

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 section 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 an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State of Kentucky** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:
Home and Community Based Waiver

C. Waiver Number: KY.0144
Original Base Waiver Number: KY.0144.

D. Amendment Number: KY.0144.R07.08

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

Approved Effective Date: 01/01/25
Approved Effective Date of Waiver being Amended: 08/01/20

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

The purpose of this amendment is to update the rate methodology and associated projected costs. Updated the Financial Management Services units and service limit from 15-minute units with an 8 unit service limit to a “per month” unit. Updated service limit for respite from a cost based limit to a unit based limit. 500 slots were added due to additional funding in SFY 25-26.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently (*check each that applies*):

Component of the Approved Waiver	Subsection(s)
Waiver Application	<input style="width: 500px; height: 20px;" type="text"/>
Appendix A ?	<input style="width: 500px; height: 20px;" type="text"/>

Component of the Approved Waiver	Subsection(s)
Waiver Administration and Operation	
Appendix B ? Participant Access and Eligibility	<input type="text"/>
Appendix C ? Participant Services	C. 1
Appendix D ? Participant Centered Service Planning and Delivery	<input type="text"/>
Appendix E ? Participant Direction of Services	<input type="text"/>
Appendix F ? Participant Rights	<input type="text"/>
Appendix G ? Participant Safeguards	<input type="text"/>
Appendix H	<input type="text"/>
Appendix I ? Financial Accountability	I.2-a
Appendix J ? Cost-Neutrality Demonstration	J.2-c, J.2-d

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment (*check each that applies*):

- Modify target group(s)**
- Modify Medicaid eligibility**
- Add/delete services**
- Revise service specifications**
- Revise provider qualifications**
- Increase/decrease number of participants**
- Revise cost neutrality demonstration**
- Add participant-direction of services**

Other
Specify:

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 section 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):

Home and Community Based Waiver

C. Type of Request: amendment

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.0144

Waiver Number:KY.0144.R07.08

Draft ID: KY.001.07.03

D. Type of Waiver (select only one):

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 08/01/20

Approved Effective Date of Waiver being Amended: 08/01/20

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

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

Hospital

Select applicable level of care

Hospital as defined in 42 CFR ?? 440.10

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR ?? 440.160

Nursing Facility

Select applicable level of care

Nursing Facility as defined in 42 CFR ?? 440.40 and 42 CFR ?? 440.155

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

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

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR § 440.150)

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

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

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

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

Waiver(s) authorized under section 1915(b) of the Act.

Specify the section 1915(b) waiver program and indicate whether a section 1915(b) waiver application has been submitted or previously approved:

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

section 1915(b)(1) (mandated enrollment to managed care)

section 1915(b)(2) (central broker)

section 1915(b)(3) (employ cost savings to furnish additional services)

section 1915(b)(4) (selective contracting/limit number of providers)

A program operated under section 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 section 1915(i) of the Act.

A program authorized under section 1915(j) of the Act.

A program authorized under section 1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

The purpose of this waiver is to prevent institutionalization of waiver participants by offering effective, individualized services that ensure the health, safety and welfare of participants so they may remain in their own home and communities.

Goals

Waiver recipients:

- 1.Are safe and healthy while living in the community;
- 2.Receive effective and individualized assistance; and
- 3.Have easy access and choice to waiver services.

Objectives

- 1.Identify individualized needs through an assessment process leading to a comprehensive person-centered service plan,
- 2.Ensure home and community-based services are comprehensive alternatives to institutional services,
- 3.Improve information, access, and utilization of community-based services,
- 4.Enhance provider competency and continuity of care by enhancing certification and training requirements, and
- 5.Clarity rights and responsibilities of employers and employees in participant-directed services.

Organizational Structure

The Department for Medicaid Services (Department) exercises administrative discretion in the operation of the waiver and in setting policies, rules, and regulations related to the waiver. The Department of Aging and Independent Living will serve as the operating entity through a contract with the Department.

Service Delivery Methods

The HCBS waiver offers statewide availability of traditional services and the ability to self-direct non-medical services. Participants can choose either all traditional, all participant-directed, or a combination (blend) of traditional and participant-directed services.

DMS is selecting the option to provide HCBS services in acute care hospitals in accordance with Section 1902(h)(1) of the Social Security Act.

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 section 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 section 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. Statewide. Indicate whether the state requests a waiver of the statewide requirements in section 1902(a)(1) of the Act (*select one*):

No

Yes

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

Geographic Limitation. A waiver of statewide requirements 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 statewide requirements 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 section 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 inpatients 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 Kentucky Department for Medicaid Services (the Department) began an exhaustive review and re-write of its 1915(c) waivers in 2017. To inform stakeholders and collect feedback in the initial assessment, planning, and re-write process, the Department used the following methods:

1. Focus Groups: The Department hosted 40 focus groups across the State to speak with stakeholders to get an understanding of the changes that were most impactful to stakeholders.
2. Dedicated Email Box: The Department established a widely publicized email box to receive comments and questions from stakeholders at large.
3. Email Repository: Established a continually updated email list of all stakeholders who contacted the Department with comments or provided an email address through in person meetings.
4. Assessment Report: Released an assessment (authored by a contracted entity) of the waivers in a 300+ page report that went into great detail about the climate of the State, nation, and provided 11 recommendations for enhancing the 1915(c) waivers.
5. Formal Response: The Department released a formal response that laid out the framework for the redesign of the waivers.
6. Town Halls: The Department hosted two rounds of town halls: 10 in 2018 and seven in 2019 to educate the public about the recommendations and the plan moving forward. The town halls also allowed for public testimony and/or attendee feedback via question and answers.
7. Frequently Asked Questions (FAQ) Document: The Department published and updated a FAQ document to provide consistent and timely responses to the most frequently asked questions.
8. Multiple Public Comment Periods: Public comment periods on proposed updates to the waiver were held from March 15, 2019, to April 15, 2019, and November 8, 2019, to December 10, 2019.

Waiver review and re-write activities were paused in February 2020 due to a change in administration in Kentucky and remain paused due to the ongoing COVID-19 pandemic. The Department considered feedback from the 2017-2020 review and re-write process when making some updates to this waiver as part of the renewal process. The proposed updates were presented to the public in October 2020 through the following methods:

1. The Department informed stakeholders of the renewal and upcoming public comment period in a notice issued on October 2, 2020.
2. The Department released a copy of the proposed waiver application and an educational summary document of proposed waiver updates to stakeholders for review on October 5, 2020.
3. The Department hosted an educational webinar to review proposed waiver updates and answer stakeholder questions on October 12, 2020.
4. The Department collected public comment from October 5, 2020, to November 6, 2020.
5. The Department reviewed public comment and issued an official response on January 8, 2021.
6. Upon approval of this waiver application, the Department will notify stakeholders of updates made to the application to remove proposed policies requiring regulatory approval, the Department's plan to implement those proposals in the future, and where they can share their questions, comments and concerns with the Department.

The Kentucky Department for Medicaid Services (the Department) issued each of the six waiver applications for public comment from September 27, 2023, to October 28, 2023 for feedback on Appendix K flexibilities being incorporated permanently. To inform stakeholders and collect feedback, the Department used the following methods:

1. Stakeholder Webinar: The Department held an all stakeholder webinar on September 25, 2023. More than six hundred stakeholders attended the call where the Department explained updates being made to the waivers. A recording of the webinar, along with the webinar presentation, are posted to the Department's Division of Long-Term Services and Supports website and will remain there for stakeholders to reference.
2. Email Updates: The Department notified stakeholders of the beginning of the public comment period via email on September 27, 2023. Stakeholders received reminders about the public comment period via email on October 16, 2023, and October 26, 2023.
3. Web and Social Media: The draft waiver application and a summary of updates were posted to the Department's Division of Long-Term Services and Supports website from September 27, 2023, through October 27, 2023. Notices about the start of public comment along with reminders were posted to the Department's social media channels.
4. Dedicated Email Box: The Department used a widely publicized email box to receive comments and questions from stakeholders at large.
5. Advocacy Organizations: Several well-known advocacy organizations shared the Department's notices and reminders to ensure as many stakeholders as possible had the opportunity to review and comment on the draft waiver application.

The public comments and responses can be found at:

<https://www.chfs.ky.gov/agencies/dms/dca/waivers/WaiverPublicCommentResponseNov23.pdf>.

Based on public comment, the Department made the following updates to the applicable waiver applications:

- Updated Home Delivered Meals definition and provider qualifications
- Updated Day Training provider qualifications
- Clarified provider type for Natural Supports Training
- Clarified E-2-h selections
- Incorporated additional telehealth flexibilities
- Clarified definition of a legally responsible individual
- Clarified circumstances for allowing HCBS delivered in acute hospital settings
- Clarified and expanded provider qualifications for Qualified Participant Approved Providers

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:

Hoffmann

First Name:

Leslie

Title:

Acting Director, Division of Long-Term Services and Supports

Agency:

Department for Medicaid Services, Cabinet for Health and Family Services

Address:

275 East Main Street

Address 2:

6W-B

City:

Frankfort

State:

Kentucky

Zip:

40621

Phone:

(502) 564-9187 Ext: TTY

Fax:

(502) 564-0249

E-mail:

leslie.hoffmann@ky.gov

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

Last Name:

Elridge

First Name:

Victoria

Title:

Commissioner

Agency:

Department for Aging and Independent Living, Cabinet for Health and Family Services

Address:

275 E. Main St.

Address 2:

3E-E

City:

Frankfort

State:

Kentucky

Zip:

40621

Phone:

(502) 564-6930 Ext: TTY

Fax:

(502) 564-4595

E-mail:

victoria.elridge@ky.gov

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under section 1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

Leslie Hoffmann

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Kentucky**

Zip:

Phone: Ext: TTY

Fax:

E-mail:

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:

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

The waiver is operated by the state Medicaid agency.

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

The Medical Assistance Unit.

Specify the unit name:

(Do not complete item A-2)

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

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

(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:

Department for Aging and Independent Living

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:

The Department has a written Memorandum of Agreement (MOA) with its sister agency, Department of Aging and Independent Living (DAIL) that is reviewed annually and is updated as needed. The Department may delegate some of the operating functions through the MOA. Functions that may be delegated may include but not limited to:

1. Quality assurance and quality improvement activities. Quality assurance and improvement activities including but not limited to, provider certification and recertification reviews, monitoring of critical incidents and mortality reviews.
2. Review of PDS legally responsible requests.
3. Technical assistance and training.

The Department uses the following method to monitor delegated functions are in accordance with the written MOA and waiver requirements by:

1. Collecting and reviewing required monitoring reports in accordance with the MOA.
2. Conducting monthly meetings between the Medicaid and contracted agencies.

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.:*

The Department contracts with a State university for the independent level of care assessment and re-assessment function. The Department contracts with Gainwell Technologies as a fiscal agent to pay claims through the Medicaid Management Information System (MMIS). The Department also has MOAs, as noted above, with the sister agencies and an additional MOA, through the Department, with DCBS for review of financial eligibility for the waiver population. The Department contracts with Netsmart to deliver electronic visit verification (EVV) 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 is responsible for assessing the performance of the contracted entities providing the functions described in section 3 of this appendix.

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:

The Department assesses the performance of the contracted entities bi-annually through policy clarification and reporting as stipulated in the entities contract.

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	Other State Operating Agency	Contracted Entity
Participant waiver enrollment			
Waiver enrollment managed against approved limits			
Waiver expenditures managed against approved levels			

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Level of care waiver eligibility 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:

Percent of required reports contracted entities provide to Department within required timeframes. N=The number of required reports contracted entities provided to the Department within the required timeframes. D=The number of required reports from contracted entities due to Department within required timeframes.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Reports submitted to the Department

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="Contracted Entities"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Percent of required reports the operating agency provides to Department in required timeframes. N= number of reports the operating agency provided to Department within the required timeframes. D= number of required reports the operating agency was required to provide to Department in the required timeframes.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Reports submitted to the Department

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 = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify:	

	<input style="width: 80%; height: 20px;" type="text"/>	
--	--	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

Performance Measure:

Percent of providers throughout all geographic areas with a uniform provider agreement and execution
N= The number of enrolled providers with a completed uniform provider agreement executed
D= The number of enrolled providers

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Medicaid Partner Portal system

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =

		<input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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.

Identified problems are researched and addressed by the Department through the use of generated monthly reports. The Department monitors to ensure that contract objectives and goals are met as appropriate.

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 Department through the use of generated monthly reports. The Department monitors to ensure that contract objectives and goals are met as appropriate. Should the delegated entity not meet the requirements then a corrective action plan is required and/or a recoupment of funds may occur.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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 Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
Aged or Disabled, or Both - General					
		Aged	65		
		Disabled (Physical)	0	64	
		Disabled (Other)	0	64	
Aged or Disabled, or Both - Specific Recognized Subgroups					
		Brain Injury			
		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:

Participants must meet the Nursing Facility Level of Care regulation as defined in the 907 KAR 1:022.

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:

There is not a maximum age for any of the waiver groups.

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	17300
Year 2	17300
Year 3	

Waiver Year	Unduplicated Number of Participants
	17300
Year 4	17300
Year 5	17800

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	<input type="text"/>
Year 2	<input type="text"/>
Year 3	<input type="text"/>
Year 4	<input type="text"/>
Year 5	<input type="text"/>

Appendix B: Participant Access and Eligibility

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

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

Not applicable. The state does not reserve capacity.

The state reserves capacity for the following purpose(s).

Purpose(s) the state reserves capacity for:

Purposes	
Nursing Home Transition	<input type="checkbox"/>

Appendix B: Participant Access and Eligibility

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

Purpose (*provide a title or short description to use for lookup*):

Purpose *(describe)*:

Kentucky will reserve 150 slots per year to allow for the transition of individuals served under Kentucky Transitions Program (Money Follows the Person) and individuals transitioning from nursing homes.

Describe how the amount of reserved capacity was determined:

Capacity is reserved for Money Follows the Persons grant members who will admit into the HCB Waiver as transitioned from NF facilities. Capacity is reserved based on the projected number of transitions from the MFP program. Projections are based on current transition trends. After the initial transitions, it is projected that a reserved capacity of 150 will be needed each year for future year transitions. MFP transition projections are based on trends from the past three fiscal years and CMS approved benchmarks.

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

Waiver Year	Capacity Reserved
Year 1	150
Year 2	150
Year 3	150
Year 4	150
Year 5	150

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:

When a waiver has open slots, eligible applicants are selected for entrance based on the date of their application. If the waiver has a wait list, entrants will be selected based on the date of their application.

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*):

Section 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 (TWWIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)

Working individuals with disabilities who buy into Medicaid (TWWIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)

Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)

Medically needy in 209(b) States (42 CFR §435.330)

Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)

Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state)

plan that may receive services under this waiver)

Specify:

The federal regulatory 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 spend down 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 period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), 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 September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

Spousal impoverishment rules under section 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 section 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 (Section 1634 State/SSI Criteria 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 section 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:

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 section 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:

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:

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:

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:

Assessors employed through the contracted entity shall have:

- 1) Master's degree in health or human services from an accredited college or university, OR
- 2) RN currently licensed as defined in KRS 314.011(5)

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 participant 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.

The Department uses the Kentucky Home Assessment Tool (K-HAT) to determine a participant's level of care and assess the participant for functional needs based on deficits in activities of daily living, instrumental activities of daily living, and needed non-residential and non-medical home and community supports to remain in the community.

Participants will be determined by the Department to be eligible for the waiver if the participant:

1. Has medical care needs which can be met in a community-based setting;
2. Meets nursing facility (NF) level of care requirements as defined in 907 KAR 1:022;
3. Has service needs which can be met through community-based services;
4. Would, without waiver services, be admitted by a physician's order to a NF; and
5. Meets the target group definitions described in section B-1-a

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 instrument used to establish the level of care for the HCB waiver and for a nursing facility differ; however, both instruments are designed to capture the information needed to fulfill the same regulatory criteria set forth in 907 KAR 1:022.

The instrument used for the HCB Waiver is the K-HAT. The K-HAT evaluates the participant, the home situation, and other supports that the participant receives in addition to requested waiver services. The document used for Nursing Facility Level of Care, the MAP 726A, only evaluates the participant for a 30-day period of time. Field Nurses are then dispatched to the facility to have a face-to-face meeting and a full chart review.

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 K-HAT assesses activities of daily living, instrumental activities of daily living, skilled medical treatment, mental health, and behavioral needs to determine if the individual meets the nursing facility level of care which is the requirement for this waiver. The K-HAT includes an optional assessment for children based on their developmental stage. The taxonomy for the K-HAT provides for consideration of natural supports in determining professional assistance from waiver providers.

The initial evaluation may begin outside of the individual's residence but will be completed within the individual's 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 by the Independent Assessor, it is reviewed by the Department. If the assessment meets the LOC guidelines then the individual is notified that level of care has been approved.

Services may not begin nor will payment be rendered until such time as the individual has met all eligibility requirements for the waiver.

- 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*):

A task is sent to the functional assessor electronically through MWMA sixty (60) calendar days prior to the re-evaluation due date. The task remains on the assessor's dashboard until completed or the program is closed. The assessor must make three attempts to contact the participant to schedule and conduct the reassessment. If after three attempts the participant or their guardian/legal representative has not been reached, the assessor contacts the case manager for assistance in getting the participant to schedule. If the participant or their guardian/legal representative is unable to be reached after multiple attempts the case is closed.

DMS monitors late assessments to determine root cause and provide necessary assistance or follow up.

- 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:

Copies of evaluations are retained in MWMA until after the participant's termination and then maintained electronically for five (5) years.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

Percent of applicants who submitted a waiver application whose LOC review was conducted within 30 days of the receipt of the completed app and capacity reserved in the waiver. N= applicants whose LOC was conducted within 30 days of the receipt of the completed app and capacity reserved in the waiver D= Number of applicants who submitted a complete app and capacity reserved in the waiver.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Medicaid Waiver Management Application reports

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =

		95% +/- 5%
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Percent of individuals who have been on a waitlist for over 365 days who had a level of care : re eval prior being enrolled & receiving services.N = The # of individuals who have been on a waitlist for over 365 days who had a level of care re eval prior to be enrolled and receiving service D= The # of individuals who have been on a waitlist

for over 365 days who are enrolled & receiving services.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Medicaid Waiver Management System

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:

Percent of waiver participants whose initial or subsequent LOC was appro determined using the KHAT and supporting doco based on criteria outlined in reg and waiver required by the State. N= # waiver participants whose LOC was determined appropriately using the KHAT and supportive doco based on the criteria outlined in reg and waiver required by the State. D=Total # of LOC determinations

Data Source (Select one):

Other

If 'Other' is selected, specify:

Level of Care documentation

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="95% +/- 5%"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other	Annually

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
Specify: <input type="text"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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 functional assessment which shall be conducted by the Independent Assessor within the appropriate calendar days of receipt of the request for the assessment. The Department receives monthly reports that note when waiver participants are transitioning into the State’s Managed Care Option. This would indicate to the Department that the participant’s waiver information may be incorrect or incomplete. The Department will also receive a monthly report of reassessments that were not completed within the appropriate period to allow for identification of issues.

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 Department addresses problems as discovered through the generated reports noted above. The Division of Community Alternatives will review the reports and provide remediation activities as needed.

ii. Remediation Data Aggregation

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

Responsible Party (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Specify: <div style="border: 1px solid black; height: 40px; width: 100%; margin-top: 5px;"></div>

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 participants are informed of their choice of institutional care or waiver programs and available services by their case manager (CM) or service advisor. This information is provided at the initial person-centered planning meeting and at least annually thereafter. An electronic copy of this signed form is retained in MWMA.

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

Copies of form are retained in Department-approved system until after the participant's termination and then maintained electronically for five (5) years.

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 participants 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 participants served by the provider, provision of interpreter services at no cost to the participants, and staff training. Provider procedures for assuring LEP access are ensured through routine interaction and monitoring by the Department. When the State learns of a participant needing assistance, staff consult with the participant, 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 participant.

As indicated in Appendix A, Waiver Administration and Operation, of this application, the Department contracts with several entities to perform some waiver functions. All of these entities are required, through contract, to comply with Federal standards regarding the provision of language services to improve access to their programs and activities for participants who are limited in their English proficiency. Contractors’ language services must be consistent with Federal requirements, include a method of identifying LEP participants, and provide language assistance measures including interpretation and translation, staff training, providing notice to LEP participants, and monitoring compliance and updating procedures.

The Cabinet for Health and Family Services (Cabinet) has established a Language Access Section to assist all Cabinet organizational units, including the Department, in effectively communicating with LEP participants, as well as complying with Federal requirements. The Language Access Section has qualified interpreters on staff, maintains a listing of qualified interpreters for use by Cabinet units and contractors throughout the State, contracts with a telephone interpretation service for use by Cabinet units and contractors when appropriate, provides translation services for essential program forms and documents, establishes policies and procedures applicable to Cabinet, and provides technical assistance to Cabinet units as needed. Procedures employed by individual departments and units (i.e. the Department) include posting multi-lingual signs in waiting areas to explain that interpreters will be provided at no cost; using “I Speak” cards or a telephone language identification service to help identify the primary language of LEP participants at first contact; recording the primary language of each LEP individual served; providing interpretation services at no cost to the participant served; staff training; and monitoring of staff offices and contractors.

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 Health Care		
Statutory Service	Case Management		
Statutory Service	Specialized Respite		
Supports for Participant Direction	Financial Management Services		
Supports for Participant Direction	Participant Directed Coordination		
Other Service	Attendant Care		
Other Service	Environmental and Minor Home Adaptation		
Other Service	Goods and Services		
Other Service	Home and Community Supports		
Other Service	Home Delivered Meals		
Other Service	Non-Specialized Respite		

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:

Adult Day Health

Alternate Service Title (if any):

Adult Day Health Care

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04050 adult day health

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Adult day health care (ADHC) services must include basic and ancillary services for waiver participants who are twenty one (21) years or older. ADHC services are given in accordance with 902 KAR 20:066 operations and services; adult day health care centers. Basic services may include skilled nursing services, one or more meals per day but do not constitute a full nutritional regimen (i.e. three (3) full meals per day), snacks, RN supervision, regularly scheduled daily activities, crisis service, routine personal and healthcare needs and equipment essential to the provision of the ADHC services. All personal care needs that arise when a participant is receiving ADHC services should be addressed by ADHC staff, and are considered a component of the ADHC service.

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

Two hundred (200) units per week One unit equals fifteen (15) minutes.
This service cannot be billed concurrently with other services.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Health Care Center

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Health Care

Provider Category:

Agency

Provider Type:

Adult Day Health Care Center

Provider Qualifications

License (specify):

By OIG 902 KAR 20:066

Certificate (specify):

Certified by the Department or its designee

Other Standard (specify):

The agency must meet certified waiver provider qualifications as defined in 907 KAR 7:005 and 907 KAR 7:010.

Agency staff who come into direct contact with waiver participants must meet the following qualifications:

- Be at least eighteen (18) years of age.
- Complete Department-approved, waiver-specific training and is monitored for competency on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered thinking.
- Has the ability to:
 - o Communicate effectively with a participant and the participant’s family;
 - o Read, understand, and implement written and oral instructions;
 - o Perform required documentation;
 - o Participate as a member of the participant’s person-centered team if requested by the participant; and
 - o Demonstrate competence and knowledge of topics required to safely support the participant as described in the PCSP.
- Undergoes pre-employment screenings as described in C-2.a and b of this appendix.
- Is certified in CPR and First Aid.
- If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable State laws while operating the vehicle.

Verification of Provider Qualifications

Entity Responsible for Verification:

OIG

The Department or its designee

Frequency of Verification:

Initially and every two (2) years or more frequently if necessary

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

Sub-Category 1:

01010 case management

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Case management activities include assisting participants in gaining access to waiver services and other needed services through the Medicaid State Plan and other non-Medicaid funded community-based programs to support the participant's home and community-based needs.

Case management involves working with the participant, the participant's legal guardian, and/or their authorized representative and others who the participant identifies, such as immediate family member(s), in developing a PCSP. Using a person-centered planning process, case managers assist in identifying and implementing support strategies to enable the PCSP to advance the participant's identified goals while meeting assessed community-based needs, using waiver-funded and non-waiver funded services. Support strategies incorporate: the principles of empowerment, community inclusion, health and safety assurances, and the use of formal, informal, and community supports. Case managers adhere to person-centered principles during all planning, coordination, and monitoring activities.

Case managers work closely with the participant to assess the participant's needs, outcomes, services, available resources, and overall satisfaction with HCB services and processes. Case managers assure that participants have freedom of choice of providers in a conflict-free environment. Case management must be conflict-free and the case manager or its agency cannot provide other waiver services to the participant while also providing case management.

Case management activities include face-to-face, virtual, telephonic, and other methods of communication to provide coordination and oversight, which assure the following:

- Provision of education to support participant's service delivery model selection between traditional, PDS, and blended services;
- Conflict-free options counseling to select appropriate services to meet identified needs and HCBS goals, along with education about available HCBS service providers;
- The desires and needs of the participant are determined through a person-centered planning process;
- The development and/or review of the PCSP, including monitoring of the effectiveness of the PCSP to advance person-centered goals and objectives and respond to changes in participant goals and objectives;
- The coordination of multiple services and/or among multiple providers;
- Linking waiver participants to services that support their home and community-based needs;
- Monitoring the implementation of the PCSP, participant health and welfare, and corrective action plans (CAP);
- Addressing problems in service provision;
- Implementing participant crisis mitigation plans and making appropriate referrals to address active or potential crisis;
- Detecting, reporting, and mitigating suspected abuse, neglect, and exploitation of participants, including adherence to mandatory reporter laws, and monitoring the quality of the supports and services; and,
- Assisting participant in developing and coordinating access to social networks to promote community inclusion as requested by the participant.
- Assess the quality of services, safety of services, and cost effectiveness of services being provided to a participant in order to ensure that implementation of the participant's person-centered service plan is successful and done so in a way that is efficient regarding the participant's financial assets and benefits.

Activities are documented, and plans for supports and services are reviewed by the case manager at least annually and more often as needed using the person-centered planning processes described in Appendix D.

Case managers have a role in monitoring and assisting participants who choose to self-direct their services. Appendix E describes the waiver's participant self-direction program. Case Managers have the following responsibilities, in addition to those listed above in this definition:

- Facilitate self-assessment of participant's support needs related to employer authority;
- Arrange or provide necessary support to participants as identified in the self-assessment, to offer needed assistance to execute employer authority;
- Monitor the participant's execution of employer authority and document any identified risks, challenges, and outcomes;
- The development and/or review of the PCSP, including monitoring of the effectiveness of the PCSP to advance person-centered goals and objectives and respond to changes in participant goals and objectives;
- Support selection and provide on-going coordination between the participant and the chosen FMA; and,
- Monitoring of corrective action plans (CAP).

Financial management/Case Manager providers must retain case notes and billing records for each participant separately in order to create an audit trail for each function.

This service may be provided in person or virtually via telehealth. Telehealth services may be provided under specific circumstances as described in regulation. In person services must be provided whenever possible and at minimum at least every other month. Participation in services via telehealth should be wanted by the participant, person-centered, meaningful and advance established goals. Participants who are offered telehealth by the provider have the right to request in-person services instead. DMS will support individuals who need assistance with technology required for telehealth services through the case manager. Case managers will use the Person-Centered Service Plan to determine appropriate use of technology for the participant and when appropriate will connect participants with trainings. Based on the Person-Centered Service Plan, telehealth use will be driven by participant needs and desires. Participants may opt in or out of use of telehealth services.

Case management is open to any willing and qualified provider.

This service may be provided in person or virtually via telehealth. Telehealth services may be provided under specific circumstances as described in regulation. In person services must be provided whenever possible and at minimum at least every other month. Participation in services via telehealth should be wanted by the participant, person-centered, meaningful and advance established goals. Participants who are offered telehealth by the provider have the right to request in-person services instead. DMS will support individuals who need assistance with technology required for telehealth services through the case manager. Case managers will use the Person-Centered Service Plan to determine appropriate use of technology for the participant and when appropriate will connect participants with trainings. Based on the Person-Centered Service Plan, telehealth use will be driven by participant needs and desires. Participants may opt in or out of use of telehealth services.

Case management is open to any willing and qualified provider.

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

A participant is only allowed to have one case management entity at time. Case management is limited to one (1) unit per participant per provider per month.

The Department for Medicaid Services may approve additional units if deemed appropriate.

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	Public Health Department
Agency	Centers for Independent Living
Agency	Home Health Agency
Agency	Area Agency on Aging and Independent Living
Agency	Adult Day Health Care Center
Agency	Community Mental Health Center
Agency	Certified Waiver Provider

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:

Public Health Department

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Certified by the Department or its designee

Other Standard (*specify*):

A public health department must be recognized by the Department for Public Health pursuant to 902 KAR Chapter 8.

The agency must meet certified waiver provider qualifications as defined in 907 KAR 7:005 and 907 KAR 7:010.

Agency case management staff who come into direct contact with waiver participants must have been hired before November 11, 2023 or meet the following qualifications:

Bachelor's degree in Social Work/Human Services or related field; OR
Bachelor's degree in any field not closely related AND one year of human services related experience;
OR

An associate degree in a behavioral science, social science, or a closely related field AND two years human services related experience; OR

Three years of human services related experience

Relevant fields of study may include:

- o Social Work
- o Psychology
- o Rehabilitation
- o Nursing
- o Counseling
- o Education
- o Gerontology
- o Human Services
- o Sociology

Relevant experience may include:

- o Experience as a case manager or in a related human services field
- o Certified Nursing Assistant experience
- o Certified Medical Assistant experience
- o Certified Home Health Aide experience
- o Personal Care Assistant experience
- o Paid professional experience with aging and/or disabled populations or programs as a Case Manager, a Rehabilitation Specialist or Health Specialist, and/or Social Services Coordinator
- o Assessment and care planning experience with clients
- o Experience in working directly with persons with intellectual, developmental, or other types of disabilities or mental illness.
- o Work providing assistance to individuals and groups with issue such as economically disadvantaged, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, inadequate house

Be a registered nurse (RN) currently licensed in Kentucky as defined in KRS 314.011(5) who has at least two (2) years of experience as a professional nurse in the field of aging or disabilities; or a master's degree in a health or human services field from an accredited college or university.

Completes Department-approved, waiver-specific training and is monitored for competency on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered thinking.

Completes Department-approved case management training.

• Has the ability to:

- o Communicate effectively with a participant in the participant's preferred manner of communication and with the participant's family;
- o Read, understand, and implement written and oral instructions;
- o Perform required documentation;
- o Facilitate the participant's person-centered team; and
- o Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant's PCSP.

Undergoes pre-employment screenings as described in C-2.a and b of this appendix.

Is certified in CPR and First Aid.

If the employee provides transportation, the employee must be legally licensed to operate the

transporting vehicle and obeys all applicable State laws while operating the vehicle.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department or its designee

Frequency of Verification:

Initially and every two (2) years or more frequently if necessary

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:

Centers for Independent Living

Provider Qualifications

License (specify):

Certificate (specify):

Certified by the Department or its designee

Other Standard (specify):

The agency must meet certified waiver provider qualifications as defined in 907 KAR 7:005 and 907 KAR 7:010.

Agency case management staff who come into direct contact with waiver participants must have been hired before November 11, 2023 or meet the following qualifications:

Bachelor's degree in Social Work/Human Services or related field; OR

Bachelor's degree in any field not closely related AND one year of human services related experience; OR

An associate degree in a behavioral science, social science, or a closely related field AND two years human services related experience; OR

Three years of human services related experience

Relevant fields of study may include:

- o Social Work
- o Psychology
- o Rehabilitation
- o Nursing
- o Counseling
- o Education
- o Gerontology
- o Human Services
- o Sociology

Relevant experience may include:

- o Experience as a case manager or in a related human services field
- o Certified Nursing Assistant experience
- o Certified Medical Assistant experience
- o Certified Home Health Aide experience
- o Personal Care Assistant experience
- o Paid professional experience with aging and/or disabled populations or programs as a Case Manager, a Rehabilitation Specialist or Health Specialist, and/or Social Services Coordinator
- o Assessment and care planning experience with clients
- o Experience in working directly with persons with intellectual, developmental, or other types of disabilities or mental illness.
- o Work providing assistance to individuals and groups with issue such as economically disadvantaged, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, inadequate house

Be a registered nurse (RN) currently licensed in Kentucky as defined in KRS 314.011(5) who has at least two (2) years of experience as a professional nurse in the field of aging or disabilities; or a master's degree in a health or human services field from an accredited college or university.

Completes Department-approved, waiver-specific training and is monitored for competency on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered thinking.

Completes Department-approved case management training.

• Has the ability to:

- o Communicate effectively with a participant in the participant's preferred manner of communication and with the participant's family;
- o Read, understand, and implement written and oral instructions;
- o Perform required documentation;
- o Facilitate the participant's person-centered team; and
- o Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant's PCSP.

Undergoes pre-employment screenings as described in C-2.a and b of this appendix.

Is certified in CPR and First Aid.

If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable State laws while operating the vehicle.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department or its designee

Frequency of Verification:

Initially and every two (2) years or more frequently if necessary

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:

Home Health Agency

Provider Qualifications

License (specify):

By OIG 902 KAR 20:081

Certificate (specify):

Certified by the Department or its designee

Other Standard (specify):

The agency must meet certified waiver provider qualifications as defined in 907 KAR 7:005 and 907 KAR 7:010.

Agency case management staff who come into direct contact with waiver participants must have been hired before November 11, 2023 or meet the following qualifications:

Bachelor's degree in Social Work/Human Services or related field; OR

Bachelor's degree in any field not closely related AND one year of human services related experience; OR

An associate degree in a behavioral science, social science, or a closely related field AND two years human services related experience; OR

Three years of human services related experience

Relevant fields of study may include:

- o Social Work
- o Psychology
- o Rehabilitation
- o Nursing
- o Counseling
- o Education
- o Gerontology
- o Human Services
- o Sociology

Relevant experience may include:

- o Experience as a case manager or in a related human services field
- o Certified Nursing Assistant experience
- o Certified Medical Assistant experience
- o Certified Home Health Aide experience
- o Personal Care Assistant experience
- o Paid professional experience with aging and/or disabled populations or programs as a Case Manager, a Rehabilitation Specialist or Health Specialist, and/or Social Services Coordinator
- o Assessment and care planning experience with clients
- o Experience in working directly with persons with intellectual, developmental, or other types of disabilities or mental illness.
- o Work providing assistance to individuals and groups with issue such as economically disadvantaged, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, inadequate house

Be a registered nurse (RN) currently licensed in Kentucky as defined in KRS 314.011(5) who has at least two (2) years of experience as a professional nurse in the field of aging or disabilities; or a master's degree in a health or human services field from an accredited college or university.

Completes Department-approved, waiver-specific training and is monitored for competency on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered thinking.

Completes Department-approved case management training.

• Has the ability to:

- o Communicate effectively with a participant in the participant's preferred manner of communication and with the participant's family;
- o Read, understand, and implement written and oral instructions;
- o Perform required documentation;
- o Facilitate the participant's person-centered team; and
- o Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant's PCSP.

Undergoes pre-employment screenings as described in C-2.a and b of this appendix.

Is certified in CPR and First Aid.

If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable State laws while operating the vehicle.

Verification of Provider Qualifications

Entity Responsible for Verification:

OIG
The Department or its designee

Frequency of Verification:

Initially and every two (2) years or more frequently if necessary

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:

Area Agency on Aging and Independent Living

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Certified by the Department or its designee

Other Standard (*specify*):

The agency must meet certified waiver provider qualifications as defined in 907 KAR 7:005 and 907 KAR 7:010.

Agency case management staff who come into direct contact with waiver participants must have been hired before November 11, 2023 or meet the following qualifications:

Bachelor's degree in Social Work/Human Services or related field; OR

Bachelor's degree in any field not closely related AND one year of human services related experience; OR

An associate degree in a behavioral science, social science, or a closely related field AND two years human services related experience; OR

Three years of human services related experience

Relevant fields of study may include:

- o Social Work
- o Psychology
- o Rehabilitation
- o Nursing
- o Counseling
- o Education
- o Gerontology
- o Human Services
- o Sociology

Relevant experience may include:

- o Experience as a case manager or in a related human services field
- o Certified Nursing Assistant experience
- o Certified Medical Assistant experience
- o Certified Home Health Aide experience
- o Personal Care Assistant experience
- o Paid professional experience with aging and/or disabled populations or programs as a Case Manager, a Rehabilitation Specialist or Health Specialist, and/or Social Services Coordinator
- o Assessment and care planning experience with clients
- o Experience in working directly with persons with intellectual, developmental, or other types of disabilities or mental illness.
- o Work providing assistance to individuals and groups with issue such as economically disadvantaged, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, inadequate house

Be a registered nurse (RN) currently licensed in Kentucky as defined in KRS 314.011(5) who has at least two (2) years of experience as a professional nurse in the field of aging or disabilities; or a master's degree in a health or human services field from an accredited college or university.

Completes Department-approved, waiver-specific training and is monitored for competency on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered thinking.

Completes Department-approved case management training.

• Has the ability to:

- o Communicate effectively with a participant in the participant's preferred manner of communication and with the participant's family;
- o Read, understand, and implement written and oral instructions;
- o Perform required documentation;
- o Facilitate the participant's person-centered team; and
- o Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant's PCSP.

Undergoes pre-employment screenings as described in C-2.a and b of this appendix.

Is certified in CPR and First Aid.

If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable State laws while operating the vehicle.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department or its designee

Frequency of Verification:

Initially and every two (2) years or more frequently if necessary

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:

Adult Day Health Care Center

Provider Qualifications

License (specify):

By OIG 902 KAR 20:066

Certificate (specify):

Certified by the Department or its designee

Other Standard (specify):

The agency must meet certified waiver provider qualifications as defined in 907 KAR 7:005 and 907 KAR 7:010.

Agency case management staff who come into direct contact with waiver participants must have been hired before November 11, 2023 or meet the following qualifications:

Bachelor's degree in Social Work/Human Services or related field; OR

Bachelor's degree in any field not closely related AND one year of human services related experience; OR

An associate degree in a behavioral science, social science, or a closely related field AND two years human services related experience; OR

Three years of human services related experience

Relevant fields of study may include:

- o Social Work
- o Psychology
- o Rehabilitation
- o Nursing
- o Counseling
- o Education
- o Gerontology
- o Human Services
- o Sociology

Relevant experience may include:

- o Experience as a case manager or in a related human services field
- o Certified Nursing Assistant experience
- o Certified Medical Assistant experience
- o Certified Home Health Aide experience
- o Personal Care Assistant experience
- o Paid professional experience with aging and/or disabled populations or programs as a Case Manager, a Rehabilitation Specialist or Health Specialist, and/or Social Services Coordinator
- o Assessment and care planning experience with clients
- o Experience in working directly with persons with intellectual, developmental, or other types of disabilities or mental illness.
- o Work providing assistance to individuals and groups with issue such as economically disadvantaged, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, inadequate house

Be a registered nurse (RN) currently licensed in Kentucky as defined in KRS 314.011(5) who has at least two (2) years of experience as a professional nurse in the field of aging or disabilities; or a master's degree in a health or human services field from an accredited college or university.

Completes Department-approved, waiver-specific training and is monitored for competency on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered thinking.

Completes Department-approved case management training.

• Has the ability to:

- o Communicate effectively with a participant in the participant's preferred manner of communication and with the participant's family;
- o Read, understand, and implement written and oral instructions;
- o Perform required documentation;
- o Facilitate the participant's person-centered team; and
- o Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant's PCSP.

Undergoes pre-employment screenings as described in C-2.a and b of this appendix.

Is certified in CPR and First Aid.

If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable State laws while operating the vehicle.

Verification of Provider Qualifications

Entity Responsible for Verification:

OIG
The Department or its designee

Frequency of Verification:

Initially and every two (2) years or more frequently if necessary

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:

Community Mental Health Center

Provider Qualifications

License (specify):

By OIG 902 KAR 20:091

Certificate (specify):

Certified by the Department or its designee

Other Standard (specify):

The agency must meet certified waiver provider qualifications as defined in 907 KAR 7:005 and 907 KAR 7:010.

Agency case management staff who come into direct contact with waiver participants must have been hired before November 11, 2023 or meet the following qualifications:

Bachelor's degree in Social Work/Human Services or related field; OR

Bachelor's degree in any field not closely related AND one year of human services related experience; OR

An associate degree in a behavioral science, social science, or a closely related field AND two years human services related experience; OR

Three years of human services related experience

Relevant fields of study may include:

- o Social Work
- o Psychology
- o Rehabilitation
- o Nursing
- o Counseling
- o Education
- o Gerontology
- o Human Services
- o Sociology

Relevant experience may include:

- o Experience as a case manager or in a related human services field
- o Certified Nursing Assistant experience
- o Certified Medical Assistant experience
- o Certified Home Health Aide experience
- o Personal Care Assistant experience
- o Paid professional experience with aging and/or disabled populations or programs as a Case Manager, a Rehabilitation Specialist or Health Specialist, and/or Social Services Coordinator
- o Assessment and care planning experience with clients
- o Experience in working directly with persons with intellectual, developmental, or other types of disabilities or mental illness.
- o Work providing assistance to individuals and groups with issue such as economically disadvantaged, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, inadequate house

Be a registered nurse (RN) currently licensed in Kentucky as defined in KRS 314.011(5) who has at least two (2) years of experience as a professional nurse in the field of aging or disabilities; or a master's degree in a health or human services field from an accredited college or university.

Completes Department-approved, waiver-specific training and is monitored for competency on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered thinking.

Completes Department-approved case management training.

• Has the ability to:

- o Communicate effectively with a participant in the participant's preferred manner of communication and with the participant's family;
- o Read, understand, and implement written and oral instructions;
- o Perform required documentation;
- o Facilitate the participant's person-centered team; and
- o Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant's PCSP.

Undergoes pre-employment screenings as described in C-2.a and b of this appendix.

Is certified in CPR and First Aid.

If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable State laws while operating the vehicle.

Verification of Provider Qualifications

Entity Responsible for Verification:

OIG
The Department or its designee

Frequency of Verification:

Initially and every two (2) years or more frequently if necessary

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:

Certified Waiver Provider

Provider Qualifications

License (specify):

Certificate (specify):

The Department or its designee

Other Standard (specify):

The agency must meet certified waiver provider qualifications as defined in 907 KAR 7:005 and 907 KAR 7:010.

Agency case management staff who come into direct contact with waiver participants must have been hired before November 11, 2023 or meet the following qualifications:

Bachelor's degree in Social Work/Human Services or related field; OR

Bachelor's degree in any field not closely related AND one year of human services related experience; OR

An associate degree in a behavioral science, social science, or a closely related field AND two years human services related experience; OR

Three years of human services related experience

Relevant fields of study may include:

- o Social Work
- o Psychology
- o Rehabilitation
- o Nursing
- o Counseling
- o Education
- o Gerontology
- o Human Services
- o Sociology

Relevant experience may include:

- o Experience as a case manager or in a related human services field
- o Certified Nursing Assistant experience
- o Certified Medical Assistant experience
- o Certified Home Health Aide experience
- o Personal Care Assistant experience
- o Paid professional experience with aging and/or disabled populations or programs as a Case Manager, a Rehabilitation Specialist or Health Specialist, and/or Social Services Coordinator
- o Assessment and care planning experience with clients
- o Experience in working directly with persons with intellectual, developmental, or other types of disabilities or mental illness.
- o Work providing assistance to individuals and groups with issue such as economically disadvantaged, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, inadequate house

Be a registered nurse (RN) currently licensed in Kentucky as defined in KRS 314.011(5) who has at least two (2) years of experience as a professional nurse in the field of aging or disabilities; or a master's degree in a health or human services field from an accredited college or university.

Completes Department-approved, waiver-specific training and is monitored for competency on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered thinking.

Completes Department-approved case management training.

• Has the ability to:

- o Communicate effectively with a participant in the participant's preferred manner of communication and with the participant's family;
- o Read, understand, and implement written and oral instructions;
- o Perform required documentation;
- o Facilitate the participant's person-centered team; and
- o Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant's PCSP.

Undergoes pre-employment screenings as described in C-2.a and b of this appendix.

Is certified in CPR and First Aid.

If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable State laws while operating the vehicle.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department or its designee

Frequency of Verification:

Initially and every two (2) years 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):

Specialized Respite

HCBS Taxonomy:

Category 1:

09 Caregiver Support

Sub-Category 1:

09012 respite, in-home

Category 2:

09 Caregiver Support

Sub-Category 2:

09011 respite, out-of-home

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Specialized Respite services are defined as short-term care which is provided to a waiver participant due to the need for relief of the primary caregiver or the sudden absence or illness of the primary caregiver who normally provides care for the participant.

Specialized Respite direct care staff must have 24-hour access to an RN for consultation and emergency situations.

Services must be provided at a level to appropriately and safely meet the support needs of the waiver participant and that the Specialized Respite provider has the appropriate training and qualifications. Specialized Respite care services shall be required to be of a skill level beyond normal babysitting.

Specialized Respite can be provided in conjunction with participant-directed respite but not at the same time.

Specialized Respite services shall only be provided by licensed home health agencies or adult day health care agencies and can be provided in the following locations:

- (a) The home of the participant or
- (b) An adult day health care center licensed by the state of Kentucky
- (c) Combination of home and adult day health care center

Specialized Respite services shall be prior authorized.

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

42 units per day alone or in combination with non-specialized respite. Specialized respite alone or in combination with non-specialized respite shall not exceed 1000 units per plan of care year. Respite cannot be billed concurrently with other services.

Specialized Respite services must be approved by the Department or its designee prior to service delivery.

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	Adult Day Health Care Center
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Specialized Respite

Provider Category:

Agency

Provider Type:

Adult Day Health Care Center

Provider Qualifications

License (specify):

By OIG 902 KAR 20:066

Certificate (specify):

Certified by the Department or its designee

Other Standard (specify):

The agency must meet certified waiver provider qualifications as defined in 907 KAR 7:005 and 907 KAR 7:010.

Agency staff who come into direct contact with waiver participants must meet the following qualifications:

- Completes Department-approved, waiver-specific training and is monitored for competency on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered thinking.
- Has the ability to:
 - o Communicate effectively with a participant in the participant’s preferred manner of communication and with the participant’s family;
 - o Read, understand, and implement written and oral instructions;
 - o Perform required documentation;
 - o Participate as a member of the participant’s person-centered team if requested by the participant; and
 - o Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant’s PCSP.
- Undergoes pre-employment screenings as described in C-2.a and b of this appendix.
- Is certified in CPR and First Aid.
- If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable State laws while operating the vehicle.

Verification of Provider Qualifications

Entity Responsible for Verification:

OIG
The Department or its designee

Frequency of Verification:

Initially and every two (2) years or more frequently if necessary

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Specialized Respite

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License (specify):

By OIG 902 KAR 20:081

Certificate *(specify):*

Certified by the Department or its designee

Other Standard *(specify):*

The agency must meet certified waiver provider qualifications as defined in 907 KAR 7:005 and 907 KAR 7:010.

Agency staff who come into direct contact with waiver participants must meet the following qualifications:

- Completes Department-approved, waiver-specific training and is monitored for competency on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered thinking.
- Has the ability to:
 - o Communicate effectively with a participant in the participant’s preferred manner of communication and with the participant’s family;
 - o Read, understand, and implement written and oral instructions;
 - o Perform required documentation;
 - o Participate as a member of the participant’s person-centered team if requested by the participant; and
 - o Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant’s PCSP.
- Undergoes pre-employment screenings as described in C-2.a and b of this appendix.
- Is certified in CPR and First Aid.
- If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable State laws while operating the vehicle.

Verification of Provider Qualifications

Entity Responsible for Verification:

OIG

The Department or its designee

Frequency of Verification:

Initially and every two (2) years 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

Sub-Category 1:

12020 information and assistance in support of self-direction

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Management and direction of funds in the participant's approved person-centered service plan. The provider shall perform the employer responsibilities of payroll processing which includes issuance of paychecks, withholding federal, state and local tax, making tax payments to the appropriate tax authorities, and issuance of W-2 forms. The provider shall be responsible for performing all fiscal accounting procedures including issuance of expenditure reports to the participant, their representative, the case manager and the Department for Medicaid Services. The provider shall maintain a separate account for each participant while continually tracking and reporting funds, disbursements and the service limits used. The provider shall process and pay for invoices for all participant-directed services approved in the participant's person-centered service plan. FMS is a required service for participants that elect to direct any service.

Financial Management Service is open to all willing and qualified providers.

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

Fiscal Management is defined as a monthly unit and limited to one (1) unit per participant per calendar month. Financial management services are limited to participants who opt to participant direct some or all of their non-medical services and apply only to participant-directed services.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Approved Waiver Provider
Agency	Area Development District
Agency	Community Mental Health Center

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:

Approved Waiver Provider

Provider Qualifications

License (*specify*):

Certificate (*specify*):

The Department or its designee

Other Standard (*specify*):

The agency must meet certified waiver provider qualifications as defined in 907 KAR 7:005 and 907 KAR 3:210.

Agency staff who come into direct contact with waiver participants must meet the following qualifications:

- Be at least eighteen (18) years of age.
- Have a high school diploma or GED.
- Has at least one (1) year experience with fiscal accounting, tax withholding, and/or expenditure reports

Complete Department-approved, waiver-specific training and is monitored for competency on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma informed care, and person-centered thinking.

Has the ability to:

- Communicate effectively with a participant and the participant’s family;
- Read, understand, and implement written and oral instructions;
- Perform required documentation;
- Participate as a member of the participant’s person-centered team if requested by the participant; and
- Demonstrate competence and knowledge of topics required to safely support the participant as described in the PCSP.

Undergoes pre-employment screenings as described in C-2.a and b of this appendix.

Is certified in CPR and First Aid.

If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable State laws while operating the vehicle.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department or its designee

Frequency of Verification:

Initially and annually or more frequently if necessary

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction

Service Name: Financial Management Services

Provider Category:

Agency

Provider Type:

Area Development District

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified by the Department or its designee

Other Standard *(specify):*

Area Development Districts are quasi-governmental agencies operating throughout the Commonwealth of Kentucky. These organizations were established by state law, specifying the manner of governance, organization, staffing and areas of responsibility
 KRS 147A.050 to 147A.110 Area Development Districts
 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.

All standards are identified in program regulations and services manual.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department or its designee

Frequency of Verification:

Initially and every two (2) years or more frequently if necessary

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:

Community Mental Health Center

Provider Qualifications

License *(specify):*

By OIG 902 KAR 20:091

Certificate *(specify):*

Certified by the Department or its designee

Other Standard *(specify):*

Community Mental Health Centers are quasi-governmental agencies operating throughout the Commonwealth of Kentucky. These organizations were established by state law, specifying the manner of governance, organization, staffing and areas of responsibility
 KRS 210.370 to 210.480 CMHCs
 CMHCs 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.
 All standards are identified in program regulations and services manual.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department or its designee

Frequency of Verification:

Initially and every two (2) years 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:

Other Supports for Participant Direction

Alternate Service Title (if any):

Participant Directed Coordination

HCBS Taxonomy:

Category 1:

Sub-Category 1:

12 Services Supporting Self-Direction

12020 information and assistance in support of self-direction

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Effective 5-1-24, this service will be removed from the waiver. Effective 5/1/24, the services included in PDC will be available through case management and financial management services.

Participant Directed Coordination (PDC) activities include assisting participants in gaining access to waiver services and other needed services through the Medicaid State Plan and other non-Medicaid funded community-based programs to support the participant's home and community-based needs.

The PDC, known as a service advisor, works with the participant, the participant's legal guardian, and/or their authorized representative and others who the participant identifies, such as immediate family member(s), in developing a PCSP. Using a person-centered planning process, service advisors assist in identifying and implementing support strategies to enable the PCSP to advance the participant's identified goals while meeting assessed community-based needs, using waiver-funded and non-waiver funded services. Support strategies incorporate: the principles of empowerment, community inclusion, health and safety assurances, and the use of formal, informal, and community supports. PDC adheres to person-centered principles during all planning, coordination, and monitoring activities.

PDC works closely with the participant to assess his or her ongoing expectations and satisfaction with their lives in the community, the processes and outcomes of supports, services, and available resources. PDC assures that participants have freedom of choice of providers in a conflict-free environment. PDC must be conflict-free and the PDC or its agency cannot provide other waiver services to the participant while also providing PDC.

Conflict-free case management requires that a provider who renders PDC to a participant must not also provide another waiver service to that same participant unless the service advisor is the only willing and qualified provider in the geographical area (30 miles from the participant's residence). When one entity is responsible for providing PDC and service delivery, the Department will require that appropriate safeguards and firewalls must exist to mitigate risk of potential conflict.

PDC activities include face-to-face, telephonic, and other methods of communication to provide coordination and oversight, which assure the following:

- Provision of education to support participant's service delivery model selection between traditional PDS, and blended services;
- Conflict-free options counseling to select appropriate services to meet identified needs and HCBS goals, along with education about available HCBS service providers;
- The facilitation of participant-driven PDS Employer Responsibilities Review Tool and PCSP development;
- The desires and needs of the participant are determined through a person-centered planning process;
- The development and/or review of the PCSP, including monitoring of the effectiveness of the PCSP to advance person-centered goals and objectives and respond to changes in participant goals and objectives;
- The coordination of multiple services and/or among multiple providers;
- Linking waiver participants to services that support their home and community-based needs;
- Monitoring the implementation of the PCSP, participant health and welfare, and corrective action plans (CAP);
- Addressing problems in service provision;
- Implementing participant crisis mitigation plans and making appropriate referrals to address active or potential crisis;
- Detecting, reporting, and mitigating suspected abuse, neglect, and exploitation of participants, including adherence to mandatory reporter laws, and monitoring the quality of the supports and services; and
- Assisting participant in developing and coordinating access to social networks to promote community inclusion as requested by the participant.

This service may be provided in person or virtually via telehealth. Telehealth services may be provided under specific circumstances as described in regulation. In person services must be provided whenever possible and at minimum at least every other month. Participation in services via telehealth should be wanted by the participant, person-centered, meaningful and advance established goals. Participants who are offered telehealth by the provider have the right to request in-person services instead.

Activities are documented, and plans for supports and services are reviewed by the service advisor at least annually and more often as needed using the person-centered planning processes described in Appendix D. Service advisors have a role in monitoring and assisting participants who choose to self-direct their services.

Appendix E describes the waiver's participant self-direction program. Financial Management Services (FMS) are required for participants that elect the participant-directed services model. FMS PDC 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 participant, their legal guardian/authorized representative, the service advisor and the Department for Medicaid Services. The provider shall maintain a separate account for each participant while continually tracking and reporting funds, disbursements and service limits used. The provider shall process and pay invoices for goods and services approved in the participant's PCSP.

PDC providers must retain case notes and billing records for each participant separately in order to create an audit trail for each function.

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

Two (2) units per month, 1 unit is for PDC and 1 unit is for FMS services.

The Department for Medicaid Services may approve additional units if deemed appropriate.

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	Center for Independent Living
Agency	Area Agencies on Aging

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction

Service Name: Participant Directed Coordination

Provider Category:

Agency

Provider Type:

Center for Independent Living

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified by the Department or its designee

Other Standard *(specify):*

Center for Independent Living as defined in Title VII of the Rehabilitation Act of 1973 which establishes the creation of Centers for Independent Living.

To provide Medicaid waiver services, Centers for Independent Living 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.

A public health department must be recognized by the Department for Public Health pursuant to 902 KAR Chapter 8.

The agency must meet certified waiver provider qualifications as defined in 907 KAR 7:005 and 907 KAR 7:010.

Agency case management staff who come into direct contact with waiver participants must have been hired before November 11, 2023 or meet the following qualifications:

Bachelor's degree in Social Work/Human Services or related field; OR

Bachelor's degree in any field not closely related AND one year of human services related experience; OR

An associate degree in a behavioral science, social science, or a closely related field AND two years human services related experience; OR

Three years of human services related experience

Relevant fields of study may include:

- o Social Work
- o Psychology
- o Rehabilitation
- o Nursing
- o Counseling
- o Education
- o Gerontology
- o Human Services
- o Sociology

Relevant experience may include:

- o Experience as a case manager or in a related human services field
- o Certified Nursing Assistant experience
- o Certified Medical Assistant experience
- o Certified Home Health Aide experience
- o Personal Care Assistant experience
- o Paid professional experience with aging and/or disabled populations or programs as a Case Manager, a Rehabilitation Specialist or Health Specialist, and/or Social Services Coordinator
- o Assessment and care planning experience with clients
- o Experience in working directly with persons with intellectual, developmental, or other types of disabilities or mental illness.
- o Work providing assistance to individuals and groups with issue such as economically disadvantaged, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, inadequate house

Be a registered nurse (RN) currently licensed in Kentucky as defined in KRS 314.011(5) who has at least two (2) years of experience as a professional nurse in the field of aging or disabilities; or a master's degree in a health or human services field from an accredited college or university.

Completes Department-approved, waiver-specific training and is monitored for competency on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered thinking.

Completes Department-approved case management training.

• Has the ability to:

- o Communicate effectively with a participant in the participant's preferred manner of communication and with the participant's family;

- o Read, understand, and implement written and oral instructions;
 - o Perform required documentation;
 - o Facilitate the participant’s person-centered team; and
 - o Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant’s PCSP.
- Undergoes pre-employment screenings as described in C-2.a and b of this appendix.
 Is certified in CPR and First Aid.
 If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable State laws while operating the vehicle.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department or its designee

Frequency of Verification:

Initially and every two (2) years or more frequently if necessary

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction

Service Name: Participant Directed Coordination

Provider Category:

Agency

Provider Type:

Area Agencies on Aging

Provider Qualifications

License (specify):

Certificate (specify):

Certified by the Department or its designee

Other Standard (specify):

Area Agencies on Aging 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 CMHCs; and KRS 147A.050 to 147A.110 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. Area Agencies on Aging must meet all standards identified in program regulations and services manuals.

A public health department must be recognized by the Department for Public Health pursuant to 902 KAR Chapter 8.

The agency must meet certified waiver provider qualifications as defined in 907 KAR 7:005 and 907 KAR 7:010.

Agency case management staff who come into direct contact with waiver participants must have been hired before November 11, 2023 or meet the following qualifications:

Bachelor's degree in Social Work/Human Services or related field; OR
Bachelor's degree in any field not closely related AND one year of human services related experience;
OR

An associate degree in a behavioral science, social science, or a closely related field AND two years human services related experience; OR

Three years of human services related experience

Relevant fields of study may include:

- o Social Work
- o Psychology
- o Rehabilitation
- o Nursing
- o Counseling
- o Education
- o Gerontology
- o Human Services
- o Sociology

Relevant experience may include:

- o Experience as a case manager or in a related human services field
- o Certified Nursing Assistant experience
- o Certified Medical Assistant experience
- o Certified Home Health Aide experience
- o Personal Care Assistant experience
- o Paid professional experience with aging and/or disabled populations or programs as a Case Manager, a Rehabilitation Specialist or Health Specialist, and/or Social Services Coordinator
- o Assessment and care planning experience with clients
- o Experience in working directly with persons with intellectual, developmental, or other types of disabilities or mental illness.
- o Work providing assistance to individuals and groups with issue such as economically disadvantaged, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, inadequate house

Be a registered nurse (RN) currently licensed in Kentucky as defined in KRS 314.011(5) who has at least two (2) years of experience as a professional nurse in the field of aging or disabilities; or a master's degree in a health or human services field from an accredited college or university.

Completes Department-approved, waiver-specific training and is monitored for competency on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered thinking.

Completes Department-approved case management training.

- Has the ability to:
 - o Communicate effectively with a participant in the participant’s preferred manner of communication and with the participant’s family;
 - o Read, understand, and implement written and oral instructions;
 - o Perform required documentation;
 - o Facilitate the participant’s person-centered team; and
 - o Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant’s PCSP.

Undergoes pre-employment screenings as described in C-2.a and b of this appendix.
 Is certified in CPR and First Aid.
 If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable State laws while operating the vehicle.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department or its designee

Frequency of Verification:

Initially and every two (2) years 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:

Other Service

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

Service Title:

Attendant Care

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08030 personal care

Category 2:

08 Home-Based Services

Sub-Category 2:

08040 companion

Category 3:

08 Home-Based Services

Sub-Category 3:

08050 homemaker

Category 4:

Sub-Category 4:

Service Definition (Code):

15 Non-Medical Transportation

15010 non-medical transportation

Attendant care services enable waiver participants to accomplish tasks that they normally would do for themselves if they did not have a disability. The need for assistance must be directly related to the participant’s disability, medical condition or advanced age and exceed that of his or her age matched peers. This assistance may include hands-on assistance (actually performing a task for the person), reminding, observing, guiding, and/or training a waiver participant in ADLs (such as bathing, dressing, toileting, transferring, maintaining continence) and IADLs (more complex life activities such as personal hygiene, light housework, laundry, meal planning and preparation, transportation, grocery shopping, using the telephone, money management, and medication administration). This service may also include assisting the waiver participant in managing his/her medical care including making medical appointments and accompanying the waiver participant during medical appointments. Transportation to access community services, activities and appointments shall not duplicate Medicaid state Plan transportation services. Services take place in the waiver participant’s home, and in the community as appropriate to the individual’s need. Attendant care services are available only to a waiver participant who lives in his /her own residence or in his/her family residence.

Attendant care services are not available to individuals under the age of 21 when medically necessary personal assistance services are covered by EPSDT, if available. These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. Services may not supplant educational services available under the IDEA (20 U.S.C. 1401 et seq.).

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

Forty-five (45) hours per week alone or in combination with ADHC services; or
 Maximum of \$200 per day alone or in combination with ADHC services;
 Travel to and from the participant’s residence shall be excluded.

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	Home Health Agency
Agency	Area Agencies on Aging and Independent Living
Agency	Centers for Independent Living
Agency	Adult Day Health Care
Agency	DMS Certified Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Attendant Care

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

By OIG 902 KAR 20:081

Certificate *(specify):*

Certified by the Department or its designee

Other Standard *(specify):*

The agency must meet certified waiver provider qualifications as defined in 907 KAR 7:005 and 907 KAR 7:010.
 Agency staff who come into direct contact with waiver participants must meet the following qualifications:

- Be at least eighteen (18) years of age.
- Completes Department-approved, waiver-specific training and is monitored for competency on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered thinking.
- Has the ability to:
 - o Communicate effectively with a participant in the participant’s preferred manner of communication and with the participant’s family;
 - o Read, understand, and implement written and oral instructions;
 - o Perform required documentation;
 - o Participate as a member of the participant’s person-centered team if requested by the participant; and
 - o Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant’s PCSP.
- Undergoes pre-employment screenings as described in C-2.a and b of this appendix.
- Is certified in CPR and First Aid
- If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable State laws while operating the vehicle.

Verification of Provider Qualifications

Entity Responsible for Verification:

OIG
 The Department or its designee

Frequency of Verification:

Initially and every two (2) years or more frequently if necessary

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Attendant Care

Provider Category:

Agency

Provider Type:

Area Agencies on Aging and Independent Living

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

The agency must meet certified waiver provider qualifications as defined in 907 KAR 7:005 and 907 KAR 7:010.

Agency staff who come into direct contact with waiver participants must meet the following qualifications:

- Be at least eighteen (18) years of age.
- Completes Department-approved, waiver-specific training and is monitored for competency on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered thinking.
- Has the ability to:
 - o Communicate effectively with a participant in the participant’s preferred manner of communication and with the participant’s family;
 - o Read, understand, and implement written and oral instructions;
 - o Perform required documentation;
 - o Participate as a member of the participant’s person-centered team if requested by the participant; and
 - o Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant’s PCSP.
- Undergoes pre-employment screenings as described in C-2.a and b of this appendix.
- Is certified in CPR and First Aid
- If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable State laws while operating the vehicle.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department or its designee

Frequency of Verification:

Initially and every two (2) years or more frequently if necessary

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Attendant Care

Provider Category:

Agency

Provider Type:

Centers for Independent Living

Provider Qualifications

License (specify):

[Empty box]

Certificate (specify):

Certified by the Department or its designee

Other Standard (specify):

Center for Independent Living as defined in Title VII of the Rehabilitation Act of 1973 which establishes the creation of Centers for Independent Living.

The agency must meet certified waiver provider qualifications as defined in 907 KAR 7:005 and 907 KAR 7:010.

Agency staff who come into direct contact with waiver participants must meet the following qualifications:

- Be at least eighteen (18) years of age.
- Completes Department-approved, waiver-specific training and is monitored for competency on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered thinking.
- Has the ability to:
 - o Communicate effectively with a participant in the participant’s preferred manner of communication and with the participant’s family;
 - o Read, understand, and implement written and oral instructions;
 - o Perform required documentation;
 - o Participate as a member of the participant’s person-centered team if requested by the participant; and
 - o Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant’s PCSP.
- Undergoes pre-employment screenings as described in C-2.a and b of this appendix.
- Is certified in CPR and First Aid.
- If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable State laws while operating the vehicle.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department or its designee

Frequency of Verification:

Initially and every two (2) years or more frequently if necessary

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Attendant Care

Provider Category:

Agency

Provider Type:

Adult Day Health Care

Provider Qualifications

License (specify):

by

Certificate (*specify*):

Other Standard (*specify*):

The agency must meet certified waiver provider qualifications as defined in 907 KAR 7:005 and 907 KAR 7:010.

Agency staff who come into direct contact with waiver participants must meet the following qualifications:

- Be at least eighteen (18) years of age.
- Completes Department-approved, waiver-specific training and is monitored for competency on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered thinking.
- Has the ability to:
 - o Communicate effectively with a participant in the participant’s preferred manner of communication and with the participant’s family;
 - o Read, understand, and implement written and oral instructions;
 - o Perform required documentation;
 - o Participate as a member of the participant’s person-centered team if requested by the participant; and
 - o Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant’s PCSP.
- Undergoes pre-employment screenings as described in C-2.a and b of this appendix.
- Is certified in CPR and First Aid.
- If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable State laws while operating the vehicle.

Verification of Provider Qualifications

Entity Responsible for Verification:

Frequency of Verification:

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Attendant Care

Provider Category:

Provider Type:

Provider Qualifications

License (*specify*):

Certificate (specify):

To be defined in Kentucky Administrative Regulation

Other Standard (specify):

The agency must meet certified waiver provider qualifications as defined in 907 KAR 7:005 and 907 KAR 7:010.
 Agency staff who come into direct contact with waiver participants must meet the following qualifications:

Meets all DMS standards for a waiver provider agency and employs staff with following qualifications (Note: Upon Approval, DMS will modify existing HCB Kentucky Administrative Regulation to include provider certification language in alignment with existing regulatory requirements for Personal Care service providers in other waiver programs):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department or its designee

Frequency of Verification:

Initially and every two (2) years 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:

Other Service

As provided in 42 CFR Â§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 Adaptation

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14020 home and/or vehicle accessibility adaptations

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Structural and/or permanent environmental and minor home modifications are only for the privately-owned residence of the participant or the participant’s family-owned home in which he/she resides. Physical adaptations to the home, required by the participant’s PCSP, are necessary to ensure the health, safety, and welfare of the participant, or to enable the participant to function with greater independence in the home, without which, the participant would be at risk for institutionalization.

Such adaptations may include the installation of ramps and grab bars, widening of doorways, modification of bathroom facilities for accessibility, or installation of specialized electric and plumbing systems, which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the participant.

This service excludes adaptations or improvements to the home which are of general utility and are not of direct medical or remedial benefit to the participant, such as roof repair, central air conditioning/heating, 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. This service will not include repair of previous damage, routine home maintenance, cosmetic improvements, or unnecessary repairs.

The case management / PDC must ensure the adaptations are completed by an agency that is licensed to provide these services, is a registered business, and is in good standing with the Kentucky Secretary of State.

These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

\$3,025 per LOC year

Environmental and minor home modification services must be approved by the Department or its designee prior to service delivery.

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	Public Health Department
Agency	Centers for Independent Living
Agency	Home Health Agency
Agency	Area Agency on Aging and Independent Living
Agency	Adult Day Health Care Center

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Environmental and Minor Home Adaptation

Provider Category:

Agency

Provider Type:

Public Health Department

Provider Qualifications

License (specify):

Certified by the Department or its designee

Certificate (specify):

Other Standard (specify):

A public health department must be recognized by the Department for Public Health pursuant to 902 KAR Chapter 8.

The agency must meet certified waiver provider qualifications as defined in 907 KAR 7:005 and 907 KAR 7:010.

Agency case management staff who come into direct contact with waiver participants must meet the following qualifications:

- Have a bachelor’s degree in a health or human services field from an accredited college or university; and
- at least one (1) year of experience in a health or human services field; or
- The educational or experiential equivalent in the field of aging or disabilities; or
- Be a registered nurse (RN) currently licensed in Kentucky as defined in KRS 314.011(5) who has at least two (2) years of experience as a professional nurse in the field of aging or disabilities; or
- A master’s degree in a health or human services field from an accredited college or university.
- Completes Department-approved, waiver-specific training and is monitored for competency on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered thinking.
- Completes Department-approved case management training.
- Has the ability to:
 - o Communicate effectively with a participant in the participant’s preferred manner of communication and with the participant’s family;
 - o Read, understand, and implement written and oral instructions;
 - o Perform required documentation;
 - o Facilitate the participant’s person-centered team; and
 - o Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant’s PCSP.
- Undergoes pre-employment screenings as described in C-2.a and b of this appendix.
- Is certified in CPR and First Aid.
- If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable State laws while operating the vehicle.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department or its designee

Frequency of Verification:

Initially and every two (2) years or more frequently if necessary

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Environmental and Minor Home Adaptation

Provider Category:

Agency

Provider Type:

Centers for Independent Living

Provider Qualifications

License (specify):

[Empty box]

Certificate (specify):

Certified by the Department or its designee

Other Standard (specify):

Center for Independent Living as defined in Title VII of the Rehabilitation Act of 1973 which establishes the creation of Centers for Independent Living.

The agency must meet certified waiver provider qualifications as defined in 907 KAR 7:005 and 907 KAR 7:010.

Agency case management staff who come into direct contact with waiver participants must meet the following qualifications:

- Have a bachelor’s degree in a health or human services field from an accredited college or university; and
- At least one (1) year of experience in a health or human services field; or
- The educational or experiential equivalent in the field of aging or disabilities; or
- Be a registered nurse (RN) currently licensed in Kentucky as defined in KRS 314.011(5) who has at least two (2) years of experience as a professional nurse in the field of aging or disabilities; or
- A master’s degree in a health or human services field from an accredited college or university.
- Completes Department-approved, waiver-specific training and is monitored for competency on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered thinking.
- Completes Department-approved case management training.
- Has the ability to:
 - o Communicate effectively with a participant in the participant’s preferred manner of communication and with the participant’s family;
 - o Read, understand, and implement written and oral instructions;
 - o Perform required documentation;
 - o Facilitate the participant’s person-centered team; and
 - o Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant’s PCSP.
- Undergoes pre-employment screenings as described in C-2.a and b of this appendix.
- Is certified in CPR and First Aid.
- If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable State laws while operating the vehicle.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department or its designee

Frequency of Verification:

Initially and every two (2) years or more frequently if necessary

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Environmental and Minor Home Adaptation

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications**License** (*specify*):

By OIG 902 KAR 20:081

Certificate (*specify*):

Certified by the Department or its designee

Other Standard (*specify*):

The agency must meet certified waiver provider qualifications as defined in 907 KAR 7:005 and 907 KAR 7:010.

Agency case management staff who come into direct contact with waiver participants must meet the following qualifications:

- Have a bachelor's degree in a health or human services field from an accredited college or university; and
- at least one (1) year of experience in a health or human services field; or
- The educational or experiential equivalent in the field of aging or disabilities; or
- Be a registered nurse (RN) currently licensed in Kentucky as defined in KRS 314.011(5) who has at least two (2) years of experience as a professional nurse in the field of aging or disabilities; or
- A master's degree in a health or human services field from an accredited college or university.
- Completes Department-approved, waiver-specific training and is monitored for competency on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered thinking.
- Completes Department-approved case management training.
- Has the ability to:
 - o Communicate effectively with a participant in the participant's preferred manner of communication and with the participant's family;
 - o Read, understand, and implement written and oral instructions;
 - o Perform required documentation;
 - o Facilitate the participant's person-centered team; and
 - o Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant's PCSP.
- Undergoes pre-employment screenings as described in C-2.a and b of this appendix.
- Is certified in CPR and First Aid.
- If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable State laws while operating the vehicle.

Verification of Provider Qualifications**Entity Responsible for Verification:**

OIG
The Department or its designee

Frequency of Verification:

Initially and every two (2) years or more frequently if necessary

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Environmental and Minor Home Adaptation

Provider Category:

Agency

Provider Type:

Area Agency on Aging and Independent Living

Provider Qualifications

License (specify):

Certificate (specify):

Certified by the Department or its designee

Other Standard (specify):

Area Agencies on Aging 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 CMHCs; and KRS 147A.050 to 147A.110 Area Development Districts.) Both CMHCs and Area Development Districts have a designated region within the State to which their services are mandated and limited.

The agency must meet certified waiver provider qualifications as defined in 907 KAR 7:005 and 907 KAR 7:010.

Agency case management staff who come into direct contact with waiver participants must meet the following qualifications:

- Have a bachelor’s degree in a health or human services field from an accredited college or university; and
- At least one (1) year of experience in a health or human services field; or
- The educational or experiential equivalent in the field of aging or disabilities; OR
- Be a registered nurse (RN) currently licensed in Kentucky as defined in KRS 314.011(5) who has at least two (2) years of experience as a professional nurse in the field of aging or disabilities; or
- a master’s degree in a health or human services field from an accredited college or university.
- Completes Department-approved, waiver-specific training and is monitored for competency on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered thinking.
- Completes Department-approved case management training.
- Has the ability to:
 - o Communicate effectively with a participant in the participant’s preferred manner of communication and with the participant’s family;
 - o Read, understand, and implement written and oral instructions;
 - o Perform required documentation;
 - o Facilitate the participant’s person-centered team; and
 - o Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant’s PCSP.
- Undergoes pre-employment screenings as described in C-2.a and b of this appendix.
- Is certified in CPR and First Aid.
- If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable State laws while operating the vehicle.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department or its designee

Frequency of Verification:

Initially and every two (2) years or more frequently if necessary

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Environmental and Minor Home Adaptation

Provider Category:

Agency

Provider Type:

Adult Day Health Care Center

Provider Qualifications

License (specify):

By OIG 902 KAR 20:066

Certificate (specify):

Certified by the Department or its designee

Other Standard (specify):

The agency must meet certified waiver provider qualifications as defined in 907 KAR 7:005 and 907 KAR 7:010.

Agency case management staff who come into direct contact with waiver participants must meet the following qualifications:

- Have a bachelor’s degree in a health or human services field from an accredited college or university; and
- At least one (1) year of experience in a health or human services field; or
- The educational or experiential equivalent in the field of aging or disabilities; OR
- Be a registered nurse (RN) currently licensed in Kentucky as defined in KRS 314.011(5) who has at least two (2) years of experience as a professional nurse in the field of aging or disabilities; or
- a master’s degree in a health or human services field from an accredited college or university.
- Completes Department-approved, waiver-specific training and is monitored for competency on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered thinking.
- Completes Department-approved case management training.
- Has the ability to:
 - o Communicate effectively with a participant in the participant’s preferred manner of communication and with the participant’s family;
 - o Read, understand, and implement written and oral instructions;
 - o Perform required documentation;
 - o Facilitate the participant’s person-centered team; and
 - o Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant’s PCSP.
- Undergoes pre-employment screenings as described in C-2.a and b of this appendix.
- Is certified in CPR and First Aid.
- If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable State laws while operating the vehicle.

Verification of Provider Qualifications

Entity Responsible for Verification:

OIG
The Department or its designee

Frequency of Verification:

Initially and every two (2) years 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:

Other Service

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

Service Title:

Goods and Services

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17010 goods and services

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Goods and Services must meet the following specifications:

Individual Directed Goods and Services are services, equipment or supplies not otherwise provided through this waiver or through the Medicaid state plan that address an identified need in the service plan (including improving and maintaining the participant’s opportunities for full membership in the community) and meet the following requirements: the item or service would decrease the need for other Medicaid services; AND/OR promote inclusion in the community; AND/OR increase the participant’s safety in the home environment; AND, the participant does not have the funds to purchase the item or service or the item or service is not available through another source. Experimental or prohibited treatments are excluded. Individual Directed Goods and Services must be documented in the service plan.

The items are necessary to avoid institutionalization and it must meet the following specifications:

Individual goods and services are services and supplies not otherwise provided through other services under this waiver, Medicaid State Plan services, or other resources.

Goods and services do not include:

- Experimental goods or services,
- chemical and physical restraints,
- over the counter medications or vitamins and supplements or alternative forms of nutrition not prescribed or recommended by a licensed practitioner for increased caloric needs
- supplements not prescribed or recommended by a licensed practitioner or alternative forms of nutrition. Goods and services are individualized and must be used to reduce need of personal care.

Goods and services address an identified need in the PCSP and are targeted to the participant’s disability. Goods and services will only be covered under the waiver if the item is deemed necessary to ensure health, safety, and welfare in the community but is otherwise not covered by Medicaid State Plan. Requests for goods and services must include documentation of need from a doctor, physician’s assistant (PA), advance practice registered nurse (APRN), or a licensed clinical therapist.

For all waiver participants younger than 21 years of age, goods and services must be provided under the Early Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, if available, and will not be covered through this waiver service.

These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

The limit is four thousand two hundred thirty five dollars (\$4,235) per LOC year. Any one item more than five hundred dollars (\$500) must be approved by the Department or its designee prior to service delivery.

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	Public Health Department
Agency	Community Mental Health Center
Agency	Certified Waiver Provider

Provider Category	Provider Type Title
Agency	Area Agency on Aging and Independent Living
Agency	Adult Day Health Care Center
Agency	Centers for Independent Living
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Goods and Services

Provider Category:

Agency

Provider Type:

Public Health Department

Provider Qualifications

License (specify):

Certificate (specify):

Certified by the Department or its designee

Other Standard (specify):

A public health department must be recognized by the Department for Public Health pursuant to 902 KAR Chapter 8.

The agency must meet certified waiver provider qualifications as defined in 907 KAR 7:005 and 907 KAR 7:010.

Agency case management staff who come into direct contact with waiver participants must have been hired before November 11, 2023 or meet the following qualifications:

Bachelor's degree in Social Work/Human Services or related field; OR
Bachelor's degree in any field not closely related AND one year of human services related experience;
OR

An associate degree in a behavioral science, social science, or a closely related field AND two years human services related experience; OR

Three years of human services related experience

Relevant fields of study may include:

- o Social Work
- o Psychology
- o Rehabilitation
- o Nursing
- o Counseling
- o Education
- o Gerontology
- o Human Services
- o Sociology

Relevant experience may include:

- o Experience as a case manager or in a related human services field
- o Certified Nursing Assistant experience
- o Certified Medical Assistant experience
- o Certified Home Health Aide experience
- o Personal Care Assistant experience
- o Paid professional experience with aging and/or disabled populations or programs as a Case Manager, a Rehabilitation Specialist or Health Specialist, and/or Social Services Coordinator
- o Assessment and care planning experience with clients
- o Experience in working directly with persons with intellectual, developmental, or other types of disabilities or mental illness.
- o Work providing assistance to individuals and groups with issue such as economically disadvantaged, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, inadequate house

Be a registered nurse (RN) currently licensed in Kentucky as defined in KRS 314.011(5) who has at least two (2) years of experience as a professional nurse in the field of aging or disabilities; or a master's degree in a health or human services field from an accredited college or university.

Completes Department-approved, waiver-specific training and is monitored for competency on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered thinking.

Completes Department-approved case management training.

- Has the ability to:
 - o Communicate effectively with a participant in the participant's preferred manner of communication and with the participant's family;
 - o Read, understand, and implement written and oral instructions;
 - o Perform required documentation;
 - o Facilitate the participant's person-centered team; and
 - o Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant's PCSP.

Undergoes pre-employment screenings as described in C-2.a and b of this appendix.

Is certified in CPR and First Aid.

If the employee provides transportation, the employee must be legally licensed to operate the

transporting vehicle and obeys all applicable State laws while operating the vehicle.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department or its designee

Frequency of Verification:

Initially and every two (2) years or more frequently if necessary

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Goods and Services

Provider Category:

Agency

Provider Type:

Community Mental Health Center

Provider Qualifications

License (specify):

By OIG 902 KAR 20:091

Certificate (specify):

Certified by the Department or its designee

Other Standard (specify):

The agency must meet certified waiver provider qualifications as defined in 907 KAR 7:005 and 907 KAR 7:010.

Agency case management staff who come into direct contact with waiver participants must have been hired before November 11, 2023 or meet the following qualifications:

Bachelor's degree in Social Work/Human Services or related field; OR

Bachelor's degree in any field not closely related AND one year of human services related experience; OR

An associate degree in a behavioral science, social science, or a closely related field AND two years human services related experience; OR

Three years of human services related experience

Relevant fields of study may include:

- o Social Work
- o Psychology
- o Rehabilitation
- o Nursing
- o Counseling
- o Education
- o Gerontology
- o Human Services
- o Sociology

Relevant experience may include:

- o Experience as a case manager or in a related human services field
- o Certified Nursing Assistant experience
- o Certified Medical Assistant experience
- o Certified Home Health Aide experience
- o Personal Care Assistant experience
- o Paid professional experience with aging and/or disabled populations or programs as a Case Manager, a Rehabilitation Specialist or Health Specialist, and/or Social Services Coordinator
- o Assessment and care planning experience with clients
- o Experience in working directly with persons with intellectual, developmental, or other types of disabilities or mental illness.
- o Work providing assistance to individuals and groups with issue such as economically disadvantaged, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, inadequate house

Be a registered nurse (RN) currently licensed in Kentucky as defined in KRS 314.011(5) who has at least two (2) years of experience as a professional nurse in the field of aging or disabilities; or a master's degree in a health or human services field from an accredited college or university.

Completes Department-approved, waiver-specific training and is monitored for competency on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered thinking.

Completes Department-approved case management training.

• Has the ability to:

- o Communicate effectively with a participant in the participant's preferred manner of communication and with the participant's family;
- o Read, understand, and implement written and oral instructions;
- o Perform required documentation;
- o Facilitate the participant's person-centered team; and
- o Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant's PCSP.

Undergoes pre-employment screenings as described in C-2.a and b of this appendix.

Is certified in CPR and First Aid.

If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable State laws while operating the vehicle.

Verification of Provider Qualifications

Entity Responsible for Verification:

OIG
The Department or its designee

Frequency of Verification:

Initially and every two (2) years or more frequently if necessary

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Goods and Services

Provider Category:

Agency

Provider Type:

Certified Waiver Provider

Provider Qualifications

License (specify):

Certificate (specify):

The Department or its designee

Other Standard (specify):

The agency must meet certified waiver provider qualifications as defined in 907 KAR 7:005 and 907 KAR 7:010.

Agency case management staff who come into direct contact with waiver participants must have been hired before November 11, 2023 or meet the following qualifications:

Bachelor's degree in Social Work/Human Services or related field; OR

Bachelor's degree in any field not closely related AND one year of human services related experience; OR

An associate degree in a behavioral science, social science, or a closely related field AND two years human services related experience; OR

Three years of human services related experience

Relevant fields of study may include:

- o Social Work
- o Psychology
- o Rehabilitation
- o Nursing
- o Counseling
- o Education
- o Gerontology
- o Human Services
- o Sociology

Relevant experience may include:

- o Experience as a case manager or in a related human services field
- o Certified Nursing Assistant experience
- o Certified Medical Assistant experience
- o Certified Home Health Aide experience
- o Personal Care Assistant experience
- o Paid professional experience with aging and/or disabled populations or programs as a Case Manager, a Rehabilitation Specialist or Health Specialist, and/or Social Services Coordinator
- o Assessment and care planning experience with clients
- o Experience in working directly with persons with intellectual, developmental, or other types of disabilities or mental illness.
- o Work providing assistance to individuals and groups with issue such as economically disadvantaged, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, inadequate house

Be a registered nurse (RN) currently licensed in Kentucky as defined in KRS 314.011(5) who has at least two (2) years of experience as a professional nurse in the field of aging or disabilities; or a master's degree in a health or human services field from an accredited college or university.

Completes Department-approved, waiver-specific training and is monitored for competency on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered thinking.

Completes Department-approved case management training.

• Has the ability to:

- o Communicate effectively with a participant in the participant's preferred manner of communication and with the participant's family;
- o Read, understand, and implement written and oral instructions;
- o Perform required documentation;
- o Facilitate the participant's person-centered team; and
- o Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant's PCSP.

Undergoes pre-employment screenings as described in C-2.a and b of this appendix.

Is certified in CPR and First Aid.

If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable State laws while operating the vehicle.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department or its designee

Frequency of Verification:

Initially and every two (2) years or more frequently as necessary

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Goods and Services

Provider Category:

Agency

Provider Type:

Area Agency on Aging and Independent Living

Provider Qualifications

License (specify):

Certificate (specify):

Certified by the Department or its designee

Other Standard (specify):

Area Agencies on Aging 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 CMHCs; and KRS 147A.050 to 147A.110 Area Development Districts.) Both CMHCs and Area Development Districts have a designated region within the State to which their services are mandated and limited.

The agency must meet certified waiver provider qualifications as defined in 907 KAR 7:005 and 907 KAR 7:010.

Agency case management staff who come into direct contact with waiver participants must have been hired before November 11, 2023 or meet the following qualifications:

Bachelor's degree in Social Work/Human Services or related field; OR

Bachelor's degree in any field not closely related AND one year of human services related experience; OR

An associate degree in a behavioral science, social science, or a closely related field AND two years human services related experience; OR

Three years of human services related experience

Relevant fields of study may include:

- o Social Work
- o Psychology
- o Rehabilitation
- o Nursing
- o Counseling
- o Education
- o Gerontology
- o Human Services
- o Sociology

Relevant experience may include:

- o Experience as a case manager or in a related human services field
- o Certified Nursing Assistant experience
- o Certified Medical Assistant experience
- o Certified Home Health Aide experience
- o Personal Care Assistant experience
- o Paid professional experience with aging and/or disabled populations or programs as a Case Manager, a Rehabilitation Specialist or Health Specialist, and/or Social Services Coordinator
- o Assessment and care planning experience with clients
- o Experience in working directly with persons with intellectual, developmental, or other types of disabilities or mental illness.
- o Work providing assistance to individuals and groups with issue such as economically disadvantaged, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, inadequate house

Be a registered nurse (RN) currently licensed in Kentucky as defined in KRS 314.011(5) who has at least two (2) years of experience as a professional nurse in the field of aging or disabilities; or a master's degree in a health or human services field from an accredited college or university.

Completes Department-approved, waiver-specific training and is monitored for competency on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered thinking.

Completes Department-approved case management training.

• Has the ability to:

- o Communicate effectively with a participant in the participant's preferred manner of communication and with the participant's family;
- o Read, understand, and implement written and oral instructions;
- o Perform required documentation;
- o Facilitate the participant's person-centered team; and
- o Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant's PCSP.

Undergoes pre-employment screenings as described in C-2.a and b of this appendix.
 Is certified in CPR and First Aid.
 If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable State laws while operating the vehicle.

Verification of Provider Qualifications**Entity Responsible for Verification:**

The Department or its designee

Frequency of Verification:

Initially and every two (2) years or more frequently if necessary

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

Service Type: Other Service

Service Name: Goods and Services

Provider Category:

Agency

Provider Type:

Adult Day Health Care Center

Provider Qualifications

License (specify):

By OIG 902 KAR 20:066

Certificate (specify):

Certified by the Department or its designee

Other Standard (specify):

The agency must meet certified waiver provider qualifications as defined in 907 KAR 7:005 and 907 KAR 7:010.

Agency case management staff who come into direct contact with waiver participants must have been hired before November 11, 2023 or meet the following qualifications:

Bachelor's degree in Social Work/Human Services or related field; OR

Bachelor's degree in any field not closely related AND one year of human services related experience; OR

An associate degree in a behavioral science, social science, or a closely related field AND two years human services related experience; OR

Three years of human services related experience

Relevant fields of study may include:

- o Social Work
- o Psychology
- o Rehabilitation
- o Nursing
- o Counseling
- o Education
- o Gerontology
- o Human Services
- o Sociology

Relevant experience may include:

- o Experience as a case manager or in a related human services field
- o Certified Nursing Assistant experience
- o Certified Medical Assistant experience
- o Certified Home Health Aide experience
- o Personal Care Assistant experience
- o Paid professional experience with aging and/or disabled populations or programs as a Case Manager, a Rehabilitation Specialist or Health Specialist, and/or Social Services Coordinator
- o Assessment and care planning experience with clients
- o Experience in working directly with persons with intellectual, developmental, or other types of disabilities or mental illness.
- o Work providing assistance to individuals and groups with issue such as economically disadvantaged, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, inadequate house

Be a registered nurse (RN) currently licensed in Kentucky as defined in KRS 314.011(5) who has at least two (2) years of experience as a professional nurse in the field of aging or disabilities; or a master's degree in a health or human services field from an accredited college or university.

Completes Department-approved, waiver-specific training and is monitored for competency on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered thinking.

Completes Department-approved case management training.

• Has the ability to:

- o Communicate effectively with a participant in the participant's preferred manner of communication and with the participant's family;
- o Read, understand, and implement written and oral instructions;
- o Perform required documentation;
- o Facilitate the participant's person-centered team; and
- o Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant's PCSP.

Undergoes pre-employment screenings as described in C-2.a and b of this appendix.

Is certified in CPR and First Aid.

If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable State laws while operating the vehicle.

Verification of Provider Qualifications

Entity Responsible for Verification:

OIG
The Department or its designee

Frequency of Verification:

Initially and every two (2) years or more frequently if necessary

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Goods and Services

Provider Category:

Agency

Provider Type:

Centers for Independent Living

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Certified by the Department or its designee

Other Standard (*specify*):

Center for Independent Living as defined in Title VII of the Rehabilitation Act of 1973 which establishes the creation of Centers for Independent Living.

The agency must meet certified waiver provider qualifications as defined in 907 KAR 7:005 and 907 KAR 7:010.

Agency case management staff who come into direct contact with waiver participants must have been hired before November 11, 2023 or meet the following qualifications:

Bachelor's degree in Social Work/Human Services or related field; OR
 Bachelor's degree in any field not closely related AND one year of human services related experience;
 OR

An associate degree in a behavioral science, social science, or a closely related field AND two years human services related experience; OR

Three years of human services related experience

Relevant fields of study may include:

- o Social Work
- o Psychology
- o Rehabilitation
- o Nursing
- o Counseling
- o Education
- o Gerontology
- o Human Services
- o Sociology

Relevant experience may include:

- o Experience as a case manager or in a related human services field
- o Certified Nursing Assistant experience
- o Certified Medical Assistant experience
- o Certified Home Health Aide experience
- o Personal Care Assistant experience
- o Paid professional experience with aging and/or disabled populations or programs as a Case Manager, a Rehabilitation Specialist or Health Specialist, and/or Social Services Coordinator
- o Assessment and care planning experience with clients
- o Experience in working directly with persons with intellectual, developmental, or other types of disabilities or mental illness.
- o Work providing assistance to individuals and groups with issue such as economically disadvantaged, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, inadequate house

Be a registered nurse (RN) currently licensed in Kentucky as defined in KRS 314.011(5) who has at least two (2) years of experience as a professional nurse in the field of aging or disabilities; or a master's degree in a health or human services field from an accredited college or university.

Completes Department-approved, waiver-specific training and is monitored for competency on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered thinking.

Completes Department-approved case management training.

• Has the ability to:

- o Communicate effectively with a participant in the participant's preferred manner of communication and with the participant's family;
- o Read, understand, and implement written and oral instructions;
- o Perform required documentation;
- o Facilitate the participant's person-centered team; and
- o Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant's PCSP.

Undergoes pre-employment screenings as described in C-2.a and b of this appendix.

Is certified in CPR and First Aid.

If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable State laws while operating the vehicle.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department or its designee

Frequency of Verification:

Initially and every two (2) years or more frequently if necessary

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Goods and Services

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License (specify):

By OIG 902 KAR 20:081

Certificate (specify):

Certified by the Department or its designee

Other Standard (specify):

The agency must meet certified waiver provider qualifications as defined in 907 KAR 7:005 and 907 KAR 7:010.

Agency case management staff who come into direct contact with waiver participants must have been hired before November 11, 2023 or meet the following qualifications:

Bachelor's degree in Social Work/Human Services or related field; OR

Bachelor's degree in any field not closely related AND one year of human services related experience; OR

An associate degree in a behavioral science, social science, or a closely related field AND two years human services related experience; OR

Three years of human services related experience

Relevant fields of study may include:

- o Social Work
- o Psychology
- o Rehabilitation
- o Nursing
- o Counseling
- o Education
- o Gerontology
- o Human Services
- o Sociology

Relevant experience may include:

- o Experience as a case manager or in a related human services field
- o Certified Nursing Assistant experience
- o Certified Medical Assistant experience
- o Certified Home Health Aide experience
- o Personal Care Assistant experience
- o Paid professional experience with aging and/or disabled populations or programs as a Case Manager, a Rehabilitation Specialist or Health Specialist, and/or Social Services Coordinator
- o Assessment and care planning experience with clients
- o Experience in working directly with persons with intellectual, developmental, or other types of disabilities or mental illness.
- o Work providing assistance to individuals and groups with issue such as economically disadvantaged, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, inadequate house

Be a registered nurse (RN) currently licensed in Kentucky as defined in KRS 314.011(5) who has at least two (2) years of experience as a professional nurse in the field of aging or disabilities; or a master's degree in a health or human services field from an accredited college or university.

Completes Department-approved, waiver-specific training and is monitored for competency on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered thinking.

Completes Department-approved case management training.

• Has the ability to:

- o Communicate effectively with a participant in the participant's preferred manner of communication and with the participant's family;
- o Read, understand, and implement written and oral instructions;
- o Perform required documentation;
- o Facilitate the participant's person-centered team; and
- o Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant's PCSP.

Undergoes pre-employment screenings as described in C-2.a and b of this appendix.

Is certified in CPR and First Aid.

If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable State laws while operating the vehicle.

Verification of Provider Qualifications

Entity Responsible for Verification:

OIG
The Department or its designee

Frequency of Verification:

Initially and every two (2) years 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:

Other Service

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

Service Title:

Home and Community Supports

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08030 personal care

Category 2:

08 Home-Based Services

Sub-Category 2:

08050 homemaker

Category 3:

08 Home-Based Services

Sub-Category 3:

08040 companion

Service Definition (Scope):

Category 4:

15 Non-Medical Transportation

Sub-Category 4:

15010 non-medical transportation

Home and community supports enable waiver participants who elect to utilize participant-directed services to accomplish tasks that they normally would do for themselves if they did not have a disability, medical condition or advanced age and would not be typically provided by natural supports. This assistance may include hands-on assistance (actually performing a task for the person), reminding, observing, guiding, and/or training a waiver participant in ADLs (such as bathing, dressing, toileting, transferring, maintaining continence) and IADLs (more complex life activities such as personal hygiene, light housework, laundry, meal planning and preparation, transportation, grocery shopping, using the telephone, money management, and medication administration). This service may also include assisting the waiver participant in managing his/her medical care including making medical appointments, and accompanying the waiver participant during medical appointments. Transportation to access community services, activities and appointments shall not duplicate Medicaid State Plan transportation services. The need for assistance must be directly related to the participant’s disability and exceed that of his or her age matched peers.

Home and Community Supports take place in the waiver participant’s home, and in the community as appropriate to the individual’s need.

Home and community supports are available only to a waiver participant who lives in his /her own residence or in his/her family residence.

When medically necessary and available as a service, personal assistance services are covered by EPSDT, if available. Personal assistance services may not supplant educational services available under the IDEA (20 U.S.C. 1401 et seq.).

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

Forty-five (45) hours per week; Maximum of \$200 per day alone or in combination with ADHC services; Travel to and from the participant’s residence shall be excluded
 This service cannot be billed concurrently with other services.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Qualified Participant Approved Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home and Community Supports

Provider Category:

Individual

Provider Type:

Qualified Participant Approved Provider

Provider Qualifications

License *(specify):*

Certificate (specify):

Other Standard (specify):

Individuals who come into direct contact with waiver participants must meet the following qualifications:

- Be at least eighteen (18) years of age.
- Completes Department-approved, waiver-specific training and is monitored for competency on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, professional boundaries, trauma-informed care, and person-centered thinking.
- Has the ability to:
 - o Communicate effectively with a participant in the participant’s preferred manner of communication and with the participant’s family;
 - o Read, understand, and implement written and oral instructions;
 - o Perform required documentation;
 - o Participate as a member of the participant’s person-centered team if requested by the participant; and
 - o Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant’s PCSP.
- Undergoes pre-employment screenings as described in C-2.a and b of this appendix.
- If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable State laws while operating the vehicle.

Verification of Provider Qualifications

Entity Responsible for Verification:

Service Advisor

Frequency of Verification:

Prior to service delivery and as required based on the Department or its designee’s requirements.

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 Â§440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home Delivered Meals

HCBS Taxonomy:

Category 1:

06 Home Delivered Meals

Sub-Category 1:

06010 home delivered meals

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Home delivered meals service is defined as the provision of meals to a waiver participant who has a need for a home delivered meal. This is based on a deficit related to meal preparation in activities of daily living (ADL) or instrumental activities of daily living (IADL) identified during the functional assessment process. The service includes the preparation, packaging, and delivery of safe and nutritious meals to a participant at his or her home. Meals shall be individually packaged, heated, and, if not heated, shelf-stable or have components separately packaged if the components are clearly marked and components of a single meal.

Home delivered meals shall:

1. Be provided to participants who are unable or find it functionally challenging to prepare their own meals based on the results of the functional assessment and for whom there are no other persons available to do so.
2. Take into consideration the participant's medical restrictions, religious, cultural and ethnic background, and dietary preferences.
3. Be individually packaged meals. Meals may be heated, shelf-stable, chilled, or frozen.
4. Meet participant's nutritional needs.
4. Meet participant's nutritional needs.
5. Be consumed by the participant.

Home delivered meals shall not:

1. Include bulk or individual ingredients, liquids, and other food used to prepare meals independently or with assistance.
2. Include nutritional supplements such as Ensure, Boost, or any physician prescribed dietary supplements administered via G-tube or other feeding mechanism.
3. Be provided while the participant is hospitalized or residing in an institutional setting.
4. Duplicate service provided through other programs funded or operated by the Department for Aging and Independent Living (DAIL), community feeding program, or any other governmental agency.

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

A participant may receive up to two (2) meals each day up to ten (10) meals per week.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified Waiver Meal Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Certified Waiver Meal Provider

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Certified by the Department or its designee

Other Standard (*specify*):

The agency must meet certified waiver provider qualifications as defined in 907 KAR 7:005 and 907 KAR 7:010.

All home delivered meals providers shall meet the definition of a food establishment or food processing establishment in Kentucky according to the Food Establishment Act and State Retail Food Code 902 KAR 45:005 and KRS 217.015. All providers must follow regulations and procedures outlined in the above statute also known as the Kentucky Food Code.

Providers must:

1. Have all permits and conform to applicable laws and regulations under the Kentucky Food Code;
2. Deliver meals in accordance with the PCSP, in a sanitary manner, and at the correct temperature for the specific type of food;
3. Provide meals which contain at least 1/3 of the recommended daily allowance per meal and meet the requirements of the Dietary Guidelines for Americans. Menus must be certified in writing by a Licensed Dietician as meeting those criteria; and
4. Allow federal, State, and local agency staff to monitor for compliance.

Agency staff who come into direct contact with waiver participants must meet the following qualifications:

- Be at least eighteen (18) years of age.
- Has the ability to:
 - o Communicate effectively with a participant in the participant’s preferred manner of communication and with the participant’s family;
 - o Read, understand, and implement written and oral instructions;
 - o Perform required documentation;
 - o Participate as a member of the participant’s person-centered team if requested by the participant; and
 - o Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant’s PCSP.
- Undergoes pre-employment screenings as described in C-2.a and b of this appendix.
- If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable State laws while operating the vehicle.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department or its designee

Frequency of Verification:

Initially and every two (2) years 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:

Other Service

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

Service Title:

Non-Specialized Respite

HCBS Taxonomy:

Category 1:

09 Caregiver Support

Sub-Category 1:

09012 respite, in-home

Category 2:

09 Caregiver Support

Sub-Category 2:

09011 respite, out-of-home

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Non-specialized respite care is short-term care due to an absence or need for relief of the primary caregiver and be utilized for participants who are unable to independently manage or execute self-care. Non-specialized respite care services should be provided in accordance with goals established during person-centered service plan development. Non-specialized respite care shall address individualized self-care, safety, positive social impact and recreational needs, and supervision needs. Non-specialized respite care services must be provided at a level to appropriately and safely meet the needs of the participant including continual monitoring and supervision. Receipt of respite care does not preclude a participant from receiving other services on the same day if the other services are not provided concurrently.

Non-specialized respite may be provided in the participant’s residence, in the community or at an Adult Day Health Care center.

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

42 units per day alone or in combination with specialized respite. Non-specialized respite alone or in combination with specialized respite shall not exceed 1000 units per year.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Qualified Participant Approved Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Non-Specialized Respite

Provider Category:

Individual

Provider Type:

Qualified Participant Approved Provider

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

Individuals who come into direct contact with waiver participants must meet the following qualifications:

- Be at least eighteen (18) years of age.
- Completes Department-approved, waiver-specific training and is monitored for competency on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, professional boundaries, trauma-informed care, and person-centered thinking.
- Has the ability to:
 - o Communicate effectively with a participant in the participant's preferred manner of communication and with the participant's family;
 - o Read, understand, and implement written and oral instructions;
 - o Perform required documentation;
 - o Participate as a member of the participant's person-centered team if requested by the participant;
 - o Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant's PCSP; and
 - o Undergoes per-employment screenings as described in C-2.a and b of this appendix.
- If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable State laws while operating the vehicle.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Service Advisor

Frequency of Verification:

Prior to service delivery and as required based on the Department or its designee's requirements.

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.*

As a primary care case management system service under a concurrent managed care authority. *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):

- A. All providers or provider agency employees with contact with participants or PDS employees are required to undergo a background investigation at hiring and repeated as appropriate.
- B. Kentucky offers employers two options for conducting pre-employment background investigations.
- i. The Kentucky Applicant Registry and Employment Screening (KARES) system: KARES is an electronic interface and nationwide background investigation and registry system. KARES enables automatic abuse registry checks, including continuous assessment (i.e. ongoing registry checks after employment date), as well as fingerprint-based background checks through Kentucky State Police (KSP) and the Federal Bureau of Investigation (FBI).
- ii. If KARES is not used, pre-employment background investigations must be conducted using all four (4) of the following:
1. Administrative Office of the Courts (AOC) Background Check operated by Kentucky Court of Justice and an equivalent out-of-State agency if the individual resided or worked outside of Kentucky during the twelve (12) months prior to employment.
 2. Kentucky Child Abuse and Neglect (CAN) Registry operated by the Cabinet for Health and Family Services and an equivalent out-of-State agency if the individual resided or worked outside of Kentucky during the twelve (12) months prior to employment.
 3. Caregiver Misconduct Registry operated by the Cabinet for Health and Family Services.
 4. Nurse Aide Abuse Registry operated by the Kentucky Board of Nursing.
- If a potential employee has resided or worked out of state within the last 12 calendar months the other state's equivalency of all checks must be completed and results provided for that timeframe.
- C. All agency employees with contact with participants are also required to pass a six-panel drug screening prior to employment.
- D. Provider agencies are responsible for conducting pre-employment background screenings on agency employees. The following disqualifies an agency employee from providing services:
1. A prior conviction for an offense as described in KRS 17.165(1) through (3).
 2. A prior felony conviction.
 3. A drug conviction, felony plea bargain, or amended plea bargain within the past five (5) years.
 - a. Every ninety (90) days for employees who are three (3) years or less removed from his/her conviction; or
 - b. Every one-hundred eighty (180) days for employees three (3) to five (5) years removed from his/her conviction.
 - c. Random drug screenings are not required for employees who are over five (5) years removed from his/her conviction.
 4. Failing to pass a six-panel drug test.
 5. Has a conviction for abuse, neglect, or exploitation (ANE) as defined in Appendix G.
 6. Has substantiated finding of abuse, neglect or exploitation through adult protective services (APS) or child protective services (CPS).
 7. Prior substantiated case of Medicaid fraud by the Office of Medicaid Fraud and Abuse Control, Office of Inspector General (OIG), or Office of Attorney General (OAG) or Medicare fraud.
 8. Employees who have a driving under the influence conviction, amended plea bargain, or diversion in the past year shall not transport participants.
- E. The participant, as the employer, is responsible to ensure the potential hire meets qualifications.
- F. All employees, agency or PDS, must also undergo a risk assessment for tuberculosis per Department of Public Health guidelines found in 902 KAR 20:205.

- 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 traditional service providers with contact with the participant and all PDS employees must submit to a screening using KARES or a combination of other state registries at the time of hire.

The KARES system conducts a fingerprint-based background check of Kentucky State Police (KSP) and Federal Bureau of Investigation (FBI) records and checks the Kentucky Nurse Aide and Home Health Abuse Registry, the Kentucky Caregiver Misconduct Registry, the Kentucky Child Abuse and Neglect (Central) Registry, Nurse Aide Abuse Registry, and the Federal List of Excluded Individuals/Entities (LEIE) list. The KARES system will also alert an employer of any new arrest findings after the date of hire listed in the KARES system. Employees listed in the KARES system must receive a yearly validation from their employer, which consists of the employer indicating within the KARES system the employee still works for them.

Traditional service agencies and PDS employers who chose not to use the KARES system must conduct screenings of the following registries:

1. Administrative Office of the Courts (AOC) Background Check operated by Kentucky Court of Justice and an equivalent out-of-state agency if the individual resided or worked outside of Kentucky during the twelve (12) months prior to employment.
2. Kentucky Child Abuse and Neglect (CAN) Registry operated by the Cabinet for Health and Family Services and an equivalent out-of-state agency if the individual resided or worked outside of Kentucky during the twelve (12) months prior to employment.
3. Caregiver Misconduct Registry operated by the Cabinet for Health and Family Services.
4. Nurse Aide Abuse Registry operated by the Kentucky Board of Nursing.

For traditional service providers who conduct screenings using the AOC, CAN, and Caregiver Misconduct Registry, the agency must check, at random, twenty-five (25) percent of existing employees using the registries each year. Existing employees are those who have been employed by the agency for one (1) year or more. The Department reviews the findings of this check upon recertification of the provider and at provider billing reviews. PDS employees must undergo screenings at the time of hire and undergo recurring screenings per the PDS employer's policy.

Appendix C: Participant Services

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

Note: Required information from this page is contained in response to C-5.

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.*

The Department allows payment to legally responsible individuals for furnishing personal care or similar services. This option is only available through PDS and only in specified extraordinary circumstances exceeding the range of activities that a legally responsible individual would ordinarily provide 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. Services provided by a legally responsible individual should not replace the care a participant's natural supports are expected to provide. A legally responsible individual may not be approved to provide more than forty (40) hours per week of paid services similar to other PDS employees. A legally responsible individual is defined as any person who has a duty under State law to care for another person and typically includes:

- (a) the parent, stepparent, adoptive parent, or a court-appointed legal guardian of a minor child (younger than 18); or
- (b) the spouse of a waiver participant.

When a participant wants to hire a legally responsible individual, they or their PDS representative must work with the PDS case manager to submit a completed Department-approved request for review and approval. If the legally responsible individual is approved as a PDS employee, the participant's choice is documented in the participant's record. Documentation of services provided shall be submitted via electronic visit verification. The PDS case manager and financial management agency are responsible to work together to monitor service provision. The approval of a legally responsible individual does not guarantee payment of services and shall meet the service definition and provider qualifications as outlined in Appendix C.

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.*

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.

The Department-approved form for hiring a legally responsible individual as a paid service provider must be submitted and approved prior to the individual providing waiver paid services.

A legally responsible individual to a minor child is defined as a parent, stepparent, an adoptive parent, or a legally appointed guardian.

A legally responsible individual to a participant age eighteen (18) or older is defined as a spouse, an appointed legal guardian, or other individual with legal authority to make decisions on behalf of a participant.

Payment for provision of PDS shall be available to an individual who is legally responsible for a minor child enrolled in a waiver program when one of the following extraordinary conditions exist for the participant:

The minor child's level of dependency in performing activities of daily living, including the need for assistance with toileting, eating, or mobility, is directly related to his or her disability and exceeds that of his or her age matched peers; or

The minor child demonstrates destructive or injurious behaviors exceeding that of his or her age matched peers and such behaviors represent a risk of serious injury or death to self or others.

In addition, at least one of the following circumstances must be identified and verified to necessitate use of the legally responsible individual as a PDS employee:

Caregiving requirements to maintain the health and safety of the minor child in the community have reduced or eliminated the ability of the legally responsible individual to maintain paid employment within the previous twelve (12) months and there is not an alternate caregiver in the home who is functionally able to provide care.

The legally responsible individual can demonstrate attempts within the first thirty (30) days to recruit a qualified provider, both traditional or PDS, but is unable to secure another provider or secure sufficient provider coverage for needed services.

The minor child has a communication barrier exceeding that of his or her age matched peers that impacts his or her ability to effectively communicate needs and wishes to a care provider.

The approval of a legally responsible individual does not guarantee payment of services and shall meet the service definition and provider qualifications as outlined in Appendix C.

Payment for provision of PDS for adults shall be made available to any qualified person, regardless of legal responsibility or familial relationship to the participant, including a spouse, if at least one of the following circumstances has been identified and verified to necessitate use of the legally responsible individual as a PDS employee:

Caregiving requirements to maintain the health and safety of the participant in the community have reduced or eliminated the ability of the legally responsible individual to maintain paid employment within the previous twelve (12) months and there is not an alternate caregiver in the home who is functionally able to provide care.

The legally responsible individual can demonstrate attempts within the first thirty (30) days to recruit a qualified provider, both traditional and PDS, but is unable to secure another provider or secure sufficient provider coverage for all care.

The participant has a communication barrier that impacts his or her ability to effectively communicate needs and wishes to a care provider.

The approval of a legally responsible individual does not guarantee payment of services and shall meet the service definition and provider qualifications as outlined in Appendix C.

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 willing and qualified individual or entity. The application process begins by contacting the Department Provider Enrollment through a toll-free phone number or accessing the MAP 811 provider enrollment form through the Cabinet website. The Department Provider Enrollment will refer any applicants who wish to serve a waiver program to the Department's Division of Long-Term Services and Supports for certification. The provider must meet all qualifications, certification and licensing requirements set forth in Appendix C of this application for the service they seek to deliver. A potential provider must complete waiver population specific training provided by the Department during the application process and before billing for any service provided. The Cabinet is in the process of implementing a web-based process for enrolling providers. The full adoption date is to be determined.

For existing providers who add a setting, the Department or its designee will evaluate the setting to ensure it meets certification requirements. The provider does not need to apply for a new provider number.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

Percent of new providers that meet initial certification, licensure requirements and adhere to other standards prior to the furnishing of waiver services. N=Number of New Providers who meet initial certification, licensure requirements and adhere to other standards prior to furnishing services. D=Number of new providers

Data Source (Select one):

Other

If 'Other' is selected, specify:

Combination of Onsite interviews, observations, monitoring, Desk review of records

depending on the type of service and whether services are provided onsite or at the participant's place of residence.

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input data-bbox="1078 779 1264 864" type="text"/>
Other Specify: <input data-bbox="408 1003 647 1088" type="text"/>	Annually	Stratified Describe Group: <input data-bbox="1078 1003 1264 1088" type="text"/>
	Continuously and Ongoing	Other Specify: <input data-bbox="1078 1227 1264 1312" type="text"/>
	Other Specify: <input data-bbox="718 1451 954 1536" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other	Annually

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
Specify: <input type="text"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Percent of enrolled providers who continue to meet cert and licensure req and adhere to other standards following initial enrollment as required to continue to render waiver services. N=Number of enrolled providers who continue to meet cert and licensure req and adhere to other standards following initial enrollment as required to continue to render waiver services D=Number of enrolled providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Combination of Onsite interviews, observations, monitoring, Desk review of records depending on the type of service and whether services are provided onsite or at the participant’s place of residence.

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
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.

Performance Measure:

Percent of PDS employees that meet initial personnel requirements prior to the furnishing of waiver services. N=Number of PDS employees who meet initial personnel requirements prior to furnishing services. D=Number of new PDS employees.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Provider Records

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Percent of PDS employees who continue to meet personnel requirements following initial enrollment. N=Number of PDS employees who continue to meet personnel requirements following initial enrollment. D=Number of existing PDS employees.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Provider Records

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other	Annually	Stratified

Specify: <input style="width: 100%; height: 20px;" type="text"/>		Describe Group: <input style="width: 100%; height: 20px;" type="text"/>
	Continuously and Ongoing	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

c. Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

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

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Percent of providers in which 100% of staff have successfully completed mandatory annual training in accordance with state requirements and the approved waiver

N=Number of providers in which 100% of staff have successfully completed mandatory annual training in accordance with state requirements and the approved waiver D=Total number of providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Combination of Onsite interviews, observations, monitoring, Desk review of records depending on the type of service and whether services are provided onsite or at the participant’s place of residence.

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input data-bbox="1078 1263 1264 1308" type="text" value="95% +/- 5%"/>
Other Specify: <input data-bbox="408 1442 644 1523" type="text"/>	Annually	Stratified Describe Group: <input data-bbox="1078 1442 1264 1523" type="text"/>
	Continuously and Ongoing	Other Specify: <input data-bbox="1078 1666 1264 1747" type="text"/>
	Other Specify: <input data-bbox="718 1890 954 1971" type="text"/>	

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: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

- 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 HCB waiver providers are certified and/or licensed prior to rendering services. Providers who have completed the OIG process to receive a license are eligible to become a Medicaid provider. The State’s OIG monitors and re-licenses them on a three (3) year basis. If a provider’s license is revoked, the Department is notified by the OIG. The Department or its designee certifies all licensed and non-licensed waiver providers. The State does not contract with non-licensed or non-certified providers. The State implements its policies and procedures and provides for training as needed related to policy changes through letters, the Department website or by attending the various associations of each of the provider entities.

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.

If the provider agency has not provided or ensured training of their employees, the Department or its designee will follow policies and procedures as noted in the certified waiver provider regulation 907 KAR 7:005.

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Specify: <input data-bbox="319 286 794 367" type="text"/>	
	Continuously and Ongoing
	Other Specify: <input data-bbox="865 573 1337 654" type="text"/>

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

All residential and non-residential settings are confirmed to comply with the federal HCB settings requirement. DMS ascertains that all waiver settings meet federal HCB settings requirements as part of the certification and recertification processes. Services are provided Site visits are conducted as part of this process.

The settings in this waiver are non-residential and include individual homes and apartments and Adult Day Health Centers. All settings are confirmed to be integrated into and provide access to the greater community, selected by the individual among options, ensures individual rights of privacy/dignity/respect/freedom from coercion and restraint; optimize autonomy and independence; and facilitate service and provider choice. DMS confirms that all allowable settings meet federal settings requirements through provider certification, which includes site visits and occurs at least every two years.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Person-Centered Service Plan (PCSP)

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:

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:*

Case management shall be conflict free. Conflict free case management requires that a provider who renders case management to the participant must not also provide another waiver service to that same participant unless the case manager/service advisor is the only willing and qualified provider in the geographical area thirty (30) miles from the participant's residence.

Participants may request an exception to this based on lack of qualified case managers (CM) or service advisors in remote areas of the state. The Department for Medicaid Services (the Department) will ensure, on an individual basis, that participants who choose a case manager who could be conflicted will be free from undue influence when selecting a service provider. The CM/service advisor will need to upload a Department-approved form requesting an exemption at the same time they upload the completed PCSP to the Department-approved system. The form includes the following information:

1. Documentation, including denials, showing that there are no willing CMs/service advisors within thirty (30) miles of the participant's home;
2. Documentation of conflict of interest protections;
3. An explanation of how CM/service advisor functions are separated within the same entity;
4. Demonstration of the availability of a clear and accessible dispute resolution process that advocates for participants within a service or case management entity.

The Department or its designee will review the request for a conflict-free exemption. Reviewers will use the Department-approved process to verify there are no willing case managers/service advisors within thirty (30) miles of the participant's residence.

The following safeguards are instituted to assure participant's choice:

- Full disclosure to participants and assurance that participants are supported in exercising their right of free choice of providers and provided information on full range of waiver services and not just the services furnished by the entity that is the responsible for the development of the PCSP.
- Direct oversight of the process for periodic evaluation by the state agency.
- Requiring the agency that develops the PCSP to administratively separate the plan development function from the direct service provider functions. The same staff may not provide both case management and direct service care.

If the exemption requested via the Department-approved form is approved or denied, the PCSP will be returned to the case manager via MWMA and the participant will be notified via a letter.

Participants are provided with a clear and accessible informal reconsideration process in cases when adverse decisions result from missing or inadequate documentation related to the initial request for exemption. The participant may also dispute the state's determination that there is not another entity or individual that is not that individual's provider to develop the person centered service plan through a clear and accessible alternative dispute resolution process.

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.

A PCSP shall be an individualized plan that is led by the participant and the participant's legal guardian or authorized representative, if applicable, and:

A. Is collaboratively developed by:

1. A waiver participant and a waiver participant's legal guardian or authorized representative, if applicable;
2. The CM/service advisor;
3. The participant's person-centered team, which is comprised of representatives from each waiver provider entity who provides services for the participant; and/or
4. Any other person identified by the waiver participant, legal guardian, or their authorized representative.

B. Uses a process that:

1. Provides necessary information and support to empower the participant and the participant's legal guardian or authorized representative, if applicable, to direct the planning process and to have the freedom and support to control their own schedules and activities without coercion or restraint;
2. Is timely and occurs at times and locations of convenience to the participant;
3. Reflects cultural and educational considerations of the participant and is conducted by providing information in plain language and in a manner that is accessible to participants with disabilities and participants who have limited proficiency with the English language, consistent with 42 CFR 435.905(b);
4. Offers informed choice, defined as choosing from options based on accurate and thorough knowledge and understanding, to the participant regarding the services and supports they receive and from whom; and
5. Uses a process that provides support to the participant so the participant can lead the PCSP planning process and self-advocate for their goals, objectives, wishes, and needs to the maximum extent possible throughout the process.

C. It is the responsibility of the CM/service advisor to provide detailed information to the participant and the participant's legal guardian and/or authorized representative, if applicable, regarding available waiver services and providers to meet their identified needs, driven by statewide provider information included in the Department-maintained provider directory. CMs/service advisors can generate local lists from the directory to provide to the participant and have use of the directory to provide options counseling on available service providers. The CM/service advisor must ensure the information from the directory is made accessible to the participant. The CM/service advisor will provide detailed information to the participant about available non-waiver services that may assist in reaching their goals and objectives.

D. All individuals participating in the development and execution of the PCSP, including participants, any legal guardian/authorized representatives, the CM or service advisor, and all providers responsible for implementing services, must sign the PCSP to indicate their involvement and understanding of the plan's contents. The signatures will be recorded on the Department-approved form, uploaded to, and housed in MWMA. The signatures should not be obtained until the person-centered planning process and the PCSP are complete. CM/service advisor will provide detailed information to the participant about available non-waiver services that may assist in reaching their goals and objectives.

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 enrollment notice sent to the participant advises the participant and the participant's legal guardian and/or authorized representative, if applicable, that they must select a CM/service advisor to initiate service planning prior to receipt of services. The enrollment notice contains information on how to access information on case management agencies so that the participant may initiate contact and selection of a CM/service advisor. Once a CM/service advisor is selected, they must associate themselves in MWMA.

The independent functional assessor must contact the individual to schedule the functional assessment. The assessment must be completed and uploaded in MWMA.

The functional assessor is responsible to verbally advise the participant and the participant's legal guardian and/or authorized representative, if applicable, or informal supports who attend the assessment, of next steps to initiate services, expressly advising them of the need to schedule their person-centered service planning meeting with their CM/service advisor. After completion and upload of the functional assessment, the CM/service advisor must conduct an initial home visit.

Process for Developing a Person-Centered Service Plan (PCSP)

The person-centered planning process and development of the PCSP takes place as follows:

1. The first step is to clarify the needed individuals and their roles on the participant's person-centered team as defined in D-1-c. of this appendix. A participant is free to designate any family, friends, and other caregivers, both paid and unpaid, to participate in this process. The participant and the participant's legal guardian or authorized representative, if applicable, may remove any individuals at their discretion. The CM/service advisor must document the individuals included in the person-centered team on the Department-approved form and upload it to MWMA. The CM/service advisor must document when a support is disinvited or removed from the person-centered planning team.

For the development of the initial PCSP, the full person-centered planning team must participate. For the annual redetermination of the PCSP, the participant and the participant's guardian or authorized representative, if applicable, has final authority to determine whether there is satisfactory team participation to conduct the PCSP annual review meeting. The CM/service advisor must document how information about the meeting was provided to absent members. Members of the person-centered planning team who do not attend the annual review meeting or who attend by phone must provide written attestation that they understand the contents of the PCSP and can support the participant's service needs at the requested amount, frequency, duration.

Once the person-centered planning team is confirmed, the CM/service advisor completes the primary activities:

- a. The team collectively reviews the findings of the participant's functional assessment. This process includes documenting any non-Medicaid paid or unpaid supports including information on the access and limitations of said supports, DAIL supports, and Medicaid State Plan services. For annual review meetings, the team should also review the participant's current PCSP.
- b. The team works collectively under the leadership of the participant and the participant's legal guardian or authorized representative, if applicable, to complete an additional review of the participant's person-centered planning needs and wishes to establish goals and objectives that enhance health, safety, and welfare, community-based independence, community participation, and quality of life. Not all goals and objectives must be accomplished using 1915(c) waiver funded services.
- c. The process of setting goals should include education and team support for the participant and the participant's legal guardian or the participant's authorized representative, if applicable. Goals and objectives for all services on the PCSP must be:

- Stated Clearly: The goal or objective should be understandable to the participant and in his/her own words.

Additionally, if a participant is receiving a service in order to improve upon current skills or acquire new skills, the goal and objectives must also be:

- Measurable: There should be markers of progress toward achieving a goal or objective that can be identified and quantified.
- Attainable: The goal or objective should be broken into small and actionable steps. Barriers to achieving the goal or

objective should be identified and a plan put in place to help mitigate those barriers.

- Relevant: The goal or objective should be important to the participant. Steps toward the goal or objective should help the participant develop and use available resources to achieve it.
- Time-Bound: There should be a defined period for when the participant is expected to achieve the goal or objective, keeping in mind that reaching the goal or objective can take time and several steps. There should also be an agreed upon schedule in place for checking progress.

d. The CM/service advisor will provide detailed information to participants about available non-waiver services that may assist in reaching their goals and objectives.

- Goals and objectives must be documented, along with an inventory of a participant's personal preferences, individualized considerations for service delivery (i.e. how to bathe, what preferred activities the participant might wish to partake in during community access, desired schedule for services, etc.), as well as information about the participant's needs, wants, and future aspirations.

The results of this conversation are to be included in the PCSP, which is housed in MWMA. It must be signed by the participant and the participant's legal guardian or authorized representative, if applicable. The CM/service advisor and all other individuals responsible for the implementation of services in order to demonstrate this information was collected, shared with all person-centered team members, and is accessible to inform ongoing development and implementation of the PCSP.

2. The CM/service advisor is required to provide options counseling and education on available service options to meet a participant's person-centered goals and objectives as established in Section D-1-d., using the process for educating the participant and other team members on service providers as described in Section D-1-c.

a. Once a participant and the participant's legal guardian or authorized representative, if applicable, selects providers to deliver services pursuant to the frequency and amount, the CM/service advisor is expected to facilitate the referral process including, but not limited to, the attainment of the providers' signatures on the PCSP. The providers' signatures reflect their understanding of the contents of the PCSP and consent to deliver services as indicated in the plan, in accordance with the scope, amount and frequency of service, accommodating any person-centered preferences for service delivery documented in the PCSP.

b. The CM/service advisor is responsible to ensure that the scope, frequency, amount and duration of services falls within the allowable utilization criteria and limitations set by the Department, including those documented in Appendix C and clearly document any planned changes in utilization anticipated over the course of the year (i.e. anticipated change in utilization while a participant under the age of 18 is out of school for the summer, anticipated increases due to anticipated changes in caregiver availability, etc.).

c. The CM/service advisor must maintain documentation showing that all needs identified through the functional assessment are addressed via unpaid supports or paid supports and that all paid services are appropriate in amount, duration, frequency as identified by the functional assessment.

3. Once signatures have been secured from all required person-centered team members, including the participant and the participant's legal guardian or authorized representative, if applicable, the CM/service advisor and all 1915(c) waiver funded service providers delivering PCSP included services, services may be initiated. The signatures should not be obtained until the person-centered planning process and the PCSP are complete.

a. Services rendered prior to signed attestation of understanding of the contents of the PCSP by these parties will not be reimbursed.

b. The participant's signature is intended to serve only as acknowledgement and understanding of the plan's contents. Signing the PCSP does not preclude the participant from grievance or appeal.

A. Initial Development of the Person-Centered Service Plan (for a new participant's first PCSP)

Once the assessment is complete and the participant chooses a case manager, the participant and the participant's legal

guardian and/or authorized representative, if applicable, begins the process of developing the PCSP with the case manager's assistance. Upon acceptance of a new participant, the CM/service advisor must conduct an initial home visit to begin the person-centered planning process.

Person-centered service planning and development of the PCSP should follow the steps described under "Process for Developing a Person-Centered Service Plan" in this section.

B. Annual Redetermination of the Person-Centered Service Plan

A participant's PCSP is recertified on an annual basis. Prior to the reviewing and modifying of the PCSP, the following activities must occur:

- a. The CM/service advisor is encouraged to co-attend and must review the annual functional assessment, which is housed in the MWMA.
- b. Should a CM/service advisor choose to attend the functional assessment, they are expected to support the participant in answering questions and not answer questions on his/her behalf or influence the participant's response or lack of response. The functional assessor is not to use information provided by a CM/service advisor that directly conflicts with assessment feedback provided by the participant.

The person-centered service planning can begin forty-five (45) calendar days prior to the end of the current LOC period. The PCSP must be completed and uploaded to MWMA seven (7) calendar days prior to the end of the current LOC period. The LOC period is defined as the period spanning 364 calendar days from the date a participant is allocated a waiver slot in MWMA. Person-centered service planning and development of the PCSP should follow the steps described under "Process for Developing a Person-Centered Service Plan" in this section.

C. Event-Based Modification of the Person-Centered Service Plan

1. A participant and a participant's legal guardian or authorized representative, if applicable, may request a modification to their PCSP due to changes in their condition or service needs at any time.

a. Additionally, throughout the course of plan monitoring, the CM/service advisor is responsible to address instances when a modification to the PCSP may be appropriate. The CM/service advisor may not initiate any modification to the PCSP without the consent of the participant and the participant's legal guardian or authorized representative, if applicable. The services providers affected by an event-based modification to the PCSP must be involved in the process as well.

2. Certain modifications or event-based circumstances may require completion of an updated functional assessment to assess changes in the participant's needs and make necessary adjustments to the participant's PCSP. The following circumstances could merit completion of a functional assessment outside of the annual assessment cycle:

a. Inpatient admission to an institutional care setting with changes at discharge in functional ability from previous assessment including:

- i. Decreased functional ability in one or more activities of daily living, or
- ii. Decreased functional ability in three (3) or more instrumental activities of daily living.

b. A change in care setting that increases the participant's level of care, including transitions between community-based settings such as moving from a participant's own home to a residential setting.

c. Long-term change in access to or ability of an unpaid caregiver(s).

d. Observed or reported changes that result in the inability of the participant to meet goals and objectives based on the current PCSP, and/or do not provide a level of service sufficient to address health, safety, or welfare concerns.

3. The CM/service advisor is responsible to initiate the event-based assessment in MWMA.

4. The CM/service advisor will be responsible to review the updated assessment and share information about the assessment outcomes with the participant and the participant's legal guardian or authorized representative, if applicable. The CM/service advisor will work with the participant, and any members of the participant's person-centered team as

requested by the participant, to modify the PCSP to address any requested or necessary modifications.

5. The updated PCSP must be signed by the participant and the participant's legal guardian or authorized representative, if applicable, the CM/service advisor, and any new service providers or providers for whom the scope, amount, or duration of service has been adjusted from what was previously consented to or for whom services have been impacted. The signatures should not be obtained until the person-centered planning process and the PCSP are complete. The modified PCSP will remain in effect until the end of the participant's original LOC year. The event-based functional assessment does not eliminate the need for a participant's annual PCSP redetermination. All providers delivering services will be notified via MWMA when a participant's PCSP has changed and will be responsible to review changes and work with the participant's CM/service advisor and person-centered team to make any adjustments or deploy mitigation strategies to assure continuity of care.

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.

Participant needs are identified through the functional assessment and via person-centered planning meetings. If assessed needs cannot be met using 1915(c) and other community-based paid or unpaid services, if the participant chooses not to access services or address certain community-based needs, or environmental, health, safety or welfare risks are identified by any member of the person-centered planning team, risk mitigation efforts must occur and be documented by the participant's case manager. Risks must be documented in MWMA. The CM/service advisor will assess the participant's individual risks by reviewing the participant's functional assessment, any critical incident reports, the participant's behavior support plan (if applicable), and through discussion with the person-centered planning team. When applicable, the following should be documented in MWMA:

1. Medical diagnoses that may require emergency intervention.
2. Behaviors that could harm the participant's health, safety, and welfare or harm the health, safety, and welfare of others.
3. Emergency backups for paid caregivers who do not show up.
4. Any other identified or observable risks that could adversely affect the environment, health, safety, and welfare of the participant or pose a risk of harm to service providers.
5. Any identified risks related to the ability of a PDS employee hired by the participant to fulfill his or her responsibilities as identified in the participant's person-centered plan and/or preserve the participant's health, safety and welfare.

Participants with legal decision-making authority have the right to accept risks. The participant's CM/service advisor is responsible to discuss risks with the participant and the participant's legal guardian or authorized representative, if applicable, and make sufficient efforts to engage the participant and the participant's person-centered team to develop risk mitigation strategies that reduce risks, particularly those adversely impacting health, safety, or welfare of the participant, individuals with whom the participant resides, and those who interact with the participant in order to deliver the PCSP.

A participant's CM/service advisor must document the outcomes of risk mitigation strategies. Documentation must demonstrate due diligence in addressing risks with the participant and members of the person-centered team. If a participant refuses to engage in risk mitigation strategies and accepts risks, the CM/service advisor is responsible to assess the participant's understanding of risks and potential consequences. The CM/service advisor is responsible to educate the participant when risks impede the ability of providers to safely and effectively deliver services, which is a violation of a participant's signed rights and responsibilities form and must make participants aware of disruption or loss of service due to ongoing risks that are not mitigated. The CM/service advisor must proceed in this manner with any participants with an appointed legal guardian or authorized representative with decision-making authority.

If concern exists that a participant may not demonstrate understanding of risk and consequence, the CM/service advisor is expected to refer participants to child or adult protective services to address any possible self-neglect, caregiver neglect, or other abuse/neglect/exploitation issues that may exist. The CM/service advisor and all Medicaid funded providers are required to cooperate with protective service investigations. Findings of an investigation may prompt necessary adjustment to the PCSP, in which case the CM/service advisor should proceed with adjustment to the PCSP in accordance with the process outlined to make an event-based modification to the PCSP as established Section D-1.c.D.1-5.

Additional risk mitigation occurs in response to critical incident investigation and remediation, as described in Appendix G.

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 participant's CM/service advisor is required to provide information about available services including, but not limited to:

- Medicaid State Plan funded services, non-Medicaid paid or unpaid supports, and DAIL supports that may support the participant's home and community-based needs;
- Traditional, PDS, and blended options;
- Services available on their 1915(c) waiver and how they can assist the participant to advance goals as specified in the PCSP;
- Available service providers in the area; and
- Understanding of freedom of choice.

Understanding of freedom of choice

The CM/service advisor is responsible for assisting the participant and the participant's legal guardian or authorized representative, if applicable, in choosing his or her providers of services specified in the PCSP. This assistance may include telephonic or on-site visits with participants and their families, assisting them in accessing the provider listing, answering questions about providers, and informing them or demonstrating use of the Partner Portal system and information housed within. CMs/service advisor are trained by the Department to respond to participant inquiries regarding choice of provider in a manner that avoids conflict of interest and/or conveys personal, subjective opinion. The CM/service advisor will ensure, on an individual basis, that participants who have a conflicted case manager due to their geographic location, and have been approved to do so by the Department, will be free from undue influence regarding choice of providers and will document those efforts in case records housed in MWMA.

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 completion of the PCSP, it is the responsibility of the CM/service advisor to submit the PCSP through MWMA for review and service authorization. Service authorization shall not be issued without appropriate review and approval.

Once the complete PCSP is submitted, it will undergo system checks and, if indicated, it will be reviewed by the Department. A sample of all PCSPs for each agency will be reviewed during annual certification reviews. Service plans are compared to the functional assessment and service utilization to validate the PCSP meets assessed needs. If the PCSP is approved, the participant will receive a letter in the mail. A copy of the notification is also available in MWMA. If the determination results in an adverse decision, the participant will receive an adverse decision notice, which informs of what was denied, why it was denied, and their right to an informal reconsideration and a fair hearing, via certified mail. The CM/service advisor is responsible for notifying providers of approval or denial of the completed PCSP.

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:

Copies of the PCSP are retained in MWMA until after the participant's termination and then maintained electronically for five (5) years.
--

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 participant's CM/service advisor is responsible for the coordination and monitoring of all the participant's waiver services included in the PCSP and will assist in identifying and connecting the participant with non-waiver services, including the monitoring of effectiveness of back-up plans.

The CM/service advisor shall conduct face-to-face visits with the participant monthly, with at least one visit at the participant's current place of residence every three (3) months. The visit must include input from the participant and the participant's legal guardian, authorized representative, or PDS representative, if applicable. For participants with communication barriers, the CM/service advisor must take steps to ensure the conversation is conducted in a way that is accessible to the participant. This could include arranging for an interpreter or a communication device.

The face-to-face contact must include discussions about:

- Progress toward PCSP goals, including any changes in goals or objectives;
- Satisfaction with services delivered via the PCSP;
- Confirming any new needs and addressing whether PCSP modification may be necessary
- Review of utilization and cost of utilization;
- Any concerns with health, safety, and welfare, and/or risk mitigation needs; and
- Review of access to any additional community-based supports, including non-Medicaid funded services, to address where additional assistance or linkage may be needed.

The CM/service advisor is also responsible to use continued professional judgment in screening for evidence of possible abuse, neglect, or exploitation, and/or the possibility of an unreported critical incident. The participant's CM/service advisor must report all suspected critical incidents, including abuse, neglect, and exploitation concerns as defined in Appendix G.

All contact and monitoring activities, observations, and outcomes must be documented via monthly case notes housed in MWMA.

b. Monitoring Safeguards. *Select one:*

Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility to monitor service plan implementation, participant

health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation.

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Providers for the participant, or those who have an interest in or are employed by a provider for the participant, must not provide case management or develop the PCSP. For participants who request an exception to this, the Department will require the CM/service advisor to provide the following to ensure the participant is free from undue influence:

1. Documentation showing that there are no willing CM/service advisors within thirty (30) miles of the participant's home;
2. Documentation of conflict of interest protections;
3. An explanation of how CM/service advisor functions are separated within the same entity; and
4. Demonstration of the availability of a clear and accessible dispute resolution process that advocates for participants within service or case management entity.

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

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's assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.*

Performance Measures

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

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

Performance Measure:

Percent of service plans with a risk assessment that also have documented risk mitigation information. N=Number of service plans with a risk assessment that also have documented risk mitigation information. D=Number of service plans with a risk assessment

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Review of person centered service plans and other documentation in the Medicaid Waiver Management Application.

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="95% +/- 5%"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="text"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Percent of service plans with goals and objectives that address assessed needs including health safety risk factors and the individual's goals N= Number of service plans with goals and objectives that address assessed needs including health and safety risk factors and the individual's goals D= Number of service plans

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Medicaid Waiver Management Application

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 = <input type="text" value="95% +/- 5%"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify:

		<input type="checkbox"/>
	<p>Other Specify:</p> <input type="text"/>	

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
<p>Other Specify:</p> <input type="text"/>	Annually
	Continuously and Ongoing
	<p>Other Specify:</p> <input type="text"/>

b. Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.

Performance Measures

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

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

c. Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the

waiver participant's needs.

Performance Measures

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

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

Performance Measure:

Percent of participants whose service plans were updated and submitted within one year of their initial or last assessment. N= Number of participants whose service plans were updated and submitted within one year of their initial or last assessment D= Number of participants whose service plans required an update

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Review of person-centered service plans and other documentation in the Medicaid Waiver Management Application

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="95% +/- 5%"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other	

	Specify: <input style="width: 100%;" type="text"/>	
--	---	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 30px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 30px;" type="text"/>

Performance Measure:

Percent of participants with a modification to the person centered service plan due to an identified change in service needs. N=Number of participants with a modification to the person centered service plan due to an identified change in serve need D= number of participants with an identified change in service needs.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Review of person centered and other documentation in the Medicaid Waiver Management Application

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100%

		Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="95% +/- 5%"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:

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

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:

Percent of participants who received participant-directed services within the approved service limit. N=Number of participants who received participant-directed services within the approved service limit. D=Number of participants who received participant-directed services.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Data Medicaid Waiver Management Application, Claims Data from the MMIS

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 = <input type="text" value="95% +/- 5%"/>
Other Specify:	Annually	Stratified Describe Group:

	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

Percent of records that demonstrate correct type, amount, scope, and frequency of services were provided for the duration specified in the person centered service plan
N=# of records that demonstrate correct type, amount, scope, and frequency of services were provided for the duration specified in the person centered service plan
D=# of records

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Review of person centered service plans and other documentation in the Medicaid

Waiver Management Application

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-left: 20px;">95% +/- 5%</div>
Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="text"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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:

Percent of participant records indicating individual has been given choice between institutional and waiver services and choice between eligible waiver providers and services. N=number of participant records indicating choice given between institutional and waiver services and choice given between eligible waiver providers and services. D=number of participants records

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Review of person centered service plans and other documentation in the Medicaid Waiver Management Application

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 = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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 Department or its designee will review critical incidents and waiver service and Medicaid State Plan utilization for appropriate response to need monthly. The Department will track, trend, and review grievances and complaints for system wide issues quarterly.

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.

If the Department or its designee determines an identified need noted on the assessment has not been addressed on the PCSP, the Department or its designee will issue written notification to the provider requiring additional information as to how these needs will be addressed.

Identified individual problems are researched and addressed by the Department or its designee. If issues are noted, the Department will follow the policies and procedures as noted in regulation.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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.

Each waiver participant chooses between three (3) service delivery options: traditional, PDS, or a combination of the two known as blended services. If interested in the PDS or blended option, the participant may complete a PDS Employer Responsibilities Review Tool. The optional tool identifies the PDS tasks a participant can perform independently and the PDS tasks that will require support from others. During person-centered planning meetings, the participant works with the service advisor to identify the services he/she wants to self-direct. A participant who chooses PDS as their option for delivery of services may elect a PDS representative to assist with the responsibilities in order to be successful with this delivery model. Participants/PDS Representatives are supported by their service advisor who takes on the following tasks:

- Educating the participant and the participant's legal guardian and/or authorized representative, if applicable, on the rights, responsibilities and risks of the PDS option;
- Assisting with the development of the PCSP;
- Assisting with the hiring and managing of employees, and;
- Monitoring the participant's health, safety, and welfare and ensuring that services are delivered effectively and meet the participant's needs through monthly face-to-face visits.

FMS staff within the Participant Directed Coordination agency is responsible to help the participant with employee payroll and other financial activities related to the participant's employees. The participant can also choose a PDS representative to assist him/her with self-directing services. This PDS representative helps the participant in fulfilling his/her duties as a PDS employer using person-centered principles.

A review and renewal of the PCSP, including service delivery options, with the participant and the participant's legal guardian and/or authorized representative takes place at least annually and can be modified more frequently as needs change.

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.

Each participant is afforded the choice of traditional, PDS, or blended services. At the time of the initial person-centered planning meeting, during the annual redetermination of the PCSP, and as needed, the service advisor is required to provide the following to the participant's legal guardian or authorized representative:

- Information about PDS, traditional, and blended service options,
- Appropriate services based on assessed needs, and
- Selection of providers.

Participants are fully informed of the rights, responsibilities, and risks of all service delivery options, including serving as an employer in the PDS option and the supports offered by the service advisor to assist participants in executing their responsibilities as an employer. The service advisor must provide the information to participants in a format that is most appropriate and understandable for them, taking into account reading level and preferred method of communication. The service advisor must provide information in writing and verbally to the participant. After the initial person-centered planning meeting, the service advisor sets up the next person-centered planning meeting, where all individuals required for implementation of services, along with the participant and the participant's legal guardian or authorized representative, if applicable, are present and must sign the completed PCSP. Person-centered planning meetings are conducted at least annually and at any point of inquiry by the participant or participant's legal guardian/authorized representative, if applicable.

Participants and the participant's legal guardian or authorized representative, if applicable, are required to document their understanding of service delivery options. The service advisor also verifies this understanding using the Department-approved process, recording this information in the participant's PDS Employer Responsibilities Review Tool. The tool is used to:

- a. Educate participants on employer authorities,
- b. Facilitate review of participant's role and responsibilities, including a task specific breakdown, to effectively self-direct waiver services,
- c. Allow participants to identify where they will need assistance with roles and responsibilities, and select their preferred source of assistance, and
- d. Identify participant's needs to enhance or keep the participant independent.

The PDS Employer Responsibilities Review Tool is an optional tool that may be completed by the service advisor, participant, and the participant's legal guardian and/or authorized representative. The tool allows the participant to identify, at a task-specific level, which tasks he or she can conduct independently and which tasks might or will require assistance from a designated representative, informal support, or the service advisor. The service advisor uses this tool upon initiation of PDS and annually to guide oversight and support activities and to discern the level of assistance that will need to be formally provided on a regular basis by the service advisor. The results of the PDS Employer Responsibilities Review Tool are housed in MWMA.

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:

An adult waiver participant may freely choose a PDS representative to assist in directing waiver services as the participant needs. However, the PDS representative may not be hired as an employee to provide any of the participant’s self-directed waiver services. The PDS representative must adhere to person-centered principles and fulfill the responsibilities as a PDS employer, demonstrating commitment to the goals and objectives established in the participant’s PCSP and PDS Employer Responsibilities Review Tool. The PDS representative must complete training on fraud, abuse, neglect, and exploitation. The PDS representative must also sign the rights, risks, and responsibilities form annually. This form explains the rights and responsibilities of the waiver program and the consequences, which may include termination from the program, if they are not followed.

The service advisor is responsible for monitoring the participant's PCSP and ensuring that needed services are being appropriately provided to the participant. If the service advisor has concerns that the PDS representative is not operating in the best interest of the participant, the service advisor shall work with the participant and PDS representative to establish a participant corrective action plan (CAP) for the PDS representative. If the issues continue, PDS service delivery will be terminated following the appropriate process described in section E-1-I and m of this application

Upon termination from the PDS program, the participant and the participant’s legal guardian or authorized representative, if applicable, are provided with written information regarding the traditional program and available providers. The service advisor shall document the reason for the PDS option withdrawal, actions taken to assist the participant to develop a CAP, the outcomes, and the support provided in obtaining traditional services. A participant-directed service shall not be terminated during the transition from PDS to traditional until a traditional service provider is ready to provide services.

If it is suspected that the participant’s health, safety, and welfare is at risk, the Service advisor immediately begins the process of determining steps and developing a CAP up to and including involuntary termination for PDS. The service advisor must also report any critical incidents, as defined in Appendix G.

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
Goods and Services		
Home and Community Supports		
Non-Specialized Respite		

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

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:

Vendor or Government Fiscal Employer Agents

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

The Department compensates FMS providers based on a specified rate per month per participant as a service through the waiver.

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:

Assist participant in verifying support worker citizenship status

Collect and process timesheets of support workers

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:

Maintain a separate account for each participant's participant-directed budget

Track and report participant funds, disbursements and the balance of participant funds

Process and pay invoices for goods and services approved in the service plan

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

Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency

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 are subject to annual reviews by the Department or its designee. This review shall include audits of reports from the EVV system, reports of service utilization provided to the service advisor or participant and participant’s legal guardian or authorized representative, if applicable, and any other supporting documentation regarding payments issued by the Participant Directed Coordination agency as part of financial management services. The audit shall identify any deficiencies and appropriate actions, including CAPs or penalties, to be taken by the Department or its designee to ensure compliance and appropriate payments.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

Case Management Activity. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

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
Goods and Services	
Home and	

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Community Supports	
Home Delivered Meals	
Financial Management Services	
Case Management	
Environmental and Minor Home Adaptation	
Attendant Care	
Adult Day Health Care	
Non-Specialized Respite	
Specialized Respite	
Participant Directed Coordination	

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)

I. 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 participant may voluntarily dis-enroll from PDS at any time.

The service advisor must meet with the participant to provide support and information on the impact of dis-enrolling from PDS and to offer any support that may be required to mitigate issues prompting the participant to request dis-enrollment. The service advisor is responsible for informing the participant of the impacts and risks of disenrollment. If the participant still wishes to continue with disenrollment the service advisor will assist the participant, their legal guardian or authorized representative, if applicable, in locating traditional service providers to meet their needs. The service advisor shall take action in locating traditional service providers within seven (7) calendar days of the participant's, their legal guardian, or authorized representative request to disenroll.

If the participant selects to terminate PDS, they may be subject to waiver program termination based on the following guidelines:

- If a participant does not access any waiver services, outlined in the PCSP, for a period greater than sixty (60) consecutive calendar days without receiving an extension based on demonstration of good cause, the participant may be terminated from the waiver.
- A one-time, sixty (60) consecutive calendar days extension may be granted in the event of good cause.
- Good cause is defined as circumstances beyond the control of the participant that affects the participant's ability to access funding or services, which includes:
 - o Illness or hospitalization of the participant that is not expected to last beyond the good cause extension; or
 - o The participant and participant's legal guardian or authorized representative, if applicable, made diligent contact with a potential provider to secure placement or access services but has not been accepted within the sixty (60) consecutive calendar day time period.

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 service advisor is responsible for monitoring the participant's PCSP and ensuring needed services are provided effectively to the participant to advance his or her goals and objectives, as identified in the PCSP. If services are not being provided as documented within the PCSP or if the service advisor has concerns that the participant's needs are not met, the service advisor shall work with the participant and the participant's legal guardian or authorized representative, if applicable, to create a participant corrective action plan (CAP) within fourteen(14) calendar days of identifying the service delivery issue. A CAP is developed to address issues that interfere with the delivery of PDS services, including but not limited to:

1. The participant does not comply with the PCSP, including over-utilization of services, or accessing unauthorized waiver services not included in the PCSP;
2. The participant and/or an immediate family member, an employee, legal guardian or authorized representative consistently refuses services from a provider;
3. The participant and/or an immediate family member, an employee, legal guardian or authorized representative threatens, demonstrates abusive behavior towards a provider;
4. Imminent threat of harm to the participant's health, safety, or welfare is observed; or
5. The participant, an immediate family member, an employee, legal guardian or authorized representative interferes with the delivery of case management activities, as defined in Appendix C-1.

Immediate action may need to be taken in cases where health, safety, or welfare impacts are imminent.

The service advisor monitors the progress of the CAP and resulting outcomes. A CAP must be conducted over a minimum of thirty (30) calendar days to adequately address issues. If the participant is unable to resolve the issue or unable to develop and effectively implement the intended improvements stipulated in a CAP within ninety (90) calendar days of identification of the issue, the service advisor will issue a findings packet to The Department to determine if the participant should be terminated from PDS. PDS service delivery will be terminated through the appropriate process as follows:

1. The participant receives a letter notifying them of termination from the PDS option. The letter includes appeal rights as defined in Appendix F.
2. The participant and the participant's legal guardian or authorized representative, if applicable, are provided with information, regarding the traditional program and available providers, in a manner that is understandable to the participant. The service advisor assists the participant, legal guardian / authorized representative with identifying a traditional service provider they would like.
3. The service advisor coordinates with traditional providers to make sure that there are no lapses in service and that updates to the PCSP are made in a timely manner. The service advisor shall document the reason for the PDS option withdrawal, actions taken to assist the participant to develop a CAP and the outcomes, and the support provided in obtaining traditional services.
4. The participant is provided written notice of the option for an administrative hearing thirty (30) calendar days prior to the transition to traditional services.
5. If the participant cannot obtain a willing traditional provider within sixty (60) calendar days from the termination notice, he/she is discharged from waiver with the Department approval. A one-time, sixty (60) calendar days extension may be granted in the event of good cause, as defined in E-1-1.
6. Additional and immediate action may be taken if the participant's health, safety, or welfare is at risk. The service advisor assists the participant in understanding the risks and consequences and may immediately assist the participant in transferring to a traditional waiver provider of the participant's choice. The service advisor notifies the Department of the transfer and notifies other appropriate agencies and authorities of suspected abuse, safety, and neglect allegations through the proper channels and critical incident reports as described in Appendix G of this waiver application.
7. If substantiated by the Office of the Inspector General (OIG), cases of fraud may result in the participant's termination from PDS, the waiver, or Medicaid

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	<input type="text"/>	<input type="text" value="0"/>
Year 2	<input type="text"/>	<input type="text" value="0"/>
Year 3	<input type="text"/>	<input type="text" value="0"/>
Year 4	<input type="text"/>	<input type="text" value="0"/>
Year 5	<input type="text"/>	<input type="text" value="0"/>

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:

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.

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

Employee records are reviewed as a part of the quality auditing process including the results of all background screenings, trainings and any other pre employment or annual requirements.

Determine staff duties consistent with the service specifications in Appendix C-1/C-3.

Determine staff wages and benefits subject to state limits

Schedule staff

Orient and instruct staff in duties

Supervise staff

Evaluate staff performance

Verify time worked by staff and approve time sheets

Discharge staff (common law employer)

Discharge staff from providing services (co-employer)

Other

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

Reallocate funds among services included in the budget

Determine the amount paid for services within the state's established limits

Substitute service providers

Schedule the provision of services

Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3

Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3

Identify service providers and refer for provider enrollment

Authorize payment for waiver goods and services

Review and approve provider invoices for services rendered

Other

Specify:

--

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

- ii. Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

As identified in the K-HAT, services in the person-centered service plan shall be prior authorized. The participant may negotiate wage rates with employees; however, the hourly rate shall not exceed the maximum rate listed in the waiver for the service. The authorized amount will be calculated based on the unit rate set by the participant, multiplied by the number of hours approved on the service plan plus taxes or goods and services as approved on the service plan. The service plan can be modified based on changing needs of the participant.

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 initial person-centered service plan is developed based on assessed needs. Participants and/or their legal representatives are given copies of the plan and also receive a copy of the authorization letter. The participant can at any time request a change to the person centered plan. Any modification in services are based on change in needs, goal and objectives and require a person centered team meeting. The participant will receive updated copies of the plans and authorization letters.

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 person centered service plan is based on service units and is monitored for usage by the PDC for each participant. DAIL conducts random monitoring reviews of participants who direct their services and are in contact with the PDC agency as issues arise. Corrective action plans are created in instances where the participant fails to adhere to the service plan by over/under use of service units

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.

Participants are first informed of their right to an administrative hearing, the reconsideration, and the grievance processes during the initial face-to-face visit through distribution of the waiver welcome packet. Verification that the participant has been informed of their rights to an administrative hearing is obtained by signature of the participant on the Department-approved form. A participant may request assistance from their CM/service advisor to submit a request for an administrative hearing. If the participant does not have a CM/service advisor, or would prefer assistance from another party, the following entities may assist participants with filing an administrative hearing request:

1. Office of the Ombudsman,
2. Kentucky Protection and Advocacy,
3. Office of Legal Support,
4. Department for Aging and Independent Living, or
5. By calling the Medicaid Waiver Help Desk.

Materials provided to the participant include the participant's rights and process to request an administrative hearing in the event of one of the following adverse actions:

- a. Not providing a participant the choice of home and community-based services as an alternative to institutional care;
- b. Denying a participant the service(s) of their choice, service delivery option of their choice, or the provider(s) of their choice; or
- c. Actions to deny, suspend, reduce, or terminate services.

All administrative hearings are handled by the Hearing and Appeals Branch of the Cabinet.

Participants who are denied level of care, suspension, reduction, or termination of services, or PDS employee exemptions are issued written notification of appeal rights at the time of adverse action. These rights are contained as a part of the adverse action notices issued by the Department or its designee. When this function is conducted by a designee, the Department or its designee will develop all templates and perform oversight activities to ensure timeliness and that the adverse action notice includes the following:

- Appropriate denial or change information;
- Administrative hearing rights;
- Instructions for reconsideration or administrative hearing; and
- Contact information to request assistance with a request for appeal.

All administrative hearing rights are outlined in 907 KAR 1:563 which requires written notification of appeal rights to the participant and stipulates that participants must request, in writing, an administrative hearing within thirty (30) calendar days of the date of the notification. Services will continue as previously indicated in the PCSP prior to the adverse action if the request for an administrative hearing is made within ten (10) calendar days. The notices are generated electronically at the time of an adverse action, delivered, via certified mail, to the participant and the participant's legal guardian or authorized representative, if applicable, delivered electronically to the CM/service advisor, and recorded electronically in MWMA.

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.

A reconsideration is an optional process that provides the participant an opportunity to resolve the adverse action outside of the administrative hearing process while still retaining the option to pursue an administrative hearing in the future. The reconsideration is also the most efficient and quickest way to resolve an adverse action.

The participant may request an administrative hearing immediately following an adverse action notice or after they have pursued the reconsideration process. Furthermore, the reconsideration process is not a pre-requisite for an administrative hearing. Participants are first informed of the reconsideration process during the initial functional assessment, at the same time they are informed of the administrative hearing, and complaint and grievance process. Additionally, participants are informed of those processes annually upon re-assessment and in any adverse action notice.

The Department provides for a reconsideration process. This process is operated by the Department or its designee. This reconsideration process is summarized in the following steps:

1. The provider, participant, or the participant's legal guardian / authorized representative acting on the participant's behalf can request a reconsideration.
 - A reconsideration request must be made in writing and can be submitted to the Department via U.S. Mail or by email. Participants with a disability that prevents them from submitting a request in writing can call the Department's Division of Community Alternatives for assistance.
 - Reconsideration requests must be postmarked within fourteen (14) calendar days from the date of the written notice of adverse action.
 - Reconsideration requests postmarked or dated and timestamped more than fourteen (14) calendar days from the date of the written notice of adverse action are considered invalid. The individual making the request will receive an out of timeframe letter notifying them that the request was not made in the proper timeframe.

If a reconsideration request is made after the fourteen (14) calendar day timeframe ends, the provider, participant, or the participant's legal guardian/authorized representative acting on the participant's behalf can still request an administrative hearing.

- The out of timeframe letter will explain the right to an administrative hearing and the process for requesting one as described in Appendix F-1.
- A request for an administrative hearing must be made in writing and postmarked within thirty (30) calendar days of the initial written notice of adverse action. Requests for an administrative hearing cannot be made via email.

2. The Department or its designee will conduct the reconsideration, render a determination, and send a letter to the provider, participant, and participant's legal guardian or authorized representative, if applicable, within the timeframe set forth in 907 KAR 1:563. If the adverse action is upheld, the letter will be sent via certified mail. If the adverse action is overturned, the letter will be postmarked within the timeframe referenced in 907 KAR 1:563.

3. If the reconsideration determination upholds or modifies the original decision, resulting in an adverse action, the participant, the participant's legal guardian or authorized representative may request an administrative hearing. Information on how to request an administrative hearing is included in the reconsideration determination letter. The participant has thirty (30) calendar days from the reconsideration determination to request an administrative hearing. The request must be received or postmarked within thirty (30) calendar days of the reconsideration determination letter. If the request is received or postmarked within ten (10) calendar days, previously approved services of the reconsideration determination letter, services will continue until receipt of the final order. Administrative Hearings are handled by the Hearing and Appeals Branch of the Cabinet as described in section F-1.

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:

Participants have the opportunity to register grievances and complaints concerning the provision of services by waiver providers.

The grievances and complaints system shall be operated by the Department.

Filing a grievance or complaint is not a pre-requisite or substitution for a reconsideration or administrative hearing.

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 participants may register any grievance or complaint regarding waiver service provision or service providers by contacting the Department via Medicaid Waiver Help Desk, via email, or via mail. A complaint or grievance can be submitted at any time. The participant is informed that filing a complaint or grievance is not a prerequisite of a fair hearing. These complaints and grievances are documented in a central database administered by the Department. All complaints and grievances are tracked and trended by the Department to identify if additional provider trainings and participant education opportunities should be developed and conducted.

A complaint is an expression of dissatisfaction from the participant regarding some aspect of their 1915(c) waiver service delivery or experience that does not require follow up as determined by the categorization process described below.

A grievance is an expression of dissatisfaction from the participant due, in part or in full, to the failure of the Department, or a provider to adhere to established operating procedures, regulations, and waiver requirements. Grievances may require the Department follow up and resolution as determined by the categorization process described below.

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

1. An immediate response is necessary if a participant's health, safety, or welfare are jeopardized. Grievances will be addressed and the appropriate parties notified immediately of learning of the event. The Department will contact the participant via his/her preferred method of communication once the grievance is resolved and throughout the investigation as necessary.
2. The Department will provide a timely response if a grievance requires action to be taken but does not put the health, safety, or welfare of the participant in jeopardy. These responses will be addressed as soon as possible. Some action, including opening an investigation and notifying the appropriate parties, must be taken within seven (7) calendar days of receiving the grievance. Resolution of the grievance is dependent on the nature of the grievance and resolution is not required to occur within seven (7) calendar days. The Department or its designee will contact the participant via his/her preferred method of communication once the grievance is resolved.
3. If no action is necessary, the Department or its designee will document the complaint within the Department-approved system.

During this complaint/grievance assessment, the Department will determine if other agencies are responsible for licensure, certification, or monitoring of the provider and will notify or involve these agencies as appropriate. The Department will also determine if the grievance/complaint meets the definition of a critical incident as specified in Appendix G. If a critical incident has occurred, the Department will alert the appropriate parties and follow the process described in Appendix G of this waiver application.

Lastly, the Department will require all waiver service providers to implement policies and procedures to address participant complaints, grievances, and appeals independently from the state complaint/grievance/appeal process. The providers are required to educate all participants regarding the procedure and provide adequate resolution in a timely manner. The provider grievances and appeals are monitored by the Department or its designee through certification and on-site monitoring during surveys, investigations, and technical assistance visits.

Appendix G: Participant Safeguards

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).

The Commonwealth is responsible to provide a reporting process and investigation of cases of abuse, neglect, and exploitation (ANE) of waiver participants using 907 KAR 7:010 and the following Kentucky statutes and administrative regulations:

- “Abuse” as defined in KRS 209.020(8) and 922 KAR 5:070,
- “Sexual Abuse” as defined in KRS 600.020(58),
- “Exploitation” as defined in KRS 209.020(9) and 922 KAR 5:070, and
- “Neglect” as defined in KRS 209.020(16) and 922 KAR 5:070.

The Department or its designee requires the following additional incident types to be reported:

- Serious injury requiring treatment beyond basic first aid,
- Death other than by natural causes, and
- Events that serve as indicators of risk to participant health and welfare (e.g., unplanned in-patient hospitalizations, medication errors, use of restraints or behavioral interventions).

The Department or its designee will continually monitor incident trends and patterns and may require additional incident types beyond those listed above as needed.

For organizational and prioritization purposes, the Department classifies incidents into non-critical incidents and critical incidents. Critical incidents are serious in nature and pose immediate risk to health, safety, or welfare of the waiver participant or others. Non-critical incidents are minor in nature and do not create a serious consequence or risk for waiver participants. Other sections of this appendix describe the process for categorizing and investigating these incidents.

Identification of the individuals/entities that must report critical events and incidents:

Any individual who witnesses or discovers a critical or non-critical incident is responsible to report it. This includes, but is not limited to, all persons as defined in KRS 209.030(2) and KRS 620.030.

The timeframes within which critical and non-critical incidents must be reported:

Any individual who witnesses or discovers an incident should immediately take steps to ensure the participant’s health, safety, and welfare, and notify the necessary authorities, including calling law enforcement and reporting any suspected ANE or financial exploitation to the DCBS. DCBS is part of the Cabinet and operates both Adult and Child Protective Services (APS and CPS).

For critical incidents, the participant’s legal guardian and/or authorized representative shall be notified immediately following notifications to law enforcement and/or APS/CPS, unless he/she has suspected involvement. The Department defines “immediately” as making the notification as soon as possible but no later than eight (8) hours after the incident. The participant’s case manager (CM) or service advisor shall also be notified immediately. A critical incident report shall be submitted via MWMA within eight (8) hours of the time the incident is witnessed or discovered, and no later than the next business day if it is witnessed or discovered outside of regular business hours. The provider agency must begin its investigation into the critical incident immediately upon witnessing or discovering the incident and submit a full, written investigative report using MWMA within seven (7) calendar days.

For non-critical incidents, the participant’s legal guardian and/or authorized representative and CM/service advisor shall be notified within twenty-four (24) hours upon witness or discovery of the incident. The CM/service advisor, or provider shall enter the non-critical incident report in MWMA within 24 hours of witnessing or discovering the incident. Non-critical incidents witnessed or discovered on a weekend or state holiday should be reported the next business day.

The Department or its designee reviews critical and non-critical incident summary data generated by MWMA to identify systemic issues and conduct follow-up activities as warranted.

The method of reporting:

DCBS operates both a telephone hotline and an online system for reporting suspected ANE of an adult or child. Reporters can reach the Child Protection Hotline, toll-free, at 1-877-597-2331 to report suspected ANE of either an adult or child. The phone line is staffed twenty-four (24) hours a day, seven (7) days a week including weekends and holidays. Reporters can also contact their local DCBS office to report suspected ANE.

There is also an online system for reporting suspected ANE. This system is available for reporting non-emergency situations that do not require an urgent response. The website is monitored from 8:00 a.m. to 4:30 p.m. EST, Monday

through Friday. Reports are not reviewed on evenings, weekends, or State holidays. If a child or adult is at immediate risk of abuse or neglect that could result in serious harm or death, it is considered an emergency and should be reported to local law enforcement or 911.

Any person making such a report shall provide the following information, if known:

- The name, age, and address or location where the child or adult can be found and/or any other person responsible for their care;
- The nature and extent of the ANE, including any evidence of previous ANE;
- The identity of the suspected perpetrator;
- The name and address of the reporter, if they choose to be identified; and
- Any other information that the person believes might be helpful in establishing the cause of the abuse, neglect, or exploitation.

Those who witness or discover a non-critical or critical incident shall report it using MWMA. It is the provider's responsibility to contact all pertinent entities including but not limited to CM/service advisor, law enforcement, and protective services.

- 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.

It is a responsibility of the participant's chosen CM/service advisor to ensure that the participant and their caregiver are educated about ANE and the methods available to report ANE. When a participant opts to employ PDS workers, the service advisor is responsible to ensure that all workers employed by the participant are trained on mandatory reporting laws for ANE reporting.

During the CM/service advisor's initial visit with the participant, the CM/service advisor provides information and resources to the participant, the participant's legal guardian and/or authorized representative, if applicable, and anyone else designated by the participant regarding strategies to identify, prevent, report, and intervene in any instances or potential instances of ANE. Upon completion of this discussion, the CM/service advisor reviews a Department-approved form developed by the Department with the participant. The participant signs this form, attesting to their understanding of ANE and how these critical incidents can be prevented, reported, and addressed. The CM/service advisor retains the original of this document and provides the participant and caregiver with a copy for their record. A copy is also uploaded to MWMA and is available to the Department. Participants and their caregivers are asked to attest to their knowledge and training on ANE and critical incidents annually. A copy of contact information for appropriate protection agencies must be provided and explained to each participant and/or legal guardian/authorized representative, if applicable. Training and communication must be provided to participant in a manner that is appropriate for their learning style.

The service advisor is also responsible for monitoring and oversight of PDS employee training. The service advisor notifies the PDS employee of the Department mandatory trainings and the timeframe in which the employee must complete these trainings. PDS training is provided through Department-developed materials.

Depending upon the individual needs of each participant, additional training or information shall be made available and related needs addressed in the participant's PCSP.

The Department requires all providers, both traditional and PDS, to complete training on ANE identification and reporting.

- 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 response below describes the Department's role in reviewing and responding to critical and non-critical incidents. The Department cooperates with other investigative agencies, including APS/CPS, operating agencies, and law enforcement, to complete investigative activities in a timely manner with minimal stress to the participant.

The entity that receives reports of each type of critical event or incident:

Shall submit an incident report using MWMA.

Shall report any suspected ANE to DCBS.

The entity that is responsible for evaluating reports and how reports are evaluated:

Upon receiving the report, the Department or its designee becomes responsible for evaluating reports. The Department may upgrade or downgrade an incident based on the report submitted.

A. A non-critical incident shall:

1. Be submitted via MWMA. The Department or its designee reserves the right to escalate any categorical non-critical incident to a critical incident as circumstances require;
2. Be minor in nature and not create a serious consequence or risk for participants;
3. Not require an on-site Department or its designee investigation; and/or
4. Be monitored for future follow-up and intervention as appropriate

B. A critical incident shall:

1. Be reviewed by the Department or its designee and appropriately classified as a critical or non-critical incident and the investigative process will be initiated as appropriate;
2. Be serious in nature;
3. Pose immediate risk to health, safety, or welfare of the participant, co-residing participants, or others;
4. Have an investigation report completed within seven (7) calendar days of the incident; and/or
5. Warrant an on-site Department investigation as needed

The timeframes for conducting and completing an investigation:

Individuals who witness or discover an incident shall immediately ensure the participant's health, safety, and welfare, and contact the proper authorities, including law enforcement and/or APS/CPS.

For both critical and non-critical incidents, the participant's legal guardian/authorized representative and CM/service advisor shall be notified as soon as the above steps have been taken.

Once these steps have been taken, the provider agency initiates an investigation into the incident based on its classification as follows:

Non-Critical Incidents

The Department reviews non-critical incident reporting. Based on the findings, the Department may require more information or escalate the incidents to a critical incident. If the non-critical incident is escalated to a critical incident, the critical incident processes below will apply.

Critical Incidents

Provider agencies must initiate investigations of critical incidents immediately upon witnessing or discovering the

incident. The Department shall be notified, via an incident report entered into MWMA, the same day if the incident is witnessed or is discovered during business hours and the next business day if it is witnessed or is discovered outside of

business hours. The Department or its designee conducts a review of the critical incident. The Department or its designee may intervene when deemed necessary and conduct an investigation within fourteen (14) business days of notification if the incident involves physical abuse and neglect that results in death or potentially life-threatening or serious injury or illness. APS/CPS and/or law enforcement investigations may take longer. The Department will maintain a memorandum of understanding with APS/CPS regarding the results of investigations and will take appropriate action based on the outcome. The provider must upload a complete, investigative report on the critical incident within seven (7) calendar days of witness or discovery MWMA. This report only includes provider findings.

All waiver providers are expected to meet the standards set forth in their provider agreement with the Department, with Department ANE training, Department waiver certification, and/or OIG licensure regarding ANE/critical incident investigations and reporting.

The entity that is responsible for conducting investigations and how investigations are conducted:

Providers conduct and upload investigations on critical incidents to MWMA within seven (7) calendar days.

In opening and initiating an investigation, the Department or its designee contacts and coordinates with APS/CPS, law enforcement, and other responsible agencies immediately if needed. The Department or its designee must conduct investigations in coordination with these parties, as they are identified as involved in a case, to ensure the participant's health, safety, and welfare.

The Department or its designee must also assist and support investigations in accordance with Kentucky statute and administrative regulations, including 922 KAR 1:330, 922 KAR 5:070, KRS 620.030, and KRS 209.030.

The Department or its designee will conduct an investigation using methods determined appropriate and will intervene immediately to address imminent health, safety, or welfare concerns of a participant as deemed necessary, based on the reporting and investigatory information obtained. As part of the investigation, the Department or its designee may interview parties involved in the incident including provider staff, participants, witnesses, or other parties. In addition, the Department or its designee may request and review medical reports, claims data, police reports, and other pertinent documentation to support the Department's investigation. If necessary, the Department or its designee may also conduct an on-site investigation to inspect the participant's environment at home or in a provider facility. If the investigation report results in documentation of regulatory non-compliance, a findings letter including citations, impositions of a corrective action plan (CAP), and/or sanctions is generated and sent to the provider agency via mail.

The participant or family/legal representative, as appropriate, as well as other relevant parties (the provider licensing and regulatory authority) are notified of the investigation within thirty (30) days of close of the investigation.

- 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 or its designee is responsible to oversee reporting of and response to critical incidents affecting waiver participants. The Department or its designee will conduct an investigation and will intervene to address imminent health, safety, or welfare concerns of a participant as deemed necessary. The Department tracks and trends all incident reports. The Department or its designee may conduct follow-up monitoring visits, technical assistance, or provider training as needed, based on trend analysis. Trend analysis monitors the following data elements:

- Nature of the incident,
- Frequency of incidents,
- Adherence to time standards,
- CAP status,
- High frequency providers,
- Recurring participants, and
- Rate of unreported incidents identified via MMIS claims data.

All incident reports are submitted through MWMA. The Department or its designee samples a select number of providers and verifies through certification surveys, monitoring visits, or investigations that critical incidents were appropriately addressed 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:

Kentucky recognizes that person-centered thinking and planning is key to prevention of risk of harm for all participants. It is the responsibility of all service providers to utilize person-centered thinking as a means of crisis prevention.

Kentucky is dedicated to fostering a restraint-free environment in all waiver programs. The Department prohibits the use of mechanical or chemical restraints, seclusion, manual restraints, including any manner of prone (breast-bone down) or supine (spine down) restraint.

The Department also prohibits the use of chemical restraints. The Department defines a chemical restraint as the use of a medication, either over the counter or prescribed, to temporarily control behavior or restrict movement or functioning of a participant and is not a standard treatment for the participant's medical or psychiatric diagnosis. A psychotropic per required need (PRN) is a pharmacological intervention defined as the administration of medication for an acute episodic symptom of a participant's mental illness or psychiatric condition and is not considered a chemical restraint. All medication administration must adhere to a physician's order that shall include drug, dosage, directions, and reason for use. The PCSP, risk mitigation form, and behavior support plan, if applicable, shall incorporate the protocol for use of a psychotropic PRN and is applicable to participants in the Department-approved provider sites. These are reviewed annually as part of the person-centered planning process or more often if needed.

The Department is responsible for oversight of the person-centered planning process which includes monitoring of case management reports, incident reports, and complaints. The continuous quality improvement process reveals trends, patterns, and remediation necessary to ensure proper implementation of the PCSP and participant safety.

A participant has the right to be free of any physical or chemical restraints. Any interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior must be evaluated on at least an annual basis. If a participant's unanticipated violent or aggressive behavior places him/her or others in imminent danger, a restrictive intervention may be used as a last resort to maintain health, safety, and welfare.

State laws, regulations, and policies will be made available to CMS upon request through the Medicaid agency or the operating agency.

The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

- b. Use of Restrictive Interventions.** (*Select one*):

The state does not permit or prohibits the use of restrictive interventions

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The Department or its designee is responsible for detecting the unauthorized use of restrictive interventions. The Department or its designee incorporates oversight into on-site monitoring and review of critical incidents. Incident reports are monitored quarterly for use of restrictive interventions.

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.

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:

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:

The Department or its designee is responsible for detecting the unauthorized use of seclusion, as described in section G-2-a. The Department or its designee incorporates oversight into on-site monitoring and review of critical incidents.

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.

Entity (entities) that have responsibility for monitoring medication regimens:
Licensed waiver providers are responsible for monitoring participant medication regimens in adult day health care centers and specialized respite settings.

The methods for conducting monitoring of medication regimens:

Waiver providers are 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 Department-approved training on cause and effect and proper administration and storage of medication, documentation requirements, and appropriate disposal. Training must occur at time of hire, annually, and as needed. Attendance and competency must be documented and maintained in provider personnel records.
2. Document of all medication administered, including self-administered, over-the-counter drugs, on a medication administration record (MAR), with the date, time, and initials of the person who administered the medication, and supervisors validate appropriate administration and documentation through a process approved by the Department or its designee. The Department or its designee reviews during the certification processes. The Department or its designee conducts certification annually or more frequently if necessary.
3. Ensure the medication shall:
 - a. Be kept in a locked cabinet or storage unit;
 - b. Be kept in a pharmacy labeled container or original package with participant's name and expiration date;
 - c. Be properly disposed of as needed;
 - d. If a controlled substance, be kept under double lock; and
 - e. Be documented by a cumulative monthly log with drug name and dosage with a daily medication count verified by two individuals with signature, title, date, and time.

In addition, waiver providers are required to have policy and procedures for on-going monitoring of medication administration, which must be approved by the Department or its designee.

Frequency of medication regimen monitoring:
A provider agency supervisor should verify appropriate administration of medication on a frequency approved by the Department or its designee during the provider certification and re-certification process. Licensed waiver providers are responsible for monitoring medication logs daily to ensure that medications are administered according to Department requirements and provider policies and procedures.

- 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.

The Department or its designee is responsible for oversight of medication management practices by licensed waiver providers. This oversight begins with review and approval of providers' policy and procedures for on-going monitoring of medication administration. The Department or its designee assesses medication administration policies, practices, and record-keeping, 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 MWMA, as defined in G-1-d. A provider agency supervisor should verify appropriate administration of medication on a frequency approved by the Department or its designee during the provider certification and re-certification process.

Providers deemed non-compliant with medication management requirements may receive technical assistance, CAPs, or sanctions depending on the frequency and severity of the non-compliant action. The Department or its designee conducts additional evaluation and investigation for any medication error classified as a critical incident and any recurrent non-critical incidents errors classified as a critical incident.

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).

Licensed waiver providers may be responsible for medication administration. Those who choose to be responsible receive training on medication administration. G-3-b-I of this appendix describes the Department policy regarding medication regimen reviews. In addition to these monitoring standards, the Commonwealth provides guidance to providers through State law, regulations, and policies. State laws, regulations, and policies will be made available to CMS upon request through the Medicaid agency or the operating agency.

- 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 are reported to the Department through MWMA and investigated in accordance with section G-1-D of this appendix.

(b) Specify the types of medication errors that providers are required to *record*:

A medication error occurs when a waiver participant receives an incorrect drug, dose, form, quantity, route, concentration, or rate of administration from a direct service provider. A medication error is also defined as the variance of the administration of a drug on a schedule other than intended in the prescription instructions. Therefore, a missed dose or a dose administered more than one hour before or after the scheduled time constitutes a medication error. Providers must record two (2) levels of medication errors while a participant is in their care as follows:

Non-Critical: Refusal by the participant is considered non-critical. If the participant refuses three or more doses or if they refuse doses three or more times in 90 days it is upgraded to a critical incident. For provider assisted medications (e.g., administering or cueing), medication errors only relate to medications included on the Medication Administration Record (MAR).

Critical: Errors in prescribed medication or medication management by waiver providers including a missed dose, a wrong dose or wrong medication, or that result in an adverse reaction are considered critical. For provider assisted medications (e.g., administering or cueing), medication errors only relate to medications included on the Medication Administration Record (MAR).

(c) Specify the types of medication errors that providers must *report* to the state:

All medication errors as defined in section G-3-c-iii-b must be reported to the state. Providers must report non-critical errors following the non-critical incident timeframes set forth in section G-1-B. Providers must report critical errors following the critical incident timeframes set forth in section G-1-B.

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 or its designee is responsible for monitoring waiver providers’ performance in administration of medication. This oversight begins with review and approval of provider policy and procedures for on-going monitoring of medication administration. The Department or its designee assesses medication administration policies, practices, and record-keeping, and necessary interventions employed, as part of the certification, on-site monitoring, and incident reporting process, which occurs as deemed necessary by the Department or its designee. In addition, all medication errors must be reported through MWMA and will be followed up as warranted.

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 instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:

% participants (or families/legal guardians) who recvd info how to identify and rept abuse/neglect/exploitation/unexplained death. N=# participants (or families/legal guardians) recvd info how to identify and rept abuse/neglect/exploitation/unexplained death. D=#number of participants

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Medicaid Waiver Management Application acknowledgement page

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; display: inline-block;">95% +/- 5%</div>
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify:

		<input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Percent of potential abuse, neglect, exploitation & unexplained death incidents rept in required timeframe. N=# critical incident repts of potential abuse, neglect, exploitation & unexplained death submitted in timeframe. D=# critical incident reports of potential abuse, neglect, exploitation & unexplained death.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Medicaid Waiver Management Application critical incident reporting module

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
---	--	--

State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

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: <input type="text"/>	Annually
	Continuously and Ongoing

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	Other Specify: <input type="text"/>

Performance Measure:

Percent of potential abuse, neglect, exploitation & unexpected death incidents reviewed/investigated in required timeframe. N=# critical incident repts of potential abuse, neglect, exploitation & unexpected death incidents reviewed/investigated in required timeframe. D=# critical incidents reports of potential abuse, neglect, exploitation & unexpected death received.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Medicaid Waiver Management Application critical incident reporting module

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="95% +/- 5%"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other	

	Specify: <input style="width: 100%; height: 20px;" type="text"/>	
--	---	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

Performance Measure:

% ANE & unexpl death incidents that impelled the Dept to req f/u action by prov (CAP, prov sanc, etc) where req action was compl by prov & correctly sub to the Dept. N= # ANE & unexpl death incidents that impelled the Dept to req f/u action by prov, where req action was compl by prov & correctly sub to the Dept. D= # ANE & unexpl death incidents that impelled the Dept to req f/u action by prov

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Medicaid Waiver Management Application Critical Incident Reporting Module

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100%

		Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="95% +/- 5%"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

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: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	<input type="text"/>

Performance Measure:

% of abuse/neglect/exploitation/unexplained death incidents referred to appropriate investigative entities (ex: Law Enforcement/APS/CPS) for follow-up. N=# abuse/neglect/exploitation/unexplain death incidents referred to appropriate investigative entities (ex: Law Enforce/APS/CPS) for follow-up. D=# ANE/unexplained death incidents.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Medicaid Waiver Management Application critical incident reporting module

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="95% +/- 5%"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify:	

	<input style="width: 80%; height: 20px;" type="text"/>	
--	--	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

Performance Measure:

Percent of employees who received training on abuse, neglect, exploitation and preventable deaths N=Number of employees who received training on A/N/E and preventable deaths D= Number of employee records

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Employee records

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

		Confidence Interval = <input type="text" value="95% +/- 5%"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

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: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

b. Sub-assurance: *The state demonstrates that an incident management system is in place that effectively*

resolves those incidents and prevents further similar incidents to the extent possible.

Performance Measures

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

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

Performance Measure:

Percent of critical incidents where root cause was identified. N=Number of critical incidents where root cause was identified. D=Number of critical incidents received.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Medicaid Waiver Management Application critical incident reporting module

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="95% +/- 5%"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify:	

	<input style="width: 80%; height: 20px;" type="text"/>	
--	--	--

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: <input style="width: 100%; height: 20px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

Performance Measure:

Percent of critical incidents where a common root cause was identified and systemic intervention was implemented N= Number of critical incidents with common root cause identified and systemic intervention implemented D= number of critical incidents with common root cause identified

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Medicaid Waiver Management Application critical incident reporting module

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 = <input type="text" value="95% +/- 5%"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

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: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

c. *Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.*

Performance Measures

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

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

Performance Measure:

Percent of critical incidents where use of restrictive interventions are reported and investigated in the appropriate timeframe. N=Number of critical incident reports where use of restrictive interventions were reported and investigated in the appropriate timeframe D=Number of critical incident reports listing the use of restrictive interventions

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Medicaid Waiver Management Application critical incident reporting module

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="95% +/- 5%"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>

	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	
--	---	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

d. Sub-assurance: *The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

Performance Measures

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

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

Performance Measure:

Percent of participants who received information and support to access Medicaid State Plan services identified in their PCSP. N=# of participants who received information and support to access Medicaid State Plan services. D=# participants with Medicaid State Plan services identified in PCSP.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Medicaid Waiver Management Application and participant surveys

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="95% +/- 5%"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other	Annually

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
Specify: <input data-bbox="405 340 799 423" type="text"/>	
	Continuously and Ongoing
	Other Specify: <input data-bbox="868 629 1262 712" type="text"/>

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.

Licensed provider agencies are reviewed every three (3) years by the OIG which includes the monitoring of the employees records for criminal checks and abuse registry checks. Licensed and certified agencies are reviewed by the Department or its designee annually or more frequently as required. The Department or its designee performs first line monitoring and identifies deficiencies of the HCB waiver provider. This monitoring includes, but not limited to reviewing complaint logs, MARs, policies and procedures of providers for grievances and complaints, etc. During the monitoring the Department or its designee will review the procedures of the provider that train employees and ensure the health, safety, and welfare of the participants and that incidents are reported appropriately.

The Department or its designee monitors the complaint process by examining complaint logs and the results of client satisfaction surveys. Providers must ensure that waiver participants have access to agency staff and know their case managers name and contact information.

The Department or its designee monitors the complaint process by examining complaint logs and the results of client satisfaction surveys.

Providers must ensure that waiver participants have access to agency staff and know their case managers name and contact information.

Require providers to make the toll-free Fraud and Abuse Hotline telephone number of the Office of Inspector General available to agency staff, waiver participants and their caregivers, legal guardians or authorized representatives, and other interested parties. The purpose of this telephone Hotline is to enable complaints or other concerns to be reported to the OIG.

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.

Licensed provider agencies are reviewed every three (3) years by the OIG which includes the monitoring of the employees records for criminal checks and abuse registry checks. Licensed and certified agencies are reviewed by the Department or its designee. Should an enrolled provider not meet requirements to provide services, OIG would notify Program Integrity. The Department or its designee would follow processes as described in 907 KAR 7:005. The Department or its designee performs first line monitoring and audit reviews.

All documentation concerning the monitoring process for providers is kept for a period of five (5) years after the last claim is processed or the expiration/termination of the contract, whichever is sooner.

ii. Remediation Data Aggregation

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

Responsible Party (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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 3)

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; and
- 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 3)

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.

The Department or its designee collects data from a variety of sources to help understand the effectiveness and quality of its current waiver operations. The data collected provides meaningful insights and informs decisions related to process and systems improvement. The Department has defined its quality-related operational elements including data aggregation, measurement, and reporting activities which promotes consistent, rigorous quality management approaches that are institutionalized within Cabinet operations and culture. The Department determined what data should be collected based on several factors including; relevance to participant health and welfare, reliability of data, importance to the Department operational goals, ease and feasibility of data collection, among other factors. The information collected includes data from: LOC determinations; service authorization, service and expenditure reports; individual plans and outcomes; incident reports; consumer surveys; monitoring visits; progress toward achieving corrective action plan goals; and recertification reviews.

The Department analyzes the aggregate data based on established performance targets related to each data point. The Department evaluates data collected against these performance targets to identify performance gaps. As gaps are identified, the Department evaluates program-wide data in a manner that enables the Department staff to observe overarching trends and to “drill down” to observe differences among various geographies, waivers, subpopulations, etc. so that the Department can begin to understand potential root causes of performance patterns and variation. Subsequently, the Department identifies opportunities to improve operational processes based on performance gaps and trends. The Department prioritizes the process improvement to address performance gaps and trends based on the measure. The Department strategically identifies opportunities to enhance operational processes based on how the process can improve participant health and welfare, strengthen compliance with federal regulations and guidance, improve efficiencies of staff resource use, among other factors.

Implementation of system improvements is dependent on the performance gap. The Department will assess the performance gap and identify the root cause to be addressed. The Department or its designee, will develop a tailored implementation plan, identify needed staff, and determine the steps, sequence, and timeline for system improvement so performance gaps can be addressed in a timely manner.

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Quality Improvement Committee	Annually
Other Specify: <input type="text"/>	Other Specify: <input type="text"/>

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.

The Department continually monitors system design changes by evaluating the performance data pre- and post-implementation of system changes. The Department establishes performance goals when implementing systems redesign and regularly tracks the progress towards meeting these goals. The Department will monitor the implementation of system improvements through regularly schedule meetings, progress towards key milestone, and continuous monitoring of performance measures. The Department reserves the right to increase the frequency or number of measures collected during system change implementation to identify unforeseen impacts of the system change plan. The Department can modify its design changes based on outcomes indicated by its performance data. As new performance gaps arise, the Department prioritizes additional systems changes to address these gaps. The Department or its designee creates reports to track progress of these systems improvements and discusses progress and with the appropriate parties. This process continues as the Department improves its operations to meet its program-wide goals.

- ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

The Cabinet is shifting its approach to re-orient its quality management activities from the current compliance focus to one that recognizes the importance of both regulatory compliance and quality improvement to promote improved participant outcomes and other performance improvements. The Department is creating a quality strategy that mirrors this shift in approach. The Department has selected performance measures that allows the Department the ability to understand the effectiveness and quality of its current waiver operations. The data collected provides meaningful insights and informs decisions related to process and systems improvement. The Department regularly reviews each of its 1915(c) waiver operations and identifies opportunities to modify existing measures or add measures to appropriately monitor its operational effectiveness. In addition, the Department performs a formal annual review of its quality strategy and revises, as needed.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

- a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):

No

Yes (*Complete item H.2b*)

- b. Specify the type of survey tool the state uses:

HCBS CAHPS Survey :

NCI Survey :

NCI AD Survey :

Other (*Please provide a description of the survey tool used*):

Participants are surveyed during provider certification to determine satisfaction. The tool was developed by the State to review community involvement and quality of life. The Department is also beginning the process of implementing the NCI AD.

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 or the operating agency conduct annual utilization audits of 100% of enrolled waiver providers utilizing a statistically valid sample with a confidence level of 95% +/- 5%. These audits include a post-payment review of Medicaid reimbursement to the provider agency for services rendered to a waiver participant. The Department or the operating agency shall utilize reports generated from the Medicaid Management Information System (MMIS) reflecting each service billed by the waiver provider. Comparison of payments to participant records, documentation and approved PCSP shall be conducted. If any payments were issued without the appropriate documentation or not in accordance with approved POC, the Department will initiate recoupment of the monies. Additional billing reviews are conducted based on issues identified during certification surveys or investigations. The Department or the operating agency may require corrective action plans and/or recoupment monies for failing to meet audit requirements. Monies that are recouped are not drawn from the FFP. For example if we paid claims of 12\$K but recouped \$2K we would only draw the fed share in \$10K.

The Department or the operating agency shall conduct annual audits of the financial management services (FMS) entities. These audits include a post-payment review of Medicaid reimbursement to the financial management agency for payment to the participant's employees through participant directed opportunities and annual utilization audits of 100% of enrolled waiver providers utilizing a statistically valid sample with a confidence level of 95% +/- 5%. Auditing will be conducted through random sample of all participant directed records. The Department or the operating agency shall utilize reports generated from MMIS reflecting each service billed for each participant by financial management agency. Comparison of payments to participant records, documentation and approved PCSP shall be conducted. If any payments were issued without the appropriate documentation or not in accordance with the approved PCSP, the Department or the operating agency will initiate recoupment of the monies. Additional billing reviews shall be conducted based on issues identified during these post payment audits. Monies that are recouped are not drawn from the FFP.

The Department may reflect in the monitoring report that a Corrective Action Plan (CAP) is needed. The Department requests a CAP, if needed. The enrolled provider submits a response to the CAP with supporting evidence of the implementation of the corrective action.

The Auditor of Public Accounts conducts annual audits of the HCB waiver program in accordance with the Single Audit Act. Providers may choose to have an independent audit of their financial statements but they are not required to do so. the audit encompasses the prior fiscal year.

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 coded and paid for in accordance with the established reimbursement methodology specified in the approved waiver N=Number of claims coded and paid in accordance with the established reimbursement methodology in the approved waiver. D=Number of claims coded and paid.

Data Source (Select one):

Financial records (including expenditures)

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 = <input type="text"/>
Other Specify: <input type="text" value="MMIS"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other</i> Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;">MMIS</div>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	<i>Other</i> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

Performance Measure:

Percent of waiver service claims submitted and paid for services rendered on the participants plan of care and only for services rendered. N= Number of waiver service claims that were submitted and paid for services rendered on the participant's plan of care and only for services rendered. D= Number of waiver service claims submitted and paid.

Data Source (Select one):

Financial records (including expenditures)

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):
<i>State Medicaid Agency</i>	<i>Weekly</i>	<i>100% Review</i>
<i>Operating Agency</i>	<i>Monthly</i>	<i>Less than 100% Review</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>	<i>Representative Sample</i> Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<i>Other</i> Specify:	<i>Annually</i>	<i>Stratified</i> Describe Group:

MMIS		
	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):
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
Other Specify: MMIS	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	Other 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.

Performance Measure:

Number of rates that remain consistent with the approved rate methodology throughout the five year waiver cycle. N=Number of rates that remain consistent with the approved rate methodology throughout the five year waiver cycle. D=Number of rates used throughout the five year waiver cycle.

Data Source (Select one):

Financial records (including expenditures)

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 = <input type="text"/>
Other Specify: <input type="text" value="MMIS"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

<i>Responsible Party for data aggregation and analysis (check each that applies):</i>	<i>Frequency of data aggregation and analysis (check each that applies):</i>
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other</i> <i>Specify:</i> <input type="text"/>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	<i>Other</i> <i>Specify:</i> <input type="text"/>

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 Department 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.

The Department 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.

The Department or its designee 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). The Department or its designee performs trainings upon request of providers and provides technical assistance whenever requested. Should an enrolled provider fail to meet their POC, The Department may terminate the provider's enrollment as a waiver provider.

ii. Remediation Data Aggregation

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

<i>Responsible Party (check each that applies):</i>	<i>Frequency of data aggregation and analysis (check each that applies):</i>
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other</i> <i>Specify:</i>	<i>Annually</i>

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
MMIS	
	Continuously and Ongoing
	Other Specify:

c. Timelines

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

No

Yes

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Provider rates are established under a fee-for-service system. DMS established rates for most services through an independent cost study conducted by Guidehouse Consulting to determine costs associated with each service component. The following services were included in the rate study: Adult Day Health Care, Case Management, Specialized Respite, Financial Management Services, Attendant Care, Home Delivered Meals, and Non-Specialized Respite. The methodology for the rate study is consistent with the efficiency, economy, and quality of care requirements described in §1902(a)(30)(A) of the SSA. From March-May 2022, Guidehouse administered a statewide provider cost and wage survey, requesting that providers across each of the Commonwealth's six 1915(c) home and community-based services waivers report wage and other cost information for the first quarter (January-March) of 2022, as well as other program characteristics to support rate setting. Guidehouse had administered a similar survey in February-May 2019, collecting data from provider Fiscal Year 2018.

Guidehouse employs an independent rate build-up approach, which considers median direct wages, payroll taxes, benefits, and employee-related expenses, as well as provider administrative and program support expenses, along with representative productivity rates for each service. This approach establishes a base rate that reflects wages of the direct care staff providing the service, as well as direct supervisory costs. Employee-related expenses, administrative and overhead expenses, and program support costs are calculated as a percentage of direct care wages, and then factored into the rate as a multiplier of the base wage rate. The rates also incorporate service-specific productivity factors, as well as facility, equipment, transportation, training and supply costs unique to certain types of services.

The data informing the rates derive from the provider cost and wage surveys, as well as benchmarks from the federal Bureau of Labor Statistics and the Medical Expenditure Panel Survey as well as other state and regional wage benchmarks.

Stakeholders were afforded opportunities for feedback throughout the process, as a part of the announcement of the independent rate study, during and following release of the provider cost survey, and following public notice of this waiver amendment. The public comment process includes informing stakeholders of the change, then releasing educational summary documents of rates and the proposed waiver amendment itself for 30 days and allowing stakeholders to submit comments in writing or via email, as described in further detail in section 6I. Stakeholders were informed of public comment and responses to public comment through DMS' website, a dedicated email, on DMS' social media accounts. Along with general public comment opportunities, the rate study was subject to monthly review and feedback from an advisory Rate Study Work Group, composed of provider representatives, advocacy groups, Legislators, and other state agency stakeholders.

DMS conducted a thorough review of benchmark rates in 2023. The Legislature allocated funding to cover 70% of the benchmark rate recommendations in 2024. Understanding that a reduction in rates may adversely impact the provider pool and therefore access to quality care, DMS is only implementing the 70% benchmark rate if that rate is higher than the previously approved rate. Therefore, the following services did not receive an update: Case Management, Financial Management Services, Attendant Care, and Home Delivered Meals.

In addition, providers offering some non-residential services are eligible for a 50% rate increase if they signed an attestation in which they committed to passing through 85% of the rate to direct care workers. DMS will maintain that rate in cases where that rate is higher than 70% of the benchmark rate and providers signed an attestation. DMS will increase case management rates above the benchmark rate study rate to match rates from other waivers.

Rates for Participant-Directed Services match those for traditional services, so the same rate increases will apply to PDS services. The PDS employer can establish a rate between minimum wage and the established service rate. For PDS and non-PDS services, different employees can be paid different rates based on the needs of the participant and any additional training/knowledge the employee has that enhances the way they are able to perform their job.

Rates do not vary by geographic location.

Cost-based services (e.g., Environmental and Minor Home Adaptations, Goods and Services) and Home and Community Supports were not included in the rate study. There are no changes to rates for those services. Cost-based services will continue to be paid at cost with the limits for each service described in Appendix C.

Providers were notified of rates through a provider letter via email in June 2024. Rates can be found on the fee schedule publicly at the following link: <https://www.chfs.ky.gov/agencies/dms/Pages/feesrates.aspx>

DMS will review rates every five years, or more frequently as necessary, to ensure rates are adequate to maintain the provider pool.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Billings for waiver services shall flow directly from the waiver providers to the Commonwealth's Medicaid Management Information System (MMIS).

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures (select one):

No. state or local government agencies do not certify expenditures for waiver services.

Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)

Certified Public Expenditures (CPE) of Local Government Agencies.

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

All waiver providers shall be enrolled with the Department’s Division of Program Integrity (DPI), provider enrollment, and have a signed contract on file. The Medicaid Management Information System (MMIS) has edits and audits established to ensure that: 1. The individual was eligible on the date of service 2. Services billed were included on the approved service plan. 3. Services were rendered. The Department or its designee shall conduct audits of all waiver providers. These audits shall include a post-payment review of Medicaid reimbursement to the provider agency for services rendered to a waiver participant. The Department or its contractors shall utilize reports generated from the Medicaid Management Information System (MMIS) reflecting each service billed by the waiver provider. Comparison of payments to participant records, documentation and approved person-centered service plans (PCSP) shall be conducted. If any payments were issued without the appropriate documentation or not in accordance with approved PCSP, the Department shall initiate recoupment of the monies utilizing an accounts receivable process through the MMIS. The Department subtracts the amount noted for recoupment from the federal funds that are drawn down.

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:

Local Health Departments can provide case management.

Local Area Agencies on Aging and Independent Living (AAAIL) can provide Participant Directed Coordination services if the AAAIL chooses not to perform any other services other than case management. Otherwise, the AAAIL may provide attendant care, respite and nutrition services.

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:

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:

The Department sets up accounts receivable through the MMIS to be recouped through claims payment. Public health department providers are limited to the actual costs of providing services in accordance with 907 KAR 7:015 Section 3. Providers are paid from the HCB fee schedule in the interim. Once actual costs are determined via cost reporting methods, interim payments are compared to actual costs of providing HCB services and should interim payments exceed costs, the amount is recouped from the provider as outlined in 907 KAR 1:671.

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.

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 section 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 section 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 section 1915(b)/section 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 section 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 section 1115/section 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 section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.

In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver 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 section 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.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

Appropriation of State Tax Revenues to the State Medicaid Agency

Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

In addition to the State Medicaid Agency, a portion of the non-federal share of waiver costs is from state tax revenues appropriated to the Department for Aging and Independent Living and the Department for Public Health. An Intergovernmental Transfer (IGT) from each of these state agencies to the Department for Medicaid Services is used to transfer funds.

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:

Do not complete this item.

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	5789.69	10018.32	15808.01	36272.85	1631.28	37904.13	22096.12
2	5964.26	10328.00	16292.26	37397.31	1681.85	39079.16	22786.90
3	6250.69	10637.84	16888.53	38556.63	1733.99	40290.62	23402.09
4	10507.90	10956.98	21464.88	39751.89	1787.74	41539.63	20074.75
5	11848.47	11285.69	23134.16	40984.20	1843.16	42827.36	19693.20

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	17300		17300
Year 2	17300		17300
Year 3	17300		17300
Year 4	17300		17300
Year 5	17800		17800

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay is based on MMIS claims data for the period 07/01/2017 through 6/30/2018. The total days of waiver coverage was 2,614,270. Total unduplicated waiver participants was 8,805. Dividing total days of enrollment for all participants by the number of unduplicated participants yields an average days per waiver participant of 297. The average length of stay is expected to increase in the following years based on number of new admissions to the waiver and fewer discharges.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

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 and methodology for these estimates is as follows:

Review of paid claims data from the MMIS and person centered plans of care for waiver participants for the period July 2017 through June 2019 including total units paid per service, total unduplicated users, total cost, average units of service and average cost. Costs were calculated by multiplying the estimated units of service by the unit rate to determine expected expenditures. Expected users for waiver services that remained unchanged or slightly modified were determined based on historical utilization and historic person centered plan of care requests. For new services, estimated users and units per user were based on utilization of prior services as well as the judgment of specialists with knowledge of the service needs of the targeted population. The average number of users was based on the CMS 372 reports for waiver years ending in 2018 and 2019 as well as enrollment data from the Medicaid Waiver Management Application.

Effective May 1, 2024: DMS is amending the estimates for Waiver Year 4 and 5 to reflect the temporary rate increases in Kentucky's approved Appendix K. The average cost per unit estimates in Waiver Years 4 and 5 Appendix J-2-d align with current legislatively approved rates defined in Kentucky Administrative Regulation and include a temporary rate increase as authorized by Appendix K and approved by CMS. For services provided at cost (e.g., goods and services, environmental modifications), DMS calculated the average cost per unit based on the 2019 372 report data and applied the temporary rate increase to that value to align with the approved Appendix K. DMS will monitor future 372 reports and actual utilization to determine whether amendments are needed to align with updated spending. DMS also separated PDS Coordination into two services (financial management, case management) at CMS' request. Financial management is a new service added to this amendment. For data to estimate values for FMS and Case Management, DMS used CMS 372 reports from 2019 from the PDC service as the source. We allocated projections accordingly for WYs 4 and 5. DMS also corrected the average cost per unit of WY 3 Home and Community Supports to align with actual payments.

DMS used historical utilization data from the 2019 372 reports from the Participant Directed Coordination service and applied it to the Financial Management and Case management services, as DMS does not anticipate changes in utilization for these services. DMS increased rates as described in Appendix I-2-a. The average cost per unit is estimated using these rate increases.

Rates are being updated for all services.

Rates for services in this waiver included the following:

ADHC Level I - \$3.42

ADHC Level II- \$4.15

Attendant Care - \$7.26 (\$9.00 for 85% pass through)

Case Management - \$121.00 (\$150.00 for 85% pass through)

Case Management PDS - \$196.63 (\$243.75 for 85% pass through)

Environmental Modifications- Up to \$3,025

Financial Management - \$24.58

Goods and Services – Up to \$4,235

Home Delivered Meals - \$9.08

Non Specialized Respite- \$3.33

Specialized Respite Level I- \$4.84 (\$6.00 for 85% pass through)

Specialized Respite Level II- \$12.10 (\$15.00 for 85% pass through)

DMS aligned WY4 and 5 cost per unit estimates as mandated by the Kentucky SFY 2023/2024 biennial budget.

Amendment submitted September 2024: DMS updated average cost per unit estimates for WY5 to reflect new rates per the methodology described in Appendix I. For the services that qualify for the 50% pass-through, for example, Attendant Care, we took the average of the 50% pass-through rate and the rate planned for implementation, $(\$8.13 = ((7.26 + 9.00) / 2))$. As described in Appendix I, the rate methodology was not implemented in cases that the rate would cause a decrease. The following services did not receive an update: Attendant Care and Home Delivered Meals. Rates are not decreasing but average cost per unit demonstrated in J2-d. may change for some services to reflect average of historical and future rates. For case management and financial management services, DMS updated the average units per user to align with the ALOS. For all other services, DMS did not make changes to the estimated number of users or average units per user as part of this amendment.

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:

The Factor D' is based on data from the CMS 372 Lag Report for the period 08/01/2018 through 07/31/2019. The average per capita acute care services expenditures for acute care services to Waiver participants was calculated to be \$9,717.00. This per capita was trended forward to each Waiver Year using an annual medical costs trend factor of 1.0300 based on the 10 year average CPI for medical care services from Jan 2009 to Dec. 2018 which is an annual trend of 3.01%.

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:

The Factor G is based on data from the CMS 372 Lag Report for the period 08/01/2018 through 07/31/2019. The average per capita institutional services expenditures was calculated to be \$47,192.07. This per capita was trended forward to each Waiver Year using an annual medical costs trend factor of 1.0300 based on the 10 year average CPI for medical care services from Jan 2009 to Dec. 2018 which is an annual trend of 3.01%.

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:

The Factor G' is based on data from the CMS 372 Lag Report for the period 08/01/2018 through 07/31/2019. The average per capita acute care services expenditures for institutional participants was calculated to be \$2,930.05. This per capita was trended forward to each Waiver Year using an annual medical costs trend factor of 1.0300 based on the 10 year average CPI for medical care services from Jan 2009 to Dec. 2018 which is an annual trend of 3.01%.

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 Health Care	
Case Management	
Specialized Respite	
Financial Management Services	
Participant Directed Coordination	
Attendant Care	
Environmental and Minor Home Adaptation	
Goods and Services	
Home and Community Supports	
Home Delivered Meals	
Non-Specialized Respite	

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 Health Care Total:						30447047.87
Adult Day Health Care	15 minute	2946	3651.96	2.83	30447047.87	
Case Management Total:						2366043.00
Case Management	1 month	8187	2.89	100.00	2366043.00	
Specialized Respite Total:						396144.00
Specialized Respite	15 minute	420	235.80	4.00	396144.00	
Financial Management Services Total:						0.00
Financial Management Services	15 minute	0	0.00	0.01	0.00	
Participant Directed Coordination Total:						5822700.00
Participant Directed Coordination	1 month	2986	12.00	162.50	5822700.00	
Attendant Care Total:						46928166.12
Attendant Care	15 minute	7106	1100.67	6.00	46928166.12	
Environmental and Minor Home Adaptation Total:						160365.38
Environmental and Minor Home Adaptation	Each	229	1.35	518.73	160365.38	
Goods and Services Total:						20860.00
Goods and Services	Each	3500	5.96	1.00	20860.00	
Home and Community Supports Total:						11205757.21
Home and Community Supports	15 minute	3128	1243.89	2.88	11205757.21	
Home Delivered Meals Total:						1686588.75
Home Delivered Meals	Each	1770	127.05	7.50	1686588.75	
Non-Specialized Respite Total:						1127902.16
Non-Specialized Respite	15 minute	647	633.92	2.75	1127902.16	
GRAND TOTAL:						100161574.49
Total Estimated Unduplicated Participants:						17300
Factor D (Divide total by number of participants):						5789.69
Average Length of Stay on the Waiver:						283

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 Health Care Total:						30963800.21
Adult Day Health Care	15 minute	2996	3651.96	2.83	30963800.21	
Case Management Total:						2389163.00
Case Management	1 month	8267	2.89	100.00	2389163.00	
Specialized Respite Total:						471600.00
Specialized Respite	15 minute	500	235.80	4.00	471600.00	
Financial Management Services Total:						0.00
Financial Management Services	15 minute	0	0.00	0.01	0.00	
Participant Directed Coordination Total:						5861700.00
Participant Directed Coordination	1 month	3006	12.00	162.50	5861700.00	
Attendant Care Total:						47456487.72
Attendant Care	15 minute	7186	1100.67	6.00	47456487.72	
Environmental and Minor Home Adaptation Total:						210085.65
Environmental and Minor Home Adaptation	Each	300	1.35	518.73	210085.65	
Goods and Services Total:						22052.00
Goods and Services	Each	3700	5.96	1.00	22052.00	
Home and Community Supports Total:						12933574.39
Home and Community	15 minute		1161.32	2.88	12933574.39	
GRAND TOTAL:						103181641.35
Total Estimated Unduplicated Participants:						17300
Factor D (Divide total by number of participants):						5964.26
Average Length of Stay on the Waiver:						302

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supports		3867				
Home Delivered Meals Total:						1710410.62
Home Delivered Meals	Each	1795	127.05	7.50	1710410.62	
Non-Specialized Respite Total:						1162767.76
Non-Specialized Respite	15 minute	667	633.92	2.75	1162767.76	
GRAND TOTAL:						103181641.35
Total Estimated Unduplicated Participants:						17300
Factor D (Divide total by number of participants):						5964.26
Average Length of Stay on the Waiver:						302

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 Health Care Total:						31480552.55
Adult Day Health Care	15 minute	3046	3651.96	2.83	31480552.55	
Case Management Total:						2412283.00
Case Management	1 month	8347	2.89	100.00	2412283.00	
Specialized Respite Total:						518760.00
Specialized Respite	15 minute	550	235.80	4.00	518760.00	
Financial Management Services Total:						0.00
Financial Management Services	15 minute	0	0.00	0.01	0.00	
Participant Directed Coordination Total:						5900700.00
Participant Directed Coordination	1 month	3026	12.00	162.50	5900700.00	
GRAND TOTAL:						108137006.80
Total Estimated Unduplicated Participants:						17300
Factor D (Divide total by number of participants):						6250.69
Average Length of Stay on the Waiver:						302

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Attendant Care Total:						47984809.32
Attendant Care	15 minute	7266	1100.67	6.00	47984809.32	
Environmental and Minor Home Adaptation Total:						245099.92
Environmental and Minor Home Adaptation	Each	350	1.35	518.73	245099.92	
Goods and Services Total:						2742899.28
Goods and Services	Each	3800	5.96	121.11	2742899.28	
Home and Community Supports Total:						13924801.24
Home and Community Supports	15 minute	3887	1243.89	2.88	13924801.24	
Home Delivered Meals Total:						1729468.12
Home Delivered Meals	Each	1815	127.05	7.50	1729468.12	
Non-Specialized Respite Total:						1197633.36
Non-Specialized Respite	15 minute	687	633.92	2.75	1197633.36	
GRAND TOTAL:						108137006.80
Total Estimated Unduplicated Participants:						17300
Factor D (Divide total by number of participants):						6250.69
Average Length of Stay on the Waiver:						302

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 Health Care Total:						43266742.18
Adult Day Health Care	15 minute	3126	3651.96	3.79	43266742.18	
Case Management Total:						27105650.88
GRAND TOTAL:						181786710.34
Total Estimated Unduplicated Participants:						17300
Factor D (Divide total by number of participants):						10507.90
Average Length of Stay on the Waiver:						305

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management	1 Month	11473	12.00	196.88	27105650.88	
Specialized Respite Total:						1485540.00
Specialized Respite	15 minute	600	235.80	10.50	1485540.00	
Financial Management Services Total:						598965.44
Financial Management Services	15 minutes	3046	8.00	24.58	598965.44	
Participant Directed Coordination Total:						0.00
Participant Directed Coordination	1 month	0	0.00	0.01	0.00	
Attendant Care Total:						72175334.58
Attendant Care	15 minute	7286	1100.67	9.00	72175334.58	
Environmental and Minor Home Adaptation Total:						338936.40
Environmental and Minor Home Adaptation	Each	400	1.35	627.66	338936.40	
Goods and Services Total:						3406175.76
Goods and Services	Each	3900	5.96	146.54	3406175.76	
Home and Community Supports Total:						29946029.78
Home and Community Supports	15 minute	3907	1161.32	6.60	29946029.78	
Home Delivered Meals Total:						2105345.55
Home Delivered Meals	Each	1825	127.05	9.08	2105345.55	
Non-Specialized Respite Total:						1357989.76
Non-Specialized Respite	15 minute	707	633.92	3.03	1357989.76	
GRAND TOTAL:					181786710.34	
Total Estimated Unduplicated Participants:					17300	
Factor D (Divide total by number of participants):					10507.90	
Average Length of Stay on the Waiver:						305

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be

completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Total:						46278513.59
Adult Day Health Care	15 minute	3176	3651.96	3.99	46278513.59	
Case Management Total:						49291721.60
Case Management	1 Month	11573	10.00	425.92	49291721.60	
Specialized Respite Total:						1495915.20
Specialized Respite	15 minute	650	235.80	9.76	1495915.20	
Financial Management Services Total:						5989349.80
Financial Management Services	Per month	3046	10.00	196.63	5989349.80	
Participant Directed Coordination Total:						0.00
Participant Directed Coordination	1 month	0	0.00	0.01	0.00	
Attendant Care Total:						65645807.93
Attendant Care	15 minute	7336	1100.67	8.13	65645807.93	
Environmental and Minor Home Adaptation Total:						381303.45
Environmental and Minor Home Adaptation	Each	450	1.35	627.66	381303.45	
Goods and Services Total:						3493513.60
Goods and Services	Each	4000	5.96	146.54	3493513.60	
Home and Community Supports Total:						33050238.14
Home and Community Supports	15 minute	3920	1161.32	7.26	33050238.14	
Home Delivered Meals Total:						2105345.55
Home Delivered Meals	Each	1825	127.05	9.08	2105345.55	
Non-Specialized Respite Total:						3171121.41
Non-Specialized Respite	15 minute		633.92	5.92	3171121.41	
GRAND TOTAL:						210902830.27
Total Estimated Unduplicated Participants:						17800
Factor D (Divide total by number of participants):						11848.47
Average Length of Stay on the Waiver:						305

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		845				
<i>GRAND TOTAL:</i>						210902830.27
<i>Total Estimated Unduplicated Participants:</i>						17800
<i>Factor D (Divide total by number of participants):</i>						11848.47
<i>Average Length of Stay on the Waiver:</i>						305