kentucky regulation;
b) Be certified by the department, and recertified at least annually;
c) Have an office within the Commonwealth of Kentucky;
d) Have a governing body that shall be: 1) a legally-constituted entity within the Commonwealth of Kentucky; and 2) responsible for the overall operation of the organization including establishing policy that complies with the Kentucky administrative regulation

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Department for Medicaid Services

**Frequency of Verification:**

Annually (more frequently if necessary)

## Appendix C: Participant Services

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

**b. Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ⊙ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

  *Check each that applies:*

  - ☑ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - ☐ **As an administrative activity.** *Complete item C-1-c.*

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

## Appendix C: Participant Services

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

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

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

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

All employees of enrolled waiver providers and employees of members consumer directing non-medical waiver services are required to submit to a state criminal background check. During an annual recertification the Department for Medicaid Services conducts for enrolled waiver providers, employee records are reviewed for this check. Licensed providers are also inspected annually by the Office of Inspector General and employee records are reviewed to ensure compliance. The Department for Aging and Independent Living (DAIL) monitors the completion of criminal background checks for employees of members who are consumer directing their non-medical waiver services.

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

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

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

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

## Appendix C: Participant Services

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

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

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

## Appendix C: Participant Services

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

**d. Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- ( ) **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- (●) **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

> Payment for Community Living Supports may be issued to legally responsible individuals for providing this service similar to personal care. This service is available through traditional and consumer directed services. If consumer directed, the member may choose a legally responsible individual to provide this service. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological, adoptive, foster or step) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. In order for a legally responsible individual to provide paid services the services must be extraordinary, exceeding the range of activities that a legally responsible individual would ordinarily provide in the household on behalf of a person without a disability of the same age, and which are necessary to assure health and welfare of the person and avoid institutionalization. A legally responsible individual may not be approved to provide more than forty (40) hours per week of paid services.

- [x] **Self-directed**
- [ ] **Agency-operated**

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

- ( ) **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- (●) **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

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

> Under no circumstances may a legal guardian or an immediate family member provide traditional waiver services. Immediate family member is defined according to KRS 205.8451 as: a parent, grandparent, spouse, child, stepchild, father-in-law, mother-in-law, son-in-law, daughter-in-law, sibling, brother-in-law, sister-in-law, or grandchild. Extended family members that are employed by an SCL provider may provide services.
>
> For participant directed services, the Financial Management Services provider only pays for services specified in the Individual Service Plan, and case managers additionally monitor the provision of these services. These services may be participant directed and provided by a friend, family member or other person hired by the participant. A family member living in the home of the waiver recipient may be hired by the participant to provide supports only in specific circumstances including:

- ( ) **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

○ **Other policy.**

Specify:

**f. Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Provider enrollment is continuous and open to any individual or entity. A potential provider may make application by contacting provider enrollment through a toll-free phone number, completing the application process and obtaining an agency license or certification. These provider enrollment forms are also accessible through Internet web access.

## Appendix C: Participant Services

### Quality Improvement: Qualified Providers

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

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

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

**i. Sub-Assurances:**

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

**Performance Measures**

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

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

**Performance Measure:**
**Number and percent of providers who continue to meet certification requirements following initial enrollment. N=Number of providers who continue to meet certification requirements following intial enrollment. D= number of providers.**

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

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |

| | | |
|---|---|---|
| | | |
| ☐ **Other** Specify: | ☑ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**Number and percent of providers with corrective action plans completed within required time frames. N= Number of providers with corrective action plans completed within required time frames. D= Number of providers with corrective action plans.**

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

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |

| | | |
|---|---|---|
| | | |
| ☐ **Other** Specify: | ☑ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**Number and percent of providers who meet certification requirements prior to the provision of waiver services. N=Number of providers who meet certification requirements prior to the provision of waiver services. D= Number of providers**

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

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |

| | | |
|---|---|---|
| | | |
| ☐ **Other** Specify: | ☑ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

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

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

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

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

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

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

**Performance Measure:**
**Number and percentage of provider agencies whose staff completed mandatory (CEU) annual training. N=Number of provider agencies whose staff completed mandatory (CEU) annual training or they completed following a plan of correction per program regulation requirements. D=Number of provider agencies reviewed during the review period.**

**Data Source** (Select one):
**Training verification records**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☑ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | |

| | |
|---|---|
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of new provider agencies that completed mandatory preservice (initial) training. N= Number of new provider agencies that completed mandatory preservice initial training. D= Number of new providers during the reporting period.**

**Data Source** (Select one):
**Training verification records**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☑ **Other**<br>Specify:<br>Prior to waiver service provision. | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |

| | |
|---|---|
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The state currently verifies that 100% of all ABI waiver providers are qualified, certified and licensed prior to rendering services. Providers who have completed the ABI new provider training or are licensed by OIG are eligible to become Medicaid providers. The StatesÍ. OIG monitors and re-licenses annually. ABI providers are recertified annually. The state does not contract with non-licensed or non-certified providers. All State policy and procedure updates, additions, and/or changes are communicated through letters and the DMS website.

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

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

DMS conducts monitoring of Plans of Correction submitted by the provider and provides techincal assistance or additional training in response to survey or investigation findings to ensure implementation of the approved plan of correction and compliance with the regulatory requirements. Remediation methods are determined by survey findings and are based on overall volume of deficiencies cited, historical deficiencies from previous surveys or investigations, and analysis of incident management reports. DMS remediation methods may include sanctions, including contingencies with limited timeframes for correction, shortened certification lengths, moratoriums on new admissions and even recommendations for termination of their certification and participation as a provider.

**ii. Remediation Data Aggregation**

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

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

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

## Appendix C: Participant Services

### C-3: Waiver Services Specifications

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

## Appendix C: Participant Services

### C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

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

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

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

## Appendix C: Participant Services

### C-5: Home and Community-Based Settings

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

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

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

Please see Module 1, Attachment #2 for Kentucky's ABI Waiver HCBS Settings Transition Plan for remedial activities related to non compliant settings.

## Appendix D: Participant-Centered Planning and Service Delivery

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

**State Participant-Centered Service Plan Title:**

MAP 109 ŁPlan of Care/Prior Authorization for Waiver ServicesŁ

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

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

*Specify qualifications:*

The case manager must be a registered nurse, a licensed practical nurse, or have a bachelorŁs or masterŁs degree in a human services field and meet all applicable requirements of his or her particular field including a degree in psychology, sociology, social work, rehabilitation counseling, or occupational therapy; In addition, the case manager must be an independent case manager or be employed by a free-standing case management agency, and must have completed case management training that is consistent with the curriculum that has been approved by the department prior to providing case management services.

- ☐ **Social Worker**

*Specify qualifications:*

- ☐ **Other**

*Specify the individuals and their qualifications:*

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

The state regulation includes the member's or guardian's freedom of choice of service providers as well as participation in the development of the MAP 109 or Plan of Care. The member or guardian shall sign the Plan of Care indicating their participation in the development. The provider is required to ensure the member has been informed of their rights to choose provider agencies and the individual employees of that agency. This documentation is maintained in the client's file by the case manager.

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

The member's Plan of Care (POC) is developed utilizing the in-depth waiver assessment/reassessment tool. This tool includes identification of the member's ability to perform activities of daily living (ADL's) and instrumental activities of daily living (IADL's). The assessment further identifies the member's current support systems and services (waiver and non-waiver), clinical information (including current medications) and health, safety and welfare risks.
The POC shall include all identified needs (from the assessment) as well as identify goals, objectives/interventions and outcomes. The POC is developed with the participation of the member and/or guardian as well as other service providers. All individuals participating in the development of the POC must sign the document to indicate their involvement. It is the responsibility of the case manager to provide detailed information to the member regarding available waiver services and providers to meet the identified needs. The member is free to choose from the listing of available waiver providers as well as identified services.
All POC's are reviewed and the requested services prior authorized through the Quality Improvement Organization (QIO). When POC's are submitted to the QIO, a copy of the completed assessment is included in the packet. The QIO is responsible for review of the assessment ensuring all identified needs are included and

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

Potential risks to the member are identified during the assessment/reassessment process. All health, safety and welfare risks are required to be identified and addressed on the POC. The QIO reviews the submitted assessment and POC ensuring all identified risks are appropriately addressed. If the QIO determines an identified risk has not been addressed in the POC, the QIO will issue written notification to the case manager requiring additional information as to how these risks will be addressed.

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

The memberŁs case manager is responsible for notification of available waiver service providers. Documentation of this notification is required to be maintained within the memberŁs chart and shall contain the member or guardianŁs signed acknowledgement.

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

Upon the case managerŁs completion of the Plan of Care (POC) it is the responsibility of the case manager to submit the POC and assessment/reassessment to the QIO for review and service prior authorization. A prior authorization shall not be issued without the QIO review and approval. DMS performs annual monitoring and certification of enrolled active ABI waiver providers. Staff also monitor individual's plan of care implementation and supports as a routine part of their visits to providers. A statiscally valid sample of POC reviews are conducted at this monitoring. Monitoring the POC includes ensuring all needs are met by appropriate interventions with specific goals and outcomes. If services are not appropriate, DMS will request in the report that a corrective action plan is required. The enrolled provider submits the corrective action plan with supporting evidence of the implementation and remediation.

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

*Specify the other schedule:*

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

- ☐ **Medicaid agency**
- ☐ **Operating agency**
- ☑ **Case manager**
- ☑ **Other**

*Specify:*

Quality Improvement Organization (QIO) and case manager

## Appendix D: Participant-Centered Planning and Service Delivery

### D-2: Service Plan Implementation and Monitoring

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

The memberŁs case manager is responsible for the coordination and monitoring of all of the memberŁs services including non-waiver services. The case manager shall conduct 2 face-to-face contacts every month occurring within 14 days of each other, to make arrangements for activities which ensure: the desires and needs of the individual are determined; the supports and services desired and needed by the member are identified and implemented; housing and employment issues are addressed; social networks are developed; appointments and meetings are scheduled; a person-centered approach to planning is provided; informal and community supports are utilized; the quality of the supports and services as well as the health and safety of the individual are monitored; income/benefits are maximized based on need; activities are documented; and plans of supports/services are reviewed at such intervals as are indicated during planning.

b. **Monitoring Safeguards.** *Select one:*

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

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

## Appendix D: Participant-Centered Planning and Service Delivery

### Quality Improvement: Service Plan

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

a. **Methods for Discovery: Service Plan Assurance/Sub-assurances**

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

i. **Sub-Assurances:**

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

**Performance Measures**

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

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

*are formulated, where appropriate.*

**Performance Measure:**
**Number and percent of participants reviewed who had service plans that were adequate and appropriate to their needs (including health care needs) as indicated in the assessment(s). N=Number of participants reviewed who had service plans that were adequate and appropriate to their needs. D=Number of participants reviewed.**

**Data Source** (Select one):
**Reports to State Medicaid Agency on delegated**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☑ **Other**<br>Specify:<br>QIO | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>QIO | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

| | |
|---|---|
| | |

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

**Performance Measures**

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

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

**Performance Measure:**
**Number and percent of updated service plans submitted following the interdiscplinary team meeting held within the first 30 days of initial service authorization. N= Number of updated service plans submitted within the first 30 days of intial service authorization. D= Number of updated initial service plans submitted.**

**Data Source** (Select one):
**Reports to State Medicaid Agency on delegated**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☑ **Other**<br>Specify:<br>QIO | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| | |

| | |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>QIO | ☑ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of participants receiving participant-directed services with an approved budget. N= Number of participants receiving participant directed services with an approved budget. D= Number of particpants receiving participant-directed services.**

**Data Source** (Select one):
**Reports to State Medicaid Agency on delegated**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☑ **Other**<br>Specify:<br>QIO | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|

| | |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>QIO | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of initial service plans that received prior authorization from the QIO prior to service delivery. N= Number of initial service plans that received prior authorizaton from the QIO prior to service deliver. D= Number of initial service plans that recieved prior authorization.**

**Data Source** (Select one):
**Reports to State Medicaid Agency on delegated**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☑ **Other**<br>Specify:<br>QIO | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|

| | |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>QIO | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

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

**Performance Measures**

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

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

**Performance Measure:**
**Number and percent of waiver participants whose service plans were updated and submitted prior to the annual recertification date. N= Number of waiver participants whose service plans were updated and submitted prior to the annual recertification date. D= Number of participants whose service plans were updated and submitted.**

**Data Source** (Select one):
**Reports to State Medicaid Agency on delegated**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☑ **Other**<br>Specify:<br>QIO | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |

| | | |
|---|---|---|
| | | |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>QIO | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

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

**Performance Measures**

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

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

**Performance Measure:**
**Number and percent of participants who received participant directed services within the approved budget. N= Number of participants who received participant directed services within the approved budget. D= Number of participants who received participant directed services.**

**Data Source** (Select one):
**Reports to State Medicaid Agency on delegated**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| | | |

| | | |
|---|---|---|
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☑ **Other**<br>Specify:<br>QIO | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>QIO | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of participants who received services in the type, scope, amount and duration as specified in the service plan. N= Number of participants who received services in the type,scope, amount and duration as specified in the service plan. D= Number of particpants who received services.**

**Data Source** (Select one):
**Reports to State Medicaid Agency on delegated**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| | | |

| | | |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☑ **Other**<br>Specify:<br>QIO | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>QIO | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

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

**Performance Measures**

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

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

**Performance Measure:**
**Number and percent of waiver participant records with an appropriately completed and signed freedom of choice form specifying choice was offered between waiver services and institutional care, waiver services and waiver providers. N= Number of particpant records with an appropriately completed and signed freedom of choice form. D= Number of participant records.**

**Data Source** (Select one):
**Reports to State Medicaid Agency on delegated**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☑ **Other**<br>Specify:<br>QIO | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>QIO | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

| | |
|---|---|
| | |

**Performance Measure:**
**Number and percent of waiver participants whose records contain confirmation of notification of the option to choose consumer directed options. N= Number of waiver participants whose records contain confirmation of notification of the option to choose consumer directed options. D= Number of waiver participants.**

**Data Source** (Select one):
**Reports to State Medicaid Agency on delegated**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☑ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other** Specify: QIO | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** |

| | |
|---|---|
| | Specify: |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

If the QIO determines an identified risk noted on the assessment has not been addressed on the POC, the QIO will issue written notification to the provider requiring additional information as to how these risks will be addressed.
DMS performs an annual second(2nd) line monitoring of a random sample of enrolled active ABI waiver providers.
Monitoring the POC includes ensuring all needs are met by appropriate interventions with specific goals and outcomes.
If services are not appropriate, DMS w ill request in the report that a corrective action plan is required. The enrolled provider submits the corrective action plan with supporting evidence of the implementation and remediation.
A follow-up survey/review will be performed after DMSL acceptance of the provided s corrective action plan to determine whether it has been implemented.

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

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

Identified individual problems are researched and addressed by DMS staff. This may involve DMS staff conducting an on-site agency review, and/or a home visit with the waiver member and caregivers. Issues may require policy clarification.
The State receives a utilization management report showing the number of service plans received, the number returned for lack of information, the number of service plans corrected and returned in a timely manner, the number not turned in timely and the responsible provider. DMS is able to request corrective action plans and recoupment of paid claims from the provider. DMS is able to request corrective action plans from the QIO if a service plan is approved, but does not meet requirements.
DMS monitors appropriateness and implementation of the individual support plan; and monitors documentation to ensure the member has been fully educated regarding options available and assisted to have freedom of choice and decision making authority. The monitoring occurs through review of the member's clinical record during on-site provider certification surveys conducted at least annually.

**ii. Remediation Data Aggregation**

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

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>QIO | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

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

## Appendix E: Participant Direction of Services

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

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

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

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

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

## Appendix E: Participant Direction of Services

### E-1: Overview (1 of 13)

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

Certain supports available within the ABI Waiver facilitate independence while decreasing the need for human assistance for individuals residing in their own home or the home of their family member. The supports include assistance, support (including reminding, observing, and/or guiding) and/or training in activities such as meal preparation; laundry; routine household care and maintenance; activities of daily living as such as bathing, eating, dressing, personal hygiene, shopping and the use of money; reminding, observing, and/or monitoring of medications; non-medical care (not requiring a nurse or physician intervention); respite; socialization, relationship building, leisure choice and participation in generic community activities. These supports are based upon therapeutic goals and are not diversional in nature.

These services may be participant directed and provided by a friend, a legally responsible individual or other person hired by the participant. A family member living in the home of the waiver recipient may be hired by the participant to provide supports only in specific circumstances including:

## Appendix E: Participant Direction of Services

### E-1: Overview (2 of 13)

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

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

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

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

Specify these living arrangements:

## Appendix E: Participant Direction of Services

### E-1: Overview (3 of 13)

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

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ◉ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

*Specify the criteria*

## Appendix E: Participant Direction of Services

### E-1: Overview (4 of 13)

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

The case managers will be required to provide information about participant direction opportunities to the participants at the time of initial Plan of Care, at least annually thereafter, and at any point of recipient or guardian inquiry. Case managers will complete the Plan of Care, and provide detailed information regarding the participant direction opportunities available through the waiver program. The case manager will be responsible for explaining the recipientŁs responsibilities related to participant direction opportunities.

## Appendix E: Participant Direction of Services

### E-1: Overview (5 of 13)

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

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

◉ **The State provides for the direction of waiver services by representatives.**

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

☑ **Waiver services may be directed by a legal representative of the participant.**

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

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

A non-legal representative may be freely chosen by an adult waiver member to direct waiver services. This representative may not be hired as an employee to provide any of the participant directed waiver services. The case manager will be responsible for monitoring the memberŁs Plan of Care (POC) and ensuring needed services are being appropriately provided to the member.

## Appendix E: Participant Direction of Services

### E-1: Overview (6 of 13)

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

| Waiver Service | Employer Authority | Budget Authority |
|---|---|---|
| **Community Guide** | ☑ | ☑ |
| **Adult Day Training** | ☑ | ☑ |
| **Goods and Services** | ☑ | ☐ |
| **Supported Employment** | ☑ | ☑ |
| **Respite** | ☑ | ☑ |
| **Community Living Supports** | ☑ | ☑ |

## Appendix E: Participant Direction of Services

### E-1: Overview (7 of 13)

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

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

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

- [ ] **Governmental entities**
- [x] **Private entities**

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

## Appendix E: Participant Direction of Services

### E-1: Overview (8 of 13)

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

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

**The waiver service entitled:**

Financial Management Services

( ) **FMS are provided as an administrative activity.**

**Provide the following information**

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

Financial management services (FMS) are provided throught an inter-agency contract with the Department for Aging and Independent Living (DAIL). DAIL subcontracts with the regional Community Mental Health Centers to provide FMS to members utilizing participant directed opportunities. Community Mental Health Centers are quasi-governmental agencies that provide a comprehensive range of accessible and coordinated mental health services, including direct or indirect mental health through Kentucky's 14 regional MH/MR boards. Regional Boards are private, non-profit organizations established to serve residents of a designated multicounty region.

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

DMS compensates Financial Management Service providers based on a specified rate for a 15 minute unit of service not to exceed $100.00 per month, per member.

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

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

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

*Specify:*

Supports furnished when the participant exercises budget authority:

- [x] **Maintain a separate account for each participant's participant-directed budget**
- [x] **Track and report participant funds, disbursements and the balance of participant funds**
- [x] **Process and pay invoices for goods and services approved in the service plan**
- [x] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

*Specify:*

Additional functions/activities:

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

*Specify:*

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

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

## Appendix E: Participant Direction of Services

### E-1: Overview (9 of 13)

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

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

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

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

Twice per month face-to-face contact ocurring no more than 14 days apart at a covered service site with one visit quarterly occuring at the ABI participant's residence is required between the case manager and the member and memberÍs representative (if applicable) to ensure the memberÍs needs are being met in an appropriate manner and to monitor health, safety and welfare.

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

| Participant-Directed Waiver Service | Information and Assistance Provided through this Waiver Service Coverage |
|---|---|
| **Behavioral Services** | ☐ |
| **Community Guide** | ☑ |
| **Speech Therapy** | ☐ |
| **Adult Day Training** | ☐ |

| | |
|---|---|
| **Goods and Services** | ☐ |
| **Environmental and minor home modifications** | ☐ |
| **Supported Employment** | ☐ |
| **Case Management** | ☑ |
| **Financial Management Services** | ☑ |
| **Specialized Medical Equipment** | ☐ |
| **Respite** | ☐ |
| **Supervised Residential Care Level II** | ☐ |
| **Occupational Therapy** | ☐ |
| **Assessment/reassessment** | ☐ |
| **Supervised Residential Care Level I** | ☐ |
| **Counseling** | ☐ |
| **Community Living Supports** | ☐ |
| **Group Counseling** | ☐ |
| **Supervised Residential Care Level III** | ☐ |

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

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

## Appendix E: Participant Direction of Services

### E-1: Overview (10 of 13)

**k. Independent Advocacy** *(select one).*

◉ **No. Arrangements have not been made for independent advocacy.**

○ **Yes. Independent advocacy is available to participants who direct their services.**

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

## Appendix E: Participant Direction of Services

### E-1: Overview (11 of 13)

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

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

## Appendix E: Participant Direction of Services

### E-1: Overview (12 of 13)

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

The plan of care and service provision will be continually monitored by the case manager. Should monitoring activities reflect the personLs health and safety is being jeopardized the case manager shall begin immediate involuntary termination from the participant direction opportunities. At this time the case manager should immediately begin assisting the member and/or guardian in securing traditional waiver services through a provider of their choosing. If these monitoring activities reflect the memberLs needs are not being met in accordance with the approved Plan of Care (POC) or the funds in the individualized budget are not being utilized according to program criteria, the case manager will work with the consumer or the designated representative to resolve the issues and develop a corrective action plan. The case manager will monitor the progress of the corrective action plan and resulting outcomes to resolve the issue. If the person is unable to resolve the issue, unable to develop and implement a corrective action plan or unwilling to designate a representative within ninety (90) days of identification of the issue the case manager will proceed with involuntary termination procedures. The case manager shall document the reason for the termination, actions taken to assist the person to develop a prevention plan and the outcomes. The case manager shall begin to assist the member and/or guardian within one (1) business day of the termination to assist the person in locating traditional waiver service providers of their choice.

## Appendix E: Participant Direction of Services

### E-1: Overview (13 of 13)

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

**Table E-1-n**

| | Employer Authority Only | Budget Authority Only or Budget Authority in Combination with Employer Authority |
|---|---|---|
| **Waiver Year** | **Number of Participants** | **Number of Participants** |
| **Year 1** | | 28 |
| **Year 2** | | 31 |
| **Year 3** | | 34 |
| **Year 4** | | 37 |
| **Year 5** | | 39 |

## Appendix E: Participant Direction of Services

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

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

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

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

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

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

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

☑ **Recruit staff**
☐ **Refer staff to agency for hiring (co-employer)**
☐ **Select staff from worker registry**
☑ **Hire staff common law employer**
☐ **Verify staff qualifications**

- [ ] **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

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

Specify:

## Appendix E: Participant Direction of Services

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

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

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

- [ ] **Reallocate funds among services included in the budget**
- [x] **Determine the amount paid for services within the State's established limits**
- [ ] **Substitute service providers**
- [x] **Schedule the provision of services**
- [x] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [ ] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [x] **Identify service providers and refer for provider enrollment**
- [ ] **Authorize payment for waiver goods and services**
- [x] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

## Appendix E: Participant Direction of Services

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

**b. Participant - Budget Authority**

**ii. Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating

information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The Department for Medicaid Services shall establish an individualized, flexible budget annually based on needs as identified in the MAP 109 plan of care. The budget can be adjusted as needs change. The participant may negotiate wage rates with employees, however the hourly rate shall not exceed the rate reimbursed to traditional waiver providers for a similar service.

## Appendix E: Participant Direction of Services

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

**b. Participant - Budget Authority**

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

The Case Manager notifies the participant of the amount of the participant-directed budget. Budget exceptions or modifications (adjustments) may be requested through the Case Manager. The exception and/or modification request is forwarded to the Department for Medicaid Services in determining necessity of the request. The following factors will be utilized to determine this necessity: services are necessary to prevent imminent institutionalization; the cost effectiveness of the proposed services; and, protection of the consumerLs health, safety and welfare.

## Appendix E: Participant Direction of Services

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

**b. Participant - Budget Authority**

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

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

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

## Appendix E: Participant Direction of Services

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

**b. Participant - Budget Authority**

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

The case manager, community guide (if applicable) and financial management services (FMS) entity shall continually monitor expenditures for each member. Monthly reports shall be provided to the operating agency and the Department for Medicaid Services (DMS) outlining member budget activity. Should a member be identified as prematurely depleting their budget, the case manager shall contact the member and/or representative and conduct a face-to-face visit to discuss this issue. The case manager shall assist the member and/or representative in development and implementation of a corrective action plan to avoid complete depletion of the established budget prior to allocation of the next budget. The member and/or representative and case manager shall monitor the progress of achieving the goals outlined in the corrective action plan as often as necessary to obtain compliance. It is the responsibility of the case manager to ensure the member is made aware of the implications of underutilization of their budgets.

## Appendix F: Participant Rights

### Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR ◆431.210.

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

operating or Medicaid agency.

Individuals who are denied level of care, budget adjustment, suspension, reduction or termination of services are issued written notification of appeal rights at the time of denial. These rights are contained as a part of the denial notices. All appeal rights are outlined in 907 KAR 1:563, ŁMedicaid Covered Services Hearings and AppealsŁ which requires written notification of appeal rights to the member and the continuation of waiver services if the appeal is requested within ten (10) calendar days of the date of the notification. The notices are generated electronically at the time of denial.

## Appendix F: Participant-Rights

### Appendix F-2: Additional Dispute Resolution Process

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

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

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

DMS provides for a reconsideration process that is operated currently by the QIO. The provider, recipient or guardian acting on behalf of the recipient may file a reconsideration request upon receipt of written notice of a denial of services or level of care. A written request for reconsideration must be postmarked or submitted to the QIO within ten (10) calendar days from the date of the written notice of denial. A denial may be overturned, upheld, or modified as a result of reconsideration. The process is as follows:

1. The provider, recipient, or guardian acting on behalf of the recipient may file a reconsideration request upon receipt of written notice of a denial of services or level of care.

## Appendix F: Participant-Rights

### Appendix F-3: State Grievance/Complaint System

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

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

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

Department for Medicaid Services

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

Waiver members may register any grievance/complaint regarding waiver service provision or service providers by contacting the Department for Medicaid Services. DMS will immediately assess the gravity of the grievance/complaint, and if a memberŁs health, safety or welfare are jeopardized, will immediately respond. Other complaints/grievances will be addressed within five (5) business days. Complaints/grievances are tracked to determine if additional provider trainings should be developed and conducted.
In addition to the DepartmentŁs grievance/complaint system, each waiver provider shall implement procedures to address member complaints and grievances. The providers are required to educate all members regarding this procedure and provide adequate resolution in a timely manner. The provider grievances and appeals are monitored by the DMS through on-site monitoring during surveys, investigations and technical assistance visits.

## Appendix G: Participant Safeguards

### Appendix G-1: Response to Critical Events or Incidents

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

- ◉ **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ○ **No. This Appendix does not apply** *(do not complete Items b through e)*
  If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

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

Following is a description of incidents and the required reporting for the ABI Waiver:
All incidents will be reported on a standard reporting form. There shall be three (3) classes of incidents as follows:
(a) A Class I incident which shall:
1. Be minor in nature and not create a serious consequence;
2. Not require an investigation by the provider agency;

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

The waiver provider shall have written policies and procedures detailing the processes regarding member rights to be free of abuse, neglect and exploitation. These policies and procedures shall include the process for filing complaints with the provider agencies or the contact information for the Department for Community Based Services (DCBS), Division of Permanency and Protection to initiate an investigation of the complaint. All policies and procedures are to be explained to each member and/or guardian and a copy of the DCBS contact information shall be provided. DMS monitors provider policies and procedures related to abuse, neglect and exploitation preservice and when changes occur. For participants who choose to direct their own servies, it is the responsibility of the case manager to ensure that the participant and all employees are trained on abuse, neglect and exploitation and reporting requirements. Each provider is rquired to assist and support the participant's ability to communicate freely with family members, guardians, friends, and case managers.

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

The provider agency will initiate investigations into Class II and III incidents and report the results to the case manager, the waiver memberĽs guardian and the Department for Medicaid Services.

A Class II incident must be reported to the case manager or guardian and DMS within 24 hours of discovery.

A Class III incident must be reported to the case manager or guardian and DMS within 8 hours of discovery. In addition, it must be reported to the Department for Community-Based Services immediately upon discovery, in accordance with KRS Chapter 209, relating to reporting of abuse, neglect or exploitation. A complete

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

The Department for Medicaid Services will be responsible for overseeing reporting of and response to critical incidents affecting waiver members. Waiver providers are required to complete and submit standard incident reporting forms and have a process in place for investigating, communicating and preventing incidents. DMS staff will carry out a follow-up investigation and intervene with providers as necessary for all Class III incident reports and those Class II incident reports where follow-up is deemed necessary by DMS professional staff. All incident reports will be tracked and trended, and follow-up monitoring visits, technical assistance or provider training conducted as indicated based on the trends.

Class I incident reports, which will not be required to be submitted to DMS, will be maintained in provider records and reviewed by DMS during certification surveys, monitoring visits and investigations to assure the records are being appropriately maintained and that the provider agency is following up appropriately.

# Appendix G: Participant Safeguards

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

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

○ **The State does not permit or prohibits the use of restraints**

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

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

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

Any use of chemical or physical restraints will require review and approval by the case manager and the ABI recipientĽs team. This will be accomplished by the case management provider establishing a human rights committee which shall include an:
a. Individual with a brain injury or a family member of an individual with a brain injury;
b. Individual not affiliated with the ABI provider; and
c. Individual who has knowledge and experience in rights issues;
The Human Rights Committee shall review and approve each plan of care with rights restrictions at a minimum of every six (6) months.

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

The Department for Medicaid Services will be responsible for overseeing the use of restraints and assuring that State safeguards are followed. This oversight will be incorporated into certification visits, on-site monitoring and investigations. Providers will be required to report to DMS any use of chemical or physical restraints as a Class III incident. As indicated above, DMS staff will follow up on Class III incidents and will provide technical assistance or training to providers as necessary.

## Appendix G: Participant Safeguards

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

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

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

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

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

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

Any use of restrictive interventions (chemical or physical) will require review and approval by the case manager and the ABI recipientl.s team. This will be accomplished by the case manager establishing a human rights committee which shall include an:
a. Individual with a brain injury or a family member of an individual with a brain injury;
b. Individual not affiliated with the ABI provider; and
c. Individual who has knowledge and experience in rights issues;
The Human Rights Committee shall review and approve each plan of care with rights restrictions at a minimum of every six (6) months. The term "rights restriction" refers to any restriction of services and opportunities that all people have regardless of their disability.

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

The Department for Medicaid Services will be responsible for overseeing the use of restrictive interventions and assuring that State safeguards are followed. This oversight will be incorporated into certification visits, on-site monitoring and investigations.

## Appendix G: Participant Safeguards

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

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

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

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

Kentucky's policy related to seclusion and restraint in the ABI waiver is reflected in Section G-2-a.

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

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

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

## Appendix G: Participant Safeguards

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

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

**a. Applicability.** Select one:

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

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

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

Approved waiver providers will be responsible for monitoring participant medication regimens in residential and day service settings. Waiver providers will be required to follow the guidelines indicated below for administration of medication:
Unless the employee is a licensed or registered nurse, ensure that staff administering medication:
1. Have specific training provided by a licensed medical professional and documented competency on cause and effect and proper administration and storage of medication which shall be provided by a nurse, pharmacist or medical doctor; and
2. Document all medication administered, including self-administered, over-the-counter drugs, on a medication log, with the date, time, and initials of the person who administered the medication and ensure that the medication shall:
a. Be kept in a locked container;

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

DMS will be responsible for oversight of medication management practices by approved waiver providers. This oversight will begin with review and approval of providersŁ policy and procedures for on-going monitoring of medication administration. Medication administration policies, practices and record-keeping will be assessed, and necessary interventions employed, as part of the certification and on-site monitoring process, which occurs at least annually. In addition, all medication errors must be reported through the incident reporting system, and will be followed up immediately upon report.

## Appendix G: Participant Safeguards

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

**c. Medication Administration by Waiver Providers**

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

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

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

Waiver providers will be required to follow the guidelines indicated below for administration of medication:
Unless the employee is a licensed or registered nurse, ensure that staff administering medication:
1. Have specific training provided by a licensed medical professional and documented competency on cause and effect and proper administration and storage of medication which shall be provided by a nurse, pharmacist or medical doctor; and
2. Document all medication administered, including self-administered, over-the-counter drugs, on a medication log, with the date, time, and initials of the person who administered the medication and ensure that the medication shall:
a. Be kept in a locked container;

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

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

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

All errors will be reported to the Department for Medicaid Services, through the incident reporting system. Class III medication errors will be reported to the Department for Community Based Services, the state agency responsible for investigating reports of abuse, neglect and exploitation in accordance with KRS Chapter 209. For waiver participants with a public guardian, all errors will be reported to the Division of Protection and Permanency, Department for Community Based Services.

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

Medication errors which must be recorded will include missed doses, medication not within the administration window when due, wrong dose, wrong medication given or wrong route.

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

All medication errors must be reported to DMS, including missed doses, medication not within the administration window when due, wrong dose, wrong medication given or wrong route.

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

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

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

The Department for Medicaid Services will be responsible for monitoring waiver providersŁ performance in administration of medication. This oversight will begin with review and approval of providersŁ policy and procedures for on-going monitoring of medication administration. Medication administration policies, practices and record-keeping will be assessed, and necessary interventions employed, as part of the certification and on-site monitoring process, which occurs at least annually. In addition, all medication errors must be reported through the incident reporting system, and will be followed up immediately upon report.

## Appendix G: Participant Safeguards

### Quality Improvement: Health and Welfare

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

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

**i. Sub-Assurances:**

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

**Performance Measures**

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

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

**Performance Measure:**
**Number and percent of deaths reviewed by DMS. N= Number of deaths reviewed. D= Number of deaths.**

**Data Source** (Select one):
**Critical events and incident reports**

If 'Other' is selected, specify:

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☑ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**Number and percent of critical incidents that were reported within required time frames. N= Number of critical incidents that were reported within the required time frame. D= Number of critical incidents reported.**

**Data Source** (Select one):
**Critical events and incident reports**

If 'Other' is selected, specify:

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☑ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**Number and percent of class III critical incidents that were reviewed by DMS to confirm that the incident was investigated by the appropriate entity within the required timeframes. N=Number of class II critical incidents reviewed by DMS of confirmt hat the incident was investigated by the appropriate entity within the required time frames. D= Number of class III incidents reviewed.**

**Data Source** (Select one):

**Critical events and incident reports**

If 'Other' is selected, specify:

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☑ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**

**Number and percent of cricital incidents that received follow up within required time frames. N= Number of critical incidents that received follow up within the required timeframe. D= Number of critical incidents received.**

**Data Source** (Select one):

**Critical events and incident reports**

If 'Other' is selected, specify:

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☑ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

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

**Performance Measures**

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

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

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

**Performance Measures**

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

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

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

**Performance Measures**

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

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

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Provider agencies are certified by DMS or licensed by OIG annually, which includes monitoring of the employee records for criminal checks and abuse registry checks.
DMS performs first line monitoring and identifies deficiencies of the ABI waiver provider and requires a corrective action plan to address the deficiencies identified. During the recertification process, policy and procedures for training provider staff are reviewed and review of incident reports for the period of the review are completed to ensure health, safety and welfare.
DMS monitors the complaint process by examining the complaint logs and the results of client satisfaction surveys. DMS will monitor agency reporting and remediation of critical incidents both on an individual and agency level.
DMS requires providers to post the toll-free fraud and abuse hotline telephone number of the Office Inspector General for all staff, waiver participants, and their caregivers or legal representatives and other interested parties to have access to. The purpose of this hotline is to enable complaints or other concerns to

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

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

The state incident management system requires waiver providers to complete and submit the required incident report form and have a process in place for investigation, communication and prevention of incidents within specified timeframes. As DMS staff review incidents submitted, any issues needing immediate action are assigned to a designated DMS staff person for investigation to address through technical assistance with the provider agency within specified timeframes. Priority areas of the analysis include abuse, neglect, exploitation, medication errors and emergency restraint use.

Participant safeguards in the event of critical incidents include, immediate referral to Adult Protective Services, rendering of appropriate medical treatment, referral to appropriate law enforcement agency, and ensuring the individual is in a safe environment.

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

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** | ☑ **Annually** |

| | |
|---|---|
| Specify: | |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

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

## Appendix H: Quality Improvement Strategy (1 of 2)

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

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

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

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

**Quality Improvement Strategy: Minimum Components**

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

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

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

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

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

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

## Appendix H: Quality Improvement Strategy (2 of 2)

### H-1: Systems Improvement

**a. System Improvements**

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

DMS contracts with the fiscal agent who in turn, contracts with the QIO. DMS currently receives a Utilization Management Review report, that is generated by the fiscal agent, which lists the number of LOC's, POC's approved and denied, services approved and denied. DMS is currently working with the fiscal agent to upgrade the utilization report to include provider number, member number, changes in the LOC date which will effect the waiver segment in the MMIS. DMS is also currently working on data base modifications to include information gathered during the 1st line monitoring process of the ABI waiver providers.

**ii. System Improvement Activities**

| **Responsible Party***(check each that applies):* | **Frequency of Monitoring and Analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Quality Improvement Committee** | ☑ **Annually** |
| ☑ **Other** Specify: Fiscal agent, QIO | ☐ **Other** Specify: |

**b. System Design Changes**

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

DMS or designee conducts participant Satisfaction/Quality surveys through face to face meetings with participants during home visits and provider certification surveys at least annually. Interviews may also be conducted by telephone or through a mailed survey. Findings from these surveys are shared with and addressed through technical assistance with the provider. Providers are required to address any deficiencies identified through Plans of Correction, which are then monitored by DMS staff to ensure implementation of corrective actions.
Based on information obtained from annual Satisfaction/Quality surveys and certification reviews, DMS modifies existing systems and trainings to ensure continuing quality and satisfaction. DMS reviews program data to identify changing trends so that proactive modifications may be implemented to ensure continuing quality care. Based on the continuing analysis of systems, DMS initiates any needed revisions to the governing regulation. DMS provides policy clarifications to the ABI waiver providers to ensure appropriate implementation of program policy and understanding of any programmatic or regulatory revisions as they occur.

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

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

## Appendix I: Financial Accountability

### I-1: Financial Integrity and Accountability

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

available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Department for Medicaid Services will conduct annual audits of all waiver providers. These audits will include a post-payment review of Medicaid reimbursement to the provider agency for services rendered to a waiver member. DMS will utilize reports generated from the Medicaid Management Information System (MMIS) reflecting each service billed by the waiver provider. Comparison of payments to member records, documentation and approved Plan of Care (POC) will be conducted. If any payments were issued without the appropriate documentation or not in accordance with approved POC, DMS will initiate recoupment of the monies. Additional billing reviews are conducted based on issues identified during certification surveys or investigations.

The Department for Aging and Independent Living (DAIL) will conduct annual audits of the financial management services (FMS) entities. These audits shall include a post-payment review of Medicaid reimbursement to the Community Mental Health Centers for payment to the member's employees through participant directed

## Appendix I: Financial Accountability

### Quality Improvement: Financial Accountability

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

a. **Methods for Discovery: Financial Accountability Assurance:**
***The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.*** *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. **Sub-Assurances:**

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

**Performance Measures**

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

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

**Performance Measure:**
**Number and percent of claims reviewed that were coded and paid in accordance with reimbursement methodology. N= Number of claims that were coded and paid in accordance with reimbursement methodology. D= Number of claims paid.**

**Data Source** (Select one):
**Reports to State Medicaid Agency on delegated**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☑ **Other** Specify: QIO, Fiscal agent | ☑ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |

| | | |
|---|---|---|
| | | |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>QIO, Fiscal agent | ☑ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of waiver service claims that were submitted for ABI waiver participants who were enrolled in the waiver on the service delivery date. N= Number of ABI waiver service claims that were submitted for participants who were enrolled in the waiver on the service delivery date. D= Number of ABI waiver service claims.**

**Data Source** (Select one):
**Reports to State Medicaid Agency on delegated**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☑ **Other**<br>Specify:<br>QIO, fiscal agent | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and** | ☐ **Other** |

| | | |
|---|---|---|
| | **Ongoing** | Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>QIO, fiscal agent | ☑ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

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

**Performance Measures**

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

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

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

DMS reviews and adds Edits/Audits to the Medicaid Management Information System (MMIS) periodically for program compliance and as policy is revised to ensure claims are not paid erroneously. DMS reviews the CMS-372 report for accuracy prior to submission.

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

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

DMS provides technical assistance to certified providers on an ongoing basis. Providers found out of compliance submit and are held to a plan of correction (POC). DMS performs trainings upon request of providers and provides technical assistance whenever requested. Should an enrolled provider fail to meet their POC, DMS would terminate the provider's enrollment as a waiver provider.

**ii. Remediation Data Aggregation**

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

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>QIO | ☑ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ **No**

○ **Yes**

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

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (1 of 3)

**a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Provider rates are established utilizing a fee-for-service system. The provider rates are being established based on other 1915(c) waiver programs with similar services and target populations as well as historical utilization. Provider rate setting is established in program regulations. All ordinary administrative regulations are subject to a public comment process during promulgation.

**b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Billings for waiver services will flow directly from waiver providers to the CommonwealthŁs MMIS.

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (2 of 3)

**c. Certifying Public Expenditures** *(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (3 of 3)

**d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

All ABI waiver providers shall be enrolled with the Department for Medicaid Services (DMS), provider enrollment, and have a signed contract on file. The Medicaid Management Information System (MMIS) has edits and audits established to prevent non-enrolled provider claims from processing. DMS shall conduct audits of 100 %of the ABI waiver providers annually. These audits shall include a post-payment review of Medicaid reimbursement to the provider agency for services rendered to a ABI member. DMS shall utilize reports generated from the Medicaid Management Information System (MMIS) reflecting each service billed by the waiver provider. Comparison of payments to member records, documentation and approved Plan of Care (POC) shall be conducted.

**e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR ◆92.42.

## Appendix I: Financial Accountability

### I-3: Payment (1 of 7)

**a. Method of payments -- MMIS** (*select one*):

- (●) **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ( ) **Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

( )

**Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

## Appendix I: Financial Accountability

### I-3: Payment (2 of 7)

**b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

☐ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**

☑ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**

☐ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

## Appendix I: Financial Accountability

### I-3: Payment (3 of 7)

**c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

◉ **No. The State does not make supplemental or enhanced payments for waiver services.**

○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

## Appendix I: Financial Accountability

### I-3: Payment (4 of 7)

**d. Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

- (●) **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- ( ) **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

## Appendix I: Financial Accountability

### I-3: Payment (5 of 7)

**e. Amount of Payment to State or Local Government Providers.**

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

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

- ( ) **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

## Appendix I: Financial Accountability

### I-3: Payment (6 of 7)

**f. Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- (●) **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ( ) **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

# Appendix I: Financial Accountability

## I-3: Payment (7 of 7)

**g. Additional Payment Arrangements**

**i. Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

- (●) **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ( ) **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

**ii. Organized Health Care Delivery System.** *Select one:*

- (●) **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- ( ) **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

**iii. Contracts with MCOs, PIHPs or PAHPs.** *Select one:*

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**
- ( ) **This waiver is a part of a concurrent ⧫1115/⧫1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ⧫1115 waiver specifies the types of health plans that are used and how payments to these plans are made.**

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (1 of 3)

**a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- [x] **Appropriation of State Tax Revenues to the State Medicaid agency**
- [ ] **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

- [ ] **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (2 of 3)

**b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

- (•) **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
- ( ) **Applicable**

*Check each that applies:*

- [ ] **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- [ ] **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (3 of 3)

**c. Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

  *Check each that applies:*
  - [ ] **Health care-related taxes or fees**
  - [ ] **Provider-related donations**
  - [ ] **Federal funds**

  For each source of funds indicated above, describe the source of the funds in detail:

## Appendix I: Financial Accountability

### I-5: Exclusion of Medicaid Payment for Room and Board

**a. Services Furnished in Residential Settings.** *Select one:*

- ( ) **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- (●) **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

**b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Kentucky Administrative Regulations governing the ABI Waiver specify that reimbursement for residential services shall not include payment for room and board. Approved waiver providers are paid a flat rate for residential services which is determined based on active treatment and support services costs, not the cost of room and board.

## Appendix I: Financial Accountability

### I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

**Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.** *Select one:*

- (●) **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ( ) **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

**a. Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select*

*one:*

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

**i. Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

***Charges Associated with the Provision of Waiver Services*** *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

*Specify:*

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

**a. Co-Payment Requirements.**

**ii. Participants Subject to Co-pay Charges for Waiver Services.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

**a. Co-Payment Requirements.**

**iii. Amount of Co-Pay Charges for Waiver Services.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

**a. Co-Payment Requirements.**

**iv. Cumulative Maximum Charges.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

**b. Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

## Appendix J: Cost Neutrality Demonstration

### J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

**Composite Overview.** Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

**Level(s) of Care: Nursing Facility**

| Col. 1 | Col. 2 | Col. 3 | Col. 4 | Col. 5 | Col. 6 | Col. 7 | Col. 8 |
|---|---|---|---|---|---|---|---|
| Year | Factor D | Factor D' | Total: D+D' | Factor G | Factor G' | Total: G+G' | Difference (Col 7 less Column4) |
| 1 | 64190.84 | 6040.19 | 70231.03 | 191021.25 | 7852.15 | 198873.40 | 128642.37 |
| 2 | 71640.18 | 6342.20 | 77982.38 | 200572.31 | 8244.76 | 208817.07 | 130834.69 |
| 3 | 80102.38 | 6659.31 | 86761.69 | 210600.93 | 8657.00 | 219257.93 | 132496.24 |
| 4 | 88888.81 | 6992.27 | 95881.08 | 221130.97 | 9089.85 | 230220.82 | 134339.74 |
| 5 | 100654.21 | 7341.89 | 107996.10 | 232187.52 | 9544.34 | 241731.86 | 133735.76 |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (1 of 9)

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

**Table: J-2-a: Unduplicated Participants**

| Waiver Year | Total Unduplicated Number of Participants (from Item B-3-a) | Distribution of Unduplicated Participants by Level of Care (if applicable) |
|---|---|---|
| | | Level of Care: |
| | | Nursing Facility |
| Year 1 | 383 | 383 |
| Year 2 | 383 | 383 |
| Year 3 | 383 | 383 |
| Year 4 | 383 | 383 |
| Year 5 | 383 | 383 |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (2 of 9)

b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

372 data indicate the average length of stay for the ABI waiver is 9.3 months.

## Appendix J: Cost Neutrality Demonstration

### (3 of 9)

## J-2: Derivation of Estimates

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Factor D was calculated as follows: Total dollars for each category of waiver service were determined by extracting the waiver expenditures related to the waiver members during the applicable 12-month period (2016 – 2017) from the claims processing system of the Department for Medicaid Services. Factor D estimates were based on trend data from calculating the average percent change from CMS 372 data for waiver years 2011 – 2016. The percentage change was applied to the 2016 – 2017 data to estimate expenditures for the next five-year period.

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' was calculated as follows: Total dollars for non-waiver services were determined by extracting the non-waiver expenditures related to the waiver members during the applicable 12 month period from the claims processing system of the Department for Medicaid Services. Factor D' estimates were based on trend data from calculating the average percent change from CMS 372 data for waiver years 2011 – 2016. The percentage change was applied to the 2016 – 2017 data to estimate expenditures for the next five-year period.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G was calculated as follows: Total dollars for institutional services were determined by extracting the institutional expenditures related to the comparison institutionalized population members during the applicable 12 month period from the claims processing system of the Department for Medicaid Services. Factor G estimates were based on trend data from calculating the average percent change from CMS 372 data for waiver years 2011 – 2016. The percentage change was applied to the 2016 – 2017 data to estimate expenditures for the next five-year period.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' was calculated as follows: Total dollars for non-institutional services were determined by extracting the non-institutional expenditures related to the comparison institutionalized population members during the applicable 12 month period from the claims processing system of the Department for Medicaid Services. Factor G' estimates were based on trend data from calculating the average percent change from CMS 372 data for waiver years 2011 – 2016. The percentage change was applied to the 2016 – 2017 data to estimate expenditures for the next five-year period.

# Appendix J: Cost Neutrality Demonstration

## J-2: Derivation of Estimates (4 of 9)

**Component management for waiver services.** If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

| Waiver Services | |
|---|---|
| Adult Day Training | |
| Case Management | |
| Respite | |
| Supported Employment | |
| Behavioral Services | |
| Counseling | |
| Group Counseling | |
| Occupational Therapy | |
| Specialized Medical Equipment | |
| Speech Therapy | |
| Community Guide | |
| Financial Management Services | |
| Goods and Services | |
| Assessment/reassessment | |
| Community Living Supports | |
| Environmental and minor home modifications | |
| Supervised Residential Care Level I | |
| Supervised Residential Care Level II | |
| Supervised Residential Care Level III | |

# Appendix J: Cost Neutrality Demonstration

## J-2: Derivation of Estimates (5 of 9)

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 1**

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Adult Day Training Total:** | | | | | | **2892483.20** |
| Adult Day Training | 15 min | 284 | 2320.00 | 4.39 | **2892483.20** | |
| **Case Management Total:** | | | | | | **721527.48** |
| Case Management | 1 month | 186 | 9.00 | 431.02 | **721527.48** | |
| **Respite Total:** | | | | | | **7040.00** |
| Respite | 15 min | 5 | 352.00 | 4.00 | **7040.00** | |
| **Supported Employment Total:** | | | | | | **430.92** |
| Supported Employment | 15 min | 2 | 27.00 | 7.98 | **430.92** | |
| **Behavioral Services Total:** | | | | | | **2691931.36** |
| Behavioral Services | 15 min | 151 | 536.00 | 33.26 | **2691931.36** | |
| **Counseling Total:** | | | | | | **1852946.88** |
| Counseling | 15 min | 174 | 452.00 | 23.56 | **1852946.88** | |
| **Group Counseling Total:** | | | | | | **12232.20** |
| Group Counseling | 15 min | 37 | 58.00 | 5.70 | **12232.20** | |
| **Occupational Therapy Total:** | | | | | | **4376544.12** |
| Occupational Therapy | 15 min | 188 | 909.00 | 25.61 | **4376544.12** | |
| **Specialized Medical Equipment Total:** | | | | | | **47145.84** |
| Specialized Medical Equipment | Per item | 57 | 2.00 | 413.56 | **47145.84** | |
| **Speech Therapy Total:** | | | | | | **4159510.40** |
| Speech Therapy | 15 min | 172 | 860.00 | 28.12 | **4159510.40** | |
| **Community Guide Total:** | | | | | | **0.00** |
| Community Guide | 15 min | 0 | 0.00 | 8.00 | **0.00** | |
| **Financial Management Services Total:** | | | | | | **30987.50** |
| Financial Management Services | 15 min | 37 | 67.00 | 12.50 | **30987.50** | |
| **Goods and Services Total:** | | | | | | **4464.10** |

| | | | | | | |
|---|---|---|---|---|---|---|
| Goods and Services | Per item | 5 | 2.00 | 446.41 | 4464.10 | |
| **Assessment/reassessment Total:** | | | | | | 14899.50 |
| Assessment/reassessment | Per assessment | 150 | 1.00 | 99.33 | 14899.50 | |
| **Community Living Supports Total:** | | | | | | 928620.08 |
| Community Living Supports | 15 min | 61 | 2738.00 | 5.56 | 928620.08 | |
| **Environmental and minor home modifications Total:** | | | | | | 2000.00 |
| Environmental and minor home modifications | Per modification | 1 | 1.00 | 2000.00 | 2000.00 | |
| **Supervised Residential Care Level I Total:** | | | | | | 6813229.28 |
| Supervised Residential Care Level I | Per day | 121 | 286.00 | 196.88 | 6813229.28 | |
| **Supervised Residential Care Level II Total:** | | | | | | 29100.00 |
| Supervised Residential Care Level II | Per day | 2 | 97.00 | 150.00 | 29100.00 | |
| **Supervised Residential Care Level III Total:** | | | | | | 0.00 |
| Supervised Residential Care Level III | Per day | 0 | 0.00 | 75.00 | 0.00 | |
| | | | | **GRAND TOTAL:** | | 24585092.86 |
| | | | | **Total Estimated Unduplicated Participants:** | | 383 |
| | | | | **Factor D (Divide total by number of participants):** | | 64190.84 |
| | | | | **Average Length of Stay on the Waiver:** | | 293 |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (6 of 9)

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 2**

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Adult Day Training Total:** | | | | | | 3721673.25 |
| Adult Day Training | 15 min | 309 | 2525.00 | 4.77 | 3721673.25 | |
| **Case Management Total:** | | | | | | 787473.54 |
| Case Management | 1 month | 203 | 9.00 | 431.02 | 787473.54 | |
| **Respite Total:** | | | | | | 8448.00 |
| Respite | 15 min | 6 | 352.00 | 4.00 | 8448.00 | |
| **Supported Employment Total:** | | | | | | 430.92 |
| Supported Employment | 15 min | 2 | 27.00 | 7.98 | 430.92 | |
| **Behavioral Services Total:** | | | | | | 2941514.40 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Behavioral Services | 15 min | 165 | 536.00 | 33.26 | **2941514.40** | |
| **Counseling Total:** | | | | | | **2023332.80** |
| Counseling | 15 min | 190 | 452.00 | 23.56 | **2023332.80** | |
| **Group Counseling Total:** | | | | | | **13224.00** |
| Group Counseling | 15 min | 40 | 58.00 | 5.70 | **13224.00** | |
| **Occupational Therapy Total:** | | | | | | **4772295.45** |
| Occupational Therapy | 15 min | 205 | 909.00 | 25.61 | **4772295.45** | |
| **Specialized Medical Equipment Total:** | | | | | | **51281.44** |
| Specialized Medical Equipment | Per item | 62 | 2.00 | 413.56 | **51281.44** | |
| **Speech Therapy Total:** | | | | | | **4522258.40** |
| Speech Therapy | 15 min | 187 | 860.00 | 28.12 | **4522258.40** | |
| **Community Guide Total:** | | | | | | **0.00** |
| Community Guide | 15 min | 0 | 0.00 | 8.00 | **0.00** | |
| **Financial Management Services Total:** | | | | | | **33500.00** |
| Financial Management Services | 15 min | 40 | 67.00 | 12.50 | **33500.00** | |
| **Goods and Services Total:** | | | | | | **5356.92** |
| Goods and Services | Per item | 6 | 2.00 | 446.41 | **5356.92** | |
| **Assessment/reassessment Total:** | | | | | | **16290.12** |
| Assessment/reassessment | Per assessment | 164 | 1.00 | 99.33 | **16290.12** | |
| **Community Living Supports Total:** | | | | | | **1077394.56** |
| Community Living Supports | 15 min | 66 | 2936.00 | 5.56 | **1077394.56** | |
| **Environmental and minor home modifications Total:** | | | | | | **2000.00** |
| Environmental and minor home modifications | Per modification | 1 | 1.00 | 2000.00 | **2000.00** | |
| **Supervised Residential Care Level I Total:** | | | | | | **7432613.76** |
| Supervised Residential Care Level I | Per day | 132 | 286.00 | 196.88 | **7432613.76** | |
| **Supervised Residential Care Level II Total:** | | | | | | **29100.00** |
| Supervised Residential Care Level II | Per day | 2 | 97.00 | 150.00 | **29100.00** | |
| **Supervised Residential Care Level III Total:** | | | | | | **0.00** |
| Supervised Residential Care Level III | Per day | 0 | 0.00 | 75.00 | **0.00** | |

| | |
|---|---|
| **GRAND TOTAL:** | **27438187.56** |
| **Total Estimated Unduplicated Participants:** | **383** |
| **Factor D (Divide total by number of participants):** | **71640.18** |
| **Average Length of Stay on the Waiver:** | 293 |

# Appendix J: Cost Neutrality Demonstration

## J-2: Derivation of Estimates (7 of 9)

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 3**

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Adult Day Training Total:** | | | | | | **4815595.20** |
| Adult Day Training | 15 min | 337 | 2748.00 | 5.20 | **4815595.20** | |
| **Case Management Total:** | | | | | | **857298.78** |
| Case Management | 1 month | 221 | 9.00 | 431.02 | **857298.78** | |
| **Respite Total:** | | | | | | **8448.00** |
| Respite | 15 min | 6 | 352.00 | 4.00 | **8448.00** | |
| **Supported Employment Total:** | | | | | | **646.38** |
| Supported Employment | 15 min | 3 | 27.00 | 7.98 | **646.38** | |
| **Behavioral Services Total:** | | | | | | **3191097.44** |
| Behavioral Services | 15 min | 179 | 536.00 | 33.26 | **3191097.44** | |
| **Counseling Total:** | | | | | | **2193718.72** |
| Counseling | 15 min | 206 | 452.00 | 23.56 | **2193718.72** | |
| **Group Counseling Total:** | | | | | | **14546.40** |
| Group Counseling | 15 min | 44 | 58.00 | 5.70 | **14546.40** | |
| **Occupational Therapy Total:** | | | | | | **5191326.27** |
| Occupational Therapy | 15 min | 223 | 909.00 | 25.61 | **5191326.27** | |
| **Specialized Medical Equipment Total:** | | | | | | **55417.04** |
| Specialized Medical Equipment | Per item | 67 | 2.00 | 413.56 | **55417.04** | |
| **Speech Therapy Total:** | | | | | | **4933372.80** |
| Speech Therapy | 15 min | 204 | 860.00 | 28.12 | **4933372.80** | |
| **Community Guide Total:** | | | | | | **0.00** |
| Community Guide | 15 min | 0 | 0.00 | 8.00 | **0.00** | |
| **Financial Management Services Total:** | | | | | | **36850.00** |
| Financial Management Services | 15 min | 44 | 67.00 | 12.50 | **36850.00** | |
| **Goods and Services Total:** | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | **5356.92** |
| Goods and Services | Per item | 6 | 2.00 | 446.41 | **5356.92** | |
| **Assessment/reassessment Total:** | | | | | | **17680.74** |
| Assessment/reassessment | Per assessment | 178 | 1.00 | 99.33 | **17680.74** | |
| **Community Living Supports Total:** | | | | | | **1260207.36** |
| Community Living Supports | 15 min | 72 | 3148.00 | 5.56 | **1260207.36** | |
| **Environmental and minor home modifications Total:** | | | | | | **2000.00** |
| Environmental and minor home modifications | Per modification | 1 | 1.00 | 2000.00 | **2000.00** | |
| **Supervised Residential Care Level I Total:** | | | | | | **8051998.24** |
| Supervised Residential Care Level I | Per day | 143 | 286.00 | 196.88 | **8051998.24** | |
| **Supervised Residential Care Level II Total:** | | | | | | **43650.00** |
| Supervised Residential Care Level II | Per day | 3 | 97.00 | 150.00 | **43650.00** | |
| **Supervised Residential Care Level III Total:** | | | | | | **0.00** |
| Supervised Residential Care Level III | Per day | 0 | 0.00 | 75.00 | **0.00** | |

| | |
|---|---|
| **GRAND TOTAL:** | **30679210.29** |
| **Total Estimated Unduplicated Participants:** | **383** |
| **Factor D (Divide total by number of participants):** | **80102.38** |
| **Average Length of Stay on the Waiver:** | 293 |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (8 of 9)

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 4**

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Adult Day Training Total:** | | | | | | **6198107.52** |
| Adult Day Training | 15 min | 366 | 2992.00 | 5.66 | **6198107.52** | |
| **Case Management Total:** | | | | | | **931003.20** |
| Case Management | 1 month | 240 | 9.00 | 431.02 | **931003.20** | |
| **Respite Total:** | | | | | | **9856.00** |
| Respite | 15 min | 7 | 352.00 | 4.00 | **9856.00** | |
| **Supported Employment Total:** | | | | | | **15944.04** |
| Supported Employment | 15 min | 74 | 27.00 | 7.98 | **15944.04** | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Behavioral Services Total:** | | | | | | **3476335.20** |
| Behavioral Services | 15 min | 195 | 536.00 | 33.26 | **3476335.20** | |
| **Counseling Total:** | | | | | | **2396052.00** |
| Counseling | 15 min | 225 | 452.00 | 23.56 | **2396052.00** | |
| **Group Counseling Total:** | | | | | | **15868.80** |
| Group Counseling | 15 min | 48 | 58.00 | 5.70 | **15868.80** | |
| **Occupational Therapy Total:** | | | | | | **5656916.07** |
| Occupational Therapy | 15 min | 243 | 909.00 | 25.61 | **5656916.07** | |
| **Specialized Medical Equipment Total:** | | | | | | **60379.76** |
| Specialized Medical Equipment | Per item | 73 | 2.00 | 413.56 | **60379.76** | |
| **Speech Therapy Total:** | | | | | | **5368670.40** |
| Speech Therapy | 15 min | 222 | 860.00 | 28.12 | **5368670.40** | |
| **Community Guide Total:** | | | | | | **0.00** |
| Community Guide | 15 min | 0 | 0.00 | 8.00 | **0.00** | |
| **Financial Management Services Total:** | | | | | | **40200.00** |
| Financial Management Services | 15 min | 48 | 67.00 | 12.50 | **40200.00** | |
| **Goods and Services Total:** | | | | | | **6249.74** |
| Goods and Services | Per item | 7 | 2.00 | 446.41 | **6249.74** | |
| **Assessment/reassessment Total:** | | | | | | **19270.02** |
| Assessment/reassessment | Per assessment | 194 | 1.00 | 99.33 | **19270.02** | |
| **Community Living Supports Total:** | | | | | | **1019915.28** |
| Community Living Supports | 15 min | 79 | 2322.00 | 5.56 | **1019915.28** | |
| **Environmental and minor home modifications Total:** | | | | | | **2000.00** |
| Environmental and minor home modifications | Per modification | 1 | 1.00 | 2000.00 | **2000.00** | |
| **Supervised Residential Care Level I Total:** | | | | | | **8783998.08** |
| Supervised Residential Care Level I | Per day | 156 | 286.00 | 196.88 | **8783998.08** | |
| **Supervised Residential Care Level II Total:** | | | | | | **43650.00** |
| Supervised Residential Care Level II | Per day | 3 | 97.00 | 150.00 | **43650.00** | |
| **Supervised Residential Care Level III Total:** | | | | | | |