



State Demonstrations Group

February 27, 2026

Lisa Lee
Commissioner, Department for Medicaid Services
Cabinet for Health and Family Services
275 East Main Street,
Frankfort, KY 40601

Dear Commissioner Lee:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of the Health Related Social Needs (HRSN) Implementation Plan for Kentucky's section 1115(a) demonstration, "TEAMKY" (Project Numbers 11-W-00306/4 and 21-W-00067/4). We have determined that the HRSN Implementation Plan is consistent with the requirements outlined in the special terms and conditions (STCs). CMS has incorporated the finalized HRSN Implementation Plan into the STCs as Attachment P.

CMS rescinded the November 2023 and December 2024 Center for Medicaid and CHIP Services (CMCS) Center Information Bulletins (CIB) related to coverage of certain services and supports to address "health-related social needs" while CMS evaluates policy options consistent with Medicaid and CHIP program requirements and objectives. Additional information is available on [Medicaid.gov](https://www.Medicaid.gov).

States are responsible for following all applicable federal law and regulations when they claim and use federal Medicaid and CHIP funds and must fully comply with all applicable Medicaid and CHIP statutes and regulations under a section 1115 demonstration, except where specific provisions have been expressly waived or identified as not applicable for that demonstration. This obligation includes all requirements in Title XIX and Title XXI of the Social Security Act and implementing regulations governing provider screening and enrollment activities, pre- and post-payment review claiming, payment methodologies and rate-setting, utilization controls, and program integrity including processes to identify, investigate, and refer suspected fraud, and methods to receive complaints and identify questionable practices. States must maintain effective systems and safeguards to prevent, detect, and address any fraud, waste, or abuse (FWA) in the delivery of and payment for Medicaid and CHIP services, including referrals to law enforcement when appropriate.

States should have heightened monitoring and oversight mechanisms in place featuring robust internal controls to identify and remediate all vulnerabilities (including, but not limited to, FWA and beneficiary access issues) inherent in service areas approved as part of a demonstration. At any time, CMS may request that the state provide a plan detailing the state's systems and safeguards to prevent, detect, and address any FWA relative to this demonstration. Failure to meet program integrity obligations under federal statutes and regulations or under the terms and

conditions of this demonstration approval may result in compliance actions or other enforcement measures that could include requirements to develop and implement corrective action plans, withholdings, deferrals, disallowances, and termination of demonstration authority.

We look forward to our continued partnership on the TEAMKY section 1115(a) demonstration. If you have any questions, please contact your CMS project officer, Valisha Andrus, at Valisha.Andrus@cms.hhs.gov.

Sincerely,

Andrea J. Casart
Director
Division of Eligibility and Coverage Demonstrations

Enclosure

cc: Christine Davidson, State Monitoring Lead, Medicaid and CHIP Operations Group

ATTACHMENT P:

Health-Related Social Needs (HRSN) Implementation Plan

INTRODUCTION

The Centers for Medicare & Medicaid Services (CMS) approved an extension of the TEAMKY 1115 Demonstration on December 12, 2024, through December 31, 2029 to include the Health Related Social Needs (HRSN) Demonstration. On December 31, 2024, CMS approved Kentucky’s Attachment O: Infrastructure Protocol and on January 7, 2025, CMS approved Kentucky’s Attachment K: Services Protocol and Attachment N: Updated Services Matrix.

HRSN services approved under the Demonstration are for episodic housing interventions with clinical services with room and board to include short-term pre-procedure housing and short-term post transition housing. TEAMKY HRSN 1115 services include the Recuperative Care (RC) Pilot Program which is the vessel for the delivery of the approved HRSN services.

The Implementation plan is organized by the following milestones:

<u>Milestone 1</u>	Establish and Advance Data Sharing and Partnerships (STC 39.c.i.).
<u>Milestone 2</u>	Strengthen Key Partnerships and Community Collaboration (STC 39.c.iI.)
<u>Milestone 3</u>	Enhance Information Technology (IT) Infrastructure to Support HRSN Implementation (STC 39.c.iII.).
<u>Milestone 4</u>	Track and Improve Benefit Utilization and Access to Care (STC 39.c.iv.)
<u>Milestone 5</u>	RC Pilot Readiness Assessment (STC 39.a.)

For each milestone in the Implementation Plan, Kentucky describes the activities, key strategies, and timelines for achieving activities.

MILESTONES AND STRATEGIES

Milestone 1: Establish and Advance Data Sharing and Partnerships

STC 39.c.i: A plan for establishing and/or improving data sharing and partnerships with an array of health system and social services stakeholders interested parties to the extent those entities are vital to provide needed administrative and HRSN-related data on screenings, referrals, and provision of services, which are critical for understanding program implementation and conducting demonstration monitoring and evaluation.

1.1. Overview and Purpose of Data-Sharing Framework

Kentucky's data-sharing framework is designed to ensure timely, secure, and accurate access to information needed to coordinate care, verify eligibility and document service delivery to beneficiaries. Effective data exchange is central to implementation, spanning screening, referral, eligibility, consent, service provision, and transition.

- ❖ Kentucky intends to examine the features and functionality of the Kentucky Health Information Exchange (KHIE) and its capacity to serve as the initiative's data-sharing backbone, linking the Commonwealth's managed care organizations (MCOs), providers, and community-based organizations (CBOs) to monitor services in real time.
- ❖ Kentucky intends to collect longitudinal data on reach, fidelity, outcomes, and alignment with programs like the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).
- ❖ Kentucky will explore cross-sector governance with a goal to achieve real-time interoperability across health, housing, and social service systems, with equity, security, and sustainability as guiding principles.

1.2 Key Partners Involved in Data Exchange

Data exchange may involve the following community partner groups:

- Kentucky CHFS.
- Kentucky DMS
- Kentucky Hospital Association (KHA).
- Medicaid MCOs.
- KHIE, kynect Resources, and other state specific data collection tools.
- Housing providers.
- RC Pilot Providers.
- National Institute for Medical Respite Care.
- Community Based Organizations (CBOs).
- Hospital and Emergency Department systems.
- Continuums of Care (CoC) and Public Housing Authorities (PHAs).
- Kentucky Housing Corporation (KHC)
- Healthcare for the Homeless Council and state homeless councils and coalitions.
- Kentucky Department for Community-Based Services (DCBS) responsible for administering SNAP, TANF, WIC.
- Kentucky Office of Application Technology Services (OATS).

- Kentucky Office of Data Analytics (ODA).
- State agencies administering SNAP, TANF, WIC, and housing benefits.

1.3 Data Elements for Exchange – By Function

The following presents the anticipated data elements which may be used for information sharing:

- **Screening and Eligibility Data:** Housing status, social risk factors, clinical triggers, ADLs, diagnosis codes, screening metadata, and requested HRSN service.
- **Referral Data:** Source, beneficiary, dates, service type, rationale, acceptance/denial with reasons, outcome status, service start date, and provider details.
- **Service Provision Data:** Type of service, dates, discharge information, assessments, occupancy logs, diagnoses, supportive services, staffing logs, case notes, discharge plans, follow-up care recommendations, care coordination efforts, adverse incidents, treatment plans, care plans, person-centered service plans, and billing identifiers.
- **Utilization and Outcomes Data:** ED visits, hospitalizations, readmissions, behavioral health engagement, housing transitions, benefit uptake, continuity of care, mortality, length of stay (LOS), preventive care visits, and disparities.
- **Consent Documentation:** may include informed consent for the provision of services, a release of information including authorized sharing partners, and a beneficiary's acceptance of any additional referrals/services. All documentation must follow a set of guidelines for data and consent collection and follow all state and federal guidelines.

1.4 Data Systems Infrastructure, Legal Agreements, and Consent Management

KHIE's capabilities are being evaluated to determine its capacity, in current or potential expanded forms, to provide the necessary support as the primary infrastructure; in order to provide supportive referral management, structured data storage, analytics, dashboards, and cross-sector access. Anticipated enhancements include specific templates and interoperability with external platforms for HRSN related services. MCOs will maintain care management systems as appropriate. Kentucky will look to leverage other supportive data infrastructures such as kynect (<https://kynect.ky.gov/>), which is primarily an eligibility and enrollment system for Medicaid and other public benefits, such as SNAP, TANF, etc; to better close gaps and improve current data systems.

All platforms utilized by DMS within the HRSN programs will apply State-defined and federally mandated data standards. KY will continue to explore a centralized integration layer for consolidated beneficiary records, crosswalks, and CMS reporting. All systems are intended to comply with the Health Insurance Portability and Accountability Act (HIPAA), 42 Code of Federal Regulation (CFR) Part 2, and state law, with role-based access, encryption, and audit logs. Consent may be centrally tracked and enforced in application programming interfaces (APIs), where applicable. As part of the Cabinet's existing processes and protocols, legal and IT oversight bodies perform audits and privacy impact assessments.

Data Use Agreement (DUA), Business Associate Agreement (BAA), Memorandum of Agreement (MOA), Memorandum of Understanding (MOU), and Maintenance of Effort (MOE) will be utilized across community partners and in alignment with state-defined standards. Standardized consent processes may define who collects consent, documentation and storage methods, communication across systems, and procedures for revocation, expiration, or renewal. Kentucky will explore current functionalities in the kynect resources consent management system in an attempt to leverage current data infrastructure to support the 1115 HRSN programs in meeting milestones related to data-sharing and IT infrastructure purposes.

1.5 Monitoring and Quality Assurance Support

DMS intends to establish a Data Monitoring Framework for HRSN services with identified key partners and/or systems accountable for data completeness, accuracy, and timeliness. Requirements may include:

- Screening and referral and service data within specific timeframes, including discharge records within specific business days.
- MCO monthly summary reports on timeliness and error correction.
- KHIE time-stamped ingestion logs and alerts for incomplete or late data.
- Integrity reviews by DMS.

Quality control may include, but not limited to validation checks, dashboards with real-time performance indicators, quarterly audits, and structured feedback protocols. Noncompliance may trigger corrective action plans or financial penalties. Training and technical assistance (TA) may address recurring issues, supported by collaboratives, templates, and site-level support. Data is intended to complete CMS monitoring reports, evaluator access, and crosswalks with Medicaid and public benefit data. Where necessary, existing KHIE, kynect, MCO reporting, claims data, and other identified data reporting dashboards may be enhanced to allow for program and demonstration monitoring and evaluation.

1.6 Risk Mitigation and Contingency Planning

Kentucky will evaluate and mitigate possible risks, including provider readiness variability, interoperability gaps, privacy constraints, data quality issues, duplicative referrals, and system downtime. If necessary, existing mitigation strategies such as introducing interim flat-file reporting, manual workflows during downtime, targeted TA for low-capacity providers, and/or the temporary use of other state data exchange programs may be deployed. KHIE maintains downtime logs and confirms reconciliation protocols in compliance with state outlined requirements. TA may include onboarding, training, regional workshops, and help desk support. Contingency solutions will comply with HIPAA and 42 CFR Part 2.

1.7 Alignment with Broader Statewide Data Initiatives

Kentucky's strategy aligns with its behavioral health and social determinants of health (SDoH) data system modernization, KHIE infrastructure upgrade and expansion, and Medicaid quality improvement priorities. Data collection related to HRSN services and/or the RC Pilot Program

aims to support standardized screening, automated referrals, and analytics. Kentucky continues to explore capabilities to include closed-loop referral functionality, dashboards, and CBO onboarding to the Commonwealth’s health information exchange platform.

Data may be utilized to inform population health metrics and public health dashboards. Predictive analytics and a social care referral exchange which are in development and overseen by a technical governance council, may be utilized as appropriate. Integration with SNAP, TANF, WIC, and housing programs may be utilized to identify unserved but eligible beneficiaries, support cross-program outreach, and enable data linkages with housing systems and other care providers. These efforts ensure approved Infrastructure investments to reinforce broader Kentucky Medicaid and public health transformation.

Key Strategies, Activities, and Implementation Timeline for Milestone 1

Strategy Area	Key Strategies and Activities	Implementation Timeline
Data-Sharing Framework	Enhance existing interoperable systems to support real-time information exchange across multiple health providers (i.e. physical, behavioral, mental, supportive services, etc.), housing resources, and social service providers/resources. Explore ways to leverage KHIE and affiliate data structures as the central interoperable infrastructure for data inputs and/or collections related to HRSN needs and services.	Q3 2025-Q3 2026
Partner Engagement	Formalize agreements with MCOs, CBOs, hospitals, CoCs, state agencies, and others, as needed. Partner with CBOs, hospitals, and other community partners through the development of a comprehensive communications plan, including TA, resources, training, and other supports, as needed, for implementation of data sharing with needed entities. Create and maintain cross-sector governance to build trust, reduce duplication, and ensure accountability.	Q1-Q3 2026; ongoing
Screening and Eligibility Data	Conduct analysis and evaluation of current data collection practices to standardize collection of housing status, social risk factors, medical indicators, ADLs, and diagnosis codes. Capture and store data in existing and expanded data sharing infrastructure for access by identified partners and providers.	Q4 2025-Q1 2026
Referral Data	Leverage existing referral platforms, such as kynect resources to explore capabilities and existing integration with KHIE and assess for enhancements to ensure closed-loop referral tracking across key systems. Explore use of KHIE as the primary host for data sharing to ensure documentation of referral source, beneficiary, service type, acceptance/denial, and outcomes.	Q3-Q4 2025

Service Provision Data	RC Pilot Program Providers and other data collection systems begin to submit real-time service documentation (service type, dates, diagnosis, daily utilization, discharge details, supportive services provided). Link data to billing identifiers and Medicaid claims.	Q2-Q3 2026
Utilization and Outcomes Data	Utilize Kentucky’s existing monitoring infrastructure to track ED visits, hospitalizations, readmissions, behavioral health engagement, housing connections, benefit enrollment, follow-up care, and disparities. Support CMS reporting and evaluation.	Q2-Q3 2026-ongoing with reporting to CMS
Consent Management	Where necessary, standardize informed consent processes across providers. Document date, scope, duration, and status in the identified data structure. Ensure compliance with HIPAA, 42 CFR Part 2, and state privacy laws. Leverage existing systems and create plans to enhance these infrastructures, as appropriate.	Q3 2025-Q2 2026
Data Quality and Monitoring	Deploy validation checks, quality dashboards, audits, and corrective mechanisms as necessary. Require MCOs to include RC Pilot Program data to quality reports. Establish performance standards and monitoring teams at DMS.	Q2-Q3 2026
Risk Mitigation	As needed, implement mitigation strategies that provide interim reporting via flat files, establish manual workflows during system downtime, offer TA to low-capacity providers, and allow temporary use of alternative platforms with data integration.	Q3 2025-Q2 2026
Alignment and Integration	Align HRSN data with broader CHFS modernization, KHIE infrastructure, and functionality expansion with interoperable connections with SNAP, TANF, WIC, and housing programs, where applicable.	In progress and ongoing

Milestone 2: Strengthen Key Partnerships and Community Collaboration

STC 39.c.ii: Information about key partnerships related to HRSN service delivery, including plans for capacity building for community partners and for soliciting and incorporating input from impacted groups (e.g., community partners, health care delivery system partners, and beneficiaries).

2.1 Overview and Strategic Intent

Kentucky’s HRSN 1115 demonstration embeds multisector partnerships as the foundation for the RC Pilot Program. These partnerships are central to equity, program efficiency and effectiveness, and long-term sustainability. The model relies on distributed service delivery, with DMS and MCOs coordinating networks that include, but are not limited to: RC Pilot Providers, housing navigators, behavioral health entities, primary care providers, hospitals, discharge planners, surgery centers, cancer centers, and recovery networks.

The strategy prioritizes investment in local workforce development, network adequacy for CBOs, equitable access across urban and rural communities, and inclusion of historically excluded organizations. Equity and accountability are built into governance through utilization of a standardized racial equity accountability tool across CHFS to reduce disparities and improve health outcomes and access to services across the design, implementation, and evaluation phases of this demonstration.

2.2 Inventory of Current and Planned Partnerships

- **State-Level Partners:** DMS (program administration and oversight), the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) (behavioral health integration), DCBS (public benefits and child welfare), KHC (housing programs and long-term housing alignment), state homeless councils and coalitions (regional guidance across the commonwealth), and ODA (data infrastructure). These entities will lead the HRSN Services Cross-Agency Leadership Group and Operations Workgroup to provide governance and technical guidance, coordinate policy, and equity oversight of approved HRSN services.
- **MCOs:** All Kentucky contracted MCOs are responsible for building and managing delivery networks, contracting with RC Pilot Program Providers, and ensuring culturally responsive services. MCOs are responsible for contracting with these organizations to support care coordination, provide technical guidance and assistance, and establish network adequacy.
- **Community Partners:** CBOs, CoCs, federally qualified health centers (FQHCs), community mental health centers (CMHCs), recovery organizations, and existing recuperative care providers will be essential to providing direct services through the RC Pilot Program as well as additional services offered, such as housing navigation, case management, behavioral health care, food support, and linking to other community resources that align with the person centered service plan to promote health for beneficiaries. Throughout the 1115 demonstration, Kentucky will expand its partner portfolio through community partner mapping, outreach campaigns, collaboratives, etc.
- **RC Pilot Program Providers:** Providers who have undergone readiness criteria approval and have been approved and enrolled as a RC Pilot Program Provider Type and are able to deliver RC Pilot Program approved services in the commonwealth.
- **Beneficiary:** A beneficiary is considered someone who is receiving services under the RC Pilot Program. Beneficiaries and individuals with lived experience actively participate in Kentucky's Technical Advisory Committees and Medicaid Advisory Committee. Individuals with lived experience may be consulted as experts incorporating their voice in the process when and where possible. Participatory evaluation structures may include beneficiary surveys, focus groups, key informant interviews, and learning collaboratives
- **Community Collaboration:** Current mechanisms include MCO advisory councils, and community homelessness councils and coalitions. The engagement model includes CoC outreach programs, hospital discharge programs, collaboration with Voices of the Commonwealth and those with lived experience, the Government Alliance on Race and

Equity (GARE) tool for demonstration accountability, as well as learning collaboratives organized by community partners.

2.3 Capacity Building Strategies for HRSN Services

Kentucky treats capacity building as central to implementation and equity. Capacity domains include organizational readiness, administrative systems, billing and compliance, workforce development, IT and data systems, and quality improvement.

Delivery mechanisms may include MCO-led support, statewide TA, learning collaboratives, and where possible, grant or mini funding opportunities. KY will explore if policy interventions are needed to address systemic barriers, which may include credentialing reform, flexible contracting, and payment innovation to reflect the true cost of services. Progress may be tracked through provider communications, outreach, and engagement metrics, enrollment data, TA participation, and service access benchmarks.

Kentucky’s communication strategy emphasizes transparency, dialogue, and accountability. Such strategy is developed and implemented by the dedicated CHFS communications team lead and staffed by marketing and public relations professionals, where appropriate.

Key Strategies, Activities, and Implementation Timeline for Milestone 2

Strategy Area	Key Strategies and Activities	Implementation Timeline
Partnership Model	Utilize existing practices for engaging partners, and leverage identified State-Level Partners, MCO’s, Community Partners, RC Pilot Providers, Beneficiaries, and community collaboration aspects using communication plans and strategic implementation of services.	Q1-Q3 2026
State-Level Partnerships, including Governance and Shared Accountability	Identified partners will lead the HRSN Services Cross-Agency Leadership Group and Operations Workgroup to provide governance, technical guidance, coordinate policy, and equity oversight of approved HRSN services. Status meetings, workgroup meetings, and other means of internal communications may be used to share impertinent information.	Q3-Q4 2025; ongoing
MCOs	DMS intends to use the following communication methods to effectively implement services: schedule kick-off meetings, provide a MCO Program Requirements Implementation guide, TA, MCO contract language adjustments, a provider letter, policy guidance letter, and others as needed.	Q1 2026
Community Partners	DMS, MCO’s, and RC Pilot providers to engage with CBOs, CoCs, FQHCs, CMHCs, and other organizations as trusted. Engagement will take a	Q4 2025; ongoing

	variety of forms, including but not limited to, soliciting feedback, organizing trainings, webinars, plain-language brochures, email, social media campaigns, public service announcements, and attending workgroup meetings.	
RC Pilot Providers	Utilize provider readiness materials, provider manuals, billing guides, trainings, webinars, TA, designated e-mail box, provider policy guidance letters, fee schedules, frequently asked questions, the DMS public facing website page, and work group meetings to onboard, orient, implement, and maintain provider participation. Partner with TA, MCO, and other community partners as needed to effectively implement the RC Pilot Program	Q1 2026; ongoing
Community Collaboration	Expand beneficiary engagement and those with lived experience through MCO advisory councils, peer networks, CHW coalitions, rural advisory circles, and leverage those existing partnerships with provider networks, hospital association and discharge planning teams, surgery center staff and other groups, as available. Use feedback loops, community forums, and learning collaboratives to shape implementation.	Current; ongoing
Capacity Building	Develop operational processes and provide TA regarding provider and organizational readiness, billing, compliance, workforce development, IT and data systems, and quality improvement. Extend support where possible.	Development: Q4 2025-Q2 2026 Provide TA: Q2 2026; ongoing
Strategic Communications	Kentucky may leverage existing feedback loops, including surveys, focus groups, interviews, suggestion boxes, technical advisory councils, designated email addresses, implementation teams, and lived experience panels. DMS plans to provide clear and transparent guides and instructional tools on the DMS website for ease of access and use. DMS plans to engage all of the above-mentioned parties in communications and continued community partners collaboration.	Q4 2025-Q2 2026

Milestone 3: Enhance IT Infrastructure to Support HRSN Implementation

STC 39.c.iii: Plans for changes to IT infrastructure that will support HRSN-related data exchange, including development and implementation of data systems necessary to support program implementation, monitoring, and evaluation. These existing or new data systems should, at a minimum, collect data on beneficiary characteristics, qualification and consent to receive HRSN services, screening, referrals, and service provision.

3.1 Purpose and Strategic Objectives

As reflected in the approved Attachment O: Infrastructure Protocol, Kentucky’s vision is to build a seamless, secure, and interoperable digital ecosystem that underpins HRSN services, including the approved RC Pilot Program. Assessing current capabilities and possible expansions within existing data partnerships, to explore enhancements in eligibility, closed-loop referrals, consent, service documentation, and outcomes are identified as core principles. Linking data structures such as KHIE with Medicaid claims, MCO platforms, kynect resources, and social service databases will allow for proactive service and program monitoring.

Kentucky emphasizes inclusion of small and rural CBOs through onboarding support, simplified interfaces, and TA, ensuring equitable participation in the HRSN services ecosystem. Dashboards and real-time analytics can help to guide CQI and program evaluation, while aligning with broader state modernization ensures long-term scalability and sustainability.

3.2 Planned Changes to IT Systems

Kentucky intends to leverage existing and expanded data sharing systems referenced throughout this document to serve as the operational backbone for HRSN services. IT systems are intended to include the capabilities to be able to:

- Manage service delivery through exploring a closed-loop referral structure to include capturing screenings, eligibility, and consents and will be interoperable with referral sources from kynect. Providers and MCOs may document admissions, diagnosis, LOS, assessments, person-centered care, discharge, and coordination notes in accessible systems.
- Ensure data integrity via structured templates, validation logic, audit trails, and real-time dashboards.
- Monitor compliance with federal and state requirements by flagging missing documentation, expired eligibility, or overuse. Explore how alerts and designated compliance reports can drive corrective action and TA.
- Inform outcomes by linking requested RC Pilot Program related data to Medicaid claims, housing/social benefit systems, enabling tracking of avoided hospitalizations, housing stability, care transitions, and uptake of SNAP, WIC, or TANF.

3.3 Core System Functions and Requirements

Minimum functions may include:

- Capturing demographics, screenings, and ADLs.
- Applying eligibility rules combining social risks and clinical data.
- Recording multiformat consents and linking them to referrals/services.
- Facilitating referrals with full status tracking.
- Documenting authorizations, utilization, and service episodes.

- Exchanging data with the Medicaid Management Information System and other related systems, as needed, for claims/payment validation.
- Aggregating data for dashboards, monitoring, and CMS reporting.

3.4 Systems Involved

- KHIE and its affiliate partners for the statewide central repository and data exchange for screenings, referrals, and analytics.
- MCO systems for authorizations, case management, integration with KHIE and/or other state data systems, and required monitoring/ reporting
- Referral sources, such as kynect may be integrated to make resources available within closed-loop workflows.
- Provider-level systems and EHR's aligned with State standards.
- Data aggregation and monitoring tools to meet CMS requirements for oversight and reporting.

3.5 Consent and Privacy Management

Where necessary, Kentucky will assess capabilities for comprehensive consent processes, and will aim to incorporate these into the KHIE structure while maintaining compliance with HIPAA and 42 CFR Part 2. Features may include:

- Electronic and paper consent capture with time-stamped records and auditability.
- Granular consents allowing beneficiaries to share some data, while restricting others.
- Real-time verification of consent across MCOs and platforms.
- Revocation workflows that automatically restrict access when consent is withdrawn.
- Training for providers on culturally appropriate consent processes, with multilingual materials and plain-language forms.

3.6 Data Standards, Interoperability, and Integration Strategy

Where necessary, Kentucky will ensure adoption of Health Level 7 (HL7) v2, HL7 Fast Healthcare Interoperability Resources, Consolidated Clinical Document Architecture, and United States Core Data for Interoperability standards, enabling real-time secure API exchanges or batch uploads, when necessary. A master patient index may link records across KHIE, MCOs, and CBOs. Integration with SNAP, TANF, WIC, and housing is intended to coordinate eligibility and referrals and strengthen access to services. Cross-sector data sharing is intended to follow federal guidance and rely on standardized HRSN elements.

3.7 Training and Technical Assistance

Kentucky will deliver role-specific onboarding and TA to users (MCOs, CBOs, hospitals, RC Pilot providers, state agencies, etc). Supports may include live and virtual training, on-demand modules, refreshers, and recertification as indicated by need. KHIE and designated data structures may host help desks, office hours, and targeted TA for low-performing partners. Accessibility

features include multilingual materials, American Sign Language, culturally tailored content, and mobile TA teams for rural areas. Performance will be monitored via the states identified systems, such as Adobe Learning Management Systems (ALMS) data, surveys, and help desk logs.

3.8 Monitoring, Quality Assurance, and System Performance Metrics

Kentucky will explore automated data integrity checks, dashboards, quarterly audits, and incident management protocols. Metrics may span technical performance (uptime, latency, error rates), data quality (completeness, logical consistency, duplicate rates), and user satisfaction (usability surveys, help desk resolution times). Dashboards should enable real-time oversight and corrective action.

3.9 Alignment with Broader Initiatives

IT infrastructure is embedded within Medicaid Enterprise System (MES) modernization, behavioral health exchange expansions, and SDoH integration. Enhancements to KHIE will qualify for 90/10 match and align with MES modules (provider enrollment, claims, case management). Cross-sector integration pilots will link Medicaid with SNAP, TANF, and housing. This alignment is key to delivering of HRSN services as well as sustaining the RC Pilot Program.

Key Strategies, Activities, and Implementation Timeline for Milestone 3

Strategy Area	Key Strategies and Activities	Implementation Timeline
KHIE Enhancements	Explore KHIE capabilities and expansions needed to serve as the backbone for HRSN services data, adding referral management, structured templates, RC Pilot Program-specific service codes, dashboards, analytics, and cross-sector access.	Q2-Q4 2026
MCO Care Management Systems	Leverage existing and/or enhance bidirectional interfaces with KHIE/data sharing entities utilized by the state for enhancing ability to perform real-time updates regarding beneficiary eligibility, referrals, authorizations, and service utilization. Where necessary, harmonize data standards and submission schedules under DMS oversight.	Q2-Q4 2026
Integrated Eligibility, Enrollment, and Referral Platforms	The goal is to incorporate a robust closed-loop referral process and functionality supporting HRSN services and the delivery of services provided by the RC Pilot Program. Kentucky is evaluating the current KHIE integration with kynect as potential platforms for integration.	Q3 2025-Q4 2026
Privacy and Compliance	Ensure data-sharing systems embed HIPAA, 42 CFR Part 2, and state-level privacy protections across all IT systems. May use role-based access, encryption, consent tracking, and DUAs/BAAs to govern lawful data exchange.	Continuous evaluation aligned with best practices.

Quality and Monitoring	Require HRSN services and RC Pilot Program Data to be included in MCO reporting. May use audit trails and metadata to support accountability and CMS-required monitoring.	Q2-Q4 2026
Governance	Continue to employ OATS, KHIE, and ODA to oversee IT strategy, integration testing, and performance. Use governance committees to align technical development with equity goals and federal requirements.	Current CHFS ongoing practices.
Alignment with Statewide Initiatives	As noted in Attachment O: HRSN Infrastructure Protocol, Kentucky will integrate IT investments with behavioral health/SDoH modernization, Medicaid quality improvement, and public health surveillance. Pilot predictive analytics and cross-program linkages to support a learning health system.	Q1-Q3 2026

Milestone 4: Track and Improve Benefit Access and Utilization

STC: 39.c.iv. A plan for tracking and improving the share of Medicaid demonstration beneficiaries in the state who are eligible and enrolled in SNAP, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Temporary Assistance for Needy Families (TANF), and/or federal, state, and local housing and/or other nutrition assistance programs, relative to the number of total eligible demonstration beneficiaries in the state (including those who are eligible but unenrolled);

4.1 Purpose and Strategic Alignment

Kentucky intends to establish a structured system to identify Medicaid beneficiaries who are eligible for public benefit programs, track their enrollment status, and improve uptake of supports that address HRSN related needs. This includes food, income, and housing programs, such as SNAP, WIC, TANF, federal and state housing initiatives, and other nutrition supports. The goal is to reduce unmet needs, mitigate inequities in access, and integrate benefit enrollment into care coordination for the overall of the TEAMKY 1115 HRSN demonstration.

The RC Pilot Program, as a central point of entry, where screenings and referrals will identify beneficiaries with acute and long-term housing and nutrition needs in addition to short-term pre-procedure and post-procedure housing. The strategy aligns Medicaid infrastructure with public benefits systems to reduce duplication, streamline enrollment, and improve continuity of care.

4.2 Programs in Scope

The scope of this milestone extends across multiple federal, state, and local programs.

- **Nutrition supports:** SNAP and WIC.
- **Income supports:** TANF, workforce participation subsidies, and State-supported cash assistance programs.

- **Housing supports:** Federal Housing Choice Vouchers, public housing, CoCs (including rapid rehousing and supportive housing), KHC administered programs, and state emergency shelter and transitional housing funds.
- **Other supports:** Energy assistance, childcare subsidies, food pantry partnerships, and specialized housing programs for youth aging out of foster care, justice-involved individuals, and seniors.

Kentucky’s strategy ensures that Medicaid and HRSN services systems, including integrated KHIE and MCO platforms, are able to identify potential eligibility, route referrals, and confirm benefit enrollment across these program areas.

4.3 Identification of Eligible Populations and Outreach Prioritization

Kentucky intends to leverage KHIE, and affiliate data partners, screening results, kynect data, Medicaid enrollment files, hospital referrals, primary care physicians, other providers, and MCO case management inputs to identify likely eligible beneficiaries. Kentucky aims to join with other initiatives within the state in which focus on standardized needs assessments for SDoH and partner to establish gaps in coverage for beneficiaries. Kentucky intends to leverage existing equity practices to assist with deploying outreach where under-enrollment persists. Care Coordination is pivotal to the RC Pilot Program model and service delivery and will assist in promoting other services such as SNAP, WIC, TANF in which beneficiaries may be eligible.

4.4 Partnerships and Coordination with State and Local Entities

Kentucky will determine necessary data sharing and governance agreements to support tracking and improving beneficiaries who are eligible and/or enrolled in SNAP, WIC, TANF, and other support programs.

Key Strategies, Activities, and Implementation Timeline for Milestone 4

Strategy Area	Key Strategies and Activities	Implementation Timeline
Health Care Utilization Tracking	Kentucky will explore current functions of data systems and work to design, develop, and implement technology capabilities to monitor ED visits, inpatient admissions, and hospital readmissions before and after implementation of the RC Pilot Program to assess reductions in avoidable utilization, as needed.	Q4 2025-Q3 2026
Housing Stability Outcomes	Measure successful transitions from RC Pilot Program services to permanent housing programs (e.g., supportive housing vouchers, coordinated entry, KHC programs).	Q4 2025-Q3 2026
Public Benefits Uptake	Leverage KHIE integration with kynect resources to link HRSN/SDoH related data and/or assessments with SNAP, TANF, and WIC programs to track enrollment, continuity of benefits, and service delivery.	Ongoing

Service Quality	Track LOS relative to clinical benchmarks, daily service provision (e.g., registered nurse [RN] visits, meals, care coordination), and discharge planning. May utilize audit criteria to assess as needed.	From service delivery start-Ongoing
Data Infrastructure and Reporting	Explore the abilities of KHIE to use dashboards for real-time utilization tracking. Where determined necessary, create crosswalks between KHIE, Medicaid claims, and benefit program data. Align reports with CMS reporting and evaluation requirements.	Q4 2025-Q3 2026
Community Collaboration	Involve beneficiaries and people with lived experience in reviewing utilization data, validating findings, and recommending course corrections.	Q4 2025-Q3 2026; ongoing

Milestone 5: TEAMKY Recuperative Care Pilot Readiness Assessment

STC39.a. The state is required to submit a HRSN Implementation Plan that will elaborate upon and further specify requirements for the provision of HRSN services and will be expected to provide additional details not captured in the STCs regarding implementation of demonstration policies that are outlined in the STCs.

5.1 Purpose and Overview

The set of readiness criteria for Kentucky’s RC Pilot Program is intended to ensure RC Pilot Program Providers are fully prepared to launch and sustain implementation of the short-term pre-procedure housing and short-term post-transition housing services as outlined in the State’s approved Attachment K: HRSN Services Protocol and STCs. RC Pilot Program Provider materials establish a baseline standard for enrolling and maintaining RC Pilot Program Providers as a new Medicaid provider type.

The criteria reflect Kentucky’s dual priorities: 1) safeguarding beneficiary health and safety in recovery settings; and 2) ensuring compliance with federal and state Medicaid requirements. They also provide a structured framework to help providers identify gaps and prepare for successful participation in the pilots.

5.2 Minimum Readiness Criteria for Recuperative Care Providers

At a minimum, RC Pilot Program Providers must demonstrate the following capabilities before pilot implementation:

- **Ability to deliver RC services** in full compliance with Kentucky’s HRSN Services Protocol, including provision of short-term pre-procedure housing and short-term post-transition housing within the global six-month service cap per rolling year as defined in the STCs.
- **Ability to perform medical necessity and eligibility assessments**, including intake screening, nursing assessment within 24 hours, and daily wellness checks documented in the beneficiary’s care plan.

- **Ability to develop and maintain person-centered service plans**, that are culturally responsive, trauma-informed, and developed in consultation with the beneficiary. Plans must document medical appropriateness as required in STCs.
- **Ability to provide required facility supports**, including private or semi-private recovery space, three meals daily, secure double-locked medication storage, care coordination, and transportation to medical appointments.
- **Ability to securely exchange data** required to support beneficiary access to social supports which may include integrate with KHIE and kynect systems.
- **Ability to contract with Medicaid and all Kentucky MCO's**, as to not limit access to any Medicaid beneficiary who may qualify for the service. Must meet all provider enrollment qualifications and obtain Medicaid ID number and keep up-to-date and accurate records with all parties. Must also provide requested documentation to ensure quality and prevent fraud, waste, and abuse.
- **Ability to coordinate care with MCOs**, including weekly review of care plans, referrals to behavioral health and primary care providers, and discharge planning for long-term stability.
- **Ability to provide and report data**, including encounter data, utilization metrics, and quality outcomes as specified in the STCs.
- **Ability to maintain staffing standards**, including 24/7 staffing, RN-led assessments. All staff (clinical and non-clinical) trained in cardiopulmonary resuscitation (CPR), emergency procedures, emergency response, and de-escalation; professional boundaries, ethics, and confidentiality; naloxone administration; and overdose response. Clinical staff additionally trained in Housing First or Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.
- **Ability to comply with program integrity and oversight requirements**, including certification as a RC Pilot Program Provider (as available), listing in the National Institute for Medical Respite Care (NIMRC) directory, and adherence to NIMRC standards of care.
- **Ability to support beneficiary dignity and independence**, ensuring accommodations for ADLs, mobility, privacy, and engagement in recovery activities.
- **Ability to demonstrate Medicaid billing readiness**, including encounter data submission, compliance with claims processing, and financial solvency to support operations.
- **Ability to implement and maintain beneficiary grievance and feedback mechanisms**, ensuring beneficiaries have safe and accessible channels to raise concerns.
- **Ability to provide language access services**, including translation, interpretation, and accessible materials, and ensure cultural competence across staff training and service delivery.
- **Ability to demonstrate readiness for emergency response and safety protocols**, including behavioral health emergency management, medical transfer agreements, and facility safety procedures; naloxone administration; de-escalation strategies; CPR, emergency procedures, emergency response and de-escalation; boundaries, ethics, and

confidentiality; naloxone administration and overdose response; clinical staff trained in: Housing First or Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.

5.3 State Oversight and Provider Support

DMS intends to implement a robust monitoring and oversight strategy to track provider readiness and performance throughout the RC Pilot Program. This may include:

- Regular review of provider reports and encounter data to verify accuracy, completeness, and compliance with STCs.
- Structured communication channels with providers, including scheduled readiness check-ins, feedback loops, and TA.
- Ongoing evaluation of provider challenges in meeting RC standards, with responsive support from the State to address gaps in infrastructure, staffing, or data integration.
- Coordination with MCOs to ensure beneficiary access, continuity of care, and accountability for outcomes.

Kentucky anticipates that providers may face challenges as they adapt to the RC Pilot Program model. DMS will work in tandem with providers and MCOs to troubleshoot implementation issues, share best practices, and refine processes. This collaborative approach hopes to ensure the pilot programs meet the dual goals of improving health outcomes for vulnerable populations and fulfilling federal accountability requirements under the TEAMKY 1115 Demonstration. Kentucky intends to leverage other states recuperative care/medical respite care pilot programs (such as California and Washington) insights, tools, kits, and lessons learned to help with implementing these services as a part of the demonstration and continues to explore ways to improve planning practices throughout each stage of the RC pilot program demonstration.

Key Strategies, Activities, and Implementation Timeline for Milestone 5

Strategy Area	Key Strategies and Activities	Implementation Timeline
Readiness Assessment Criteria and Tools	Utilize Readiness Criteria to ensure providers have the ability to deliver RC Pilot Program services in full compliance with HRSN Services Protocol (Attachment K), including intake assessments, nursing evaluations within 24 hours, daily wellness checks, and person-centered service plans. KY intends to use readiness criteria, tools, communication plan, and kits for providers to have a understanding of the requirements being asked of them.	Q1-Q2 2026 (verification prior to enrollment as a RC Pilot Provider)
Service Delivery Readiness	Utilize Readiness Criteria to ensure providers have the ability to deliver RC Pilot Program services in full compliance with HRSN Services Protocol (Attachment K). Provider the RC Pilot Program with a letter stating	Q1-Q2 2026 (verification prior to enrollment as a

	readiness criteria has been met before enrolling as a Medicaid Provider Type for RC.	RC Pilot Provider)
Facility Standards	Prior to the NIMRC certification process, DMS staff, or designated persons will be responsible for verifying that providers meet facility program requirements including the specifications and exclusions as listed in the approved STC's and previously mentioned attachments. Providers must also self-attest to uphold the standards of medical respite care as set forth by the National Institute for Medical Respite Care.	Q1-Q2 2026 (verification prior to enrollment as a RC Pilot Provider)
Data and Systems Integration	May require providers to complete test submissions demonstrating ability to document service provisions as previously described and to be outlined in provider guides, which may include KHIE and kynect integration, referral closure, and encounter data submission prior to launch, to be specified in provider materials.	Q1-Q2 2026
Care Coordination	Ensure providers establish review processes with MCOs, referral pathways to behavioral health and primary care, and discharge planning for long-term stability.	Q2 2026; ongoing
Staffing Standards	Validate staffing, 24/7 coverage, RN-led assessments, and comprehensive staff training.	Q1-Q2 2026 (verification prior to enrollment as a RC Pilot Provider)
Emergency and Safety Preparedness	Require providers to maintain emergency management protocols, emergency medical transfer agreements, and facility safety plans.	Q1-Q2 2026 (pre-certification)
Financial and Administrative Readiness	Assess Medicaid billing capability, encounter data readiness, and provider financial solvency to ensure sustainable operations.	Q1-Q2 2026
Beneficiary Experience and Dignity	Establish beneficiary grievance and feedback processes, privacy protections, and accommodations for ADLs, mobility, and engagement in recovery activities.	Q1 2026; ongoing
Provider Onboarding, State Oversight, and TA	Implement DMS oversight through readiness assessment and check-ins, data monitoring, and structured feedback loops. Provide onboarding activities and communications, including TA to providers facing infrastructure, staffing, or integration challenges.	Q1 2026; ongoing

TEAMKY Health-Related Social Needs (HRSN) Maintenance of Effort (MOE)

As required by the TEAMKY Section 1115(a) Demonstration — Special Terms and Conditions (STCs) 37, Maintenance of Effort (MOE). Kentucky is submitting a plan to the Centers for Medicare & Medicaid Services (CMS) that specifies how the state will determine baseline spending on these services throughout the state. According to STC 37, Kentucky must maintain a baseline level of state funding for Recuperative Care HRSN services to ensure that federal funds supplement, rather than replace, existing state investments. This baseline excludes one-time or non-recurring funding. Kentucky has developed a plan to determine baseline spending, allowing for continuous monitoring and annual MOE reporting as part of the Annual Monitoring Report outlined in STC 58.

Identifying Relevant Kentucky State-Funded Recuperative Care HRSN Programs

Recuperative care services, also known as medical respite care, provide short-term medical and social support for individuals who are experiencing or at risk of homelessness following hospital discharge. To implement this, Kentucky will conduct an inventory of existing housing transition supports that include short-term pre-procedure and post-hospitalization medical respite services, temporary housing with medical oversight, coordination with primary care, and behavioral health supports. It will identify emergency shelters or transitional care programs operating in Kentucky and categorize those receiving state funding under Recuperative care HRSN. Programs relying on one-time or temporary funding sources, such as grants or pilot programs, will be excluded.

Establishment of a Baseline Funding Level

To establish a baseline funding level, Kentucky will analyze historical state expenditures on housing HRSN-related services over a five-year period, if available. As Recuperative care does not currently exist in the state Medicaid program, historical expenditure analysis will focus on housing transition supports offered across the state. The analysis will determine the extent of state funding in each program and measure year-over-year hospital trends, as the demand for housing supports may fluctuate seasonally. Baseline calculations will include per-patient costs associated with medical oversight, housing expenses, inflation adjustments, and changes in service utilization. A fixed baseline funding amount will be established and maintained throughout the demonstration period, ensuring transparency in funding trends and allocations.

**See below detailed plan for analysis of historical state expenditures on recuperative care HRSN Services.*

Historical Expenditures on Housing

Kentucky has defined the scope of its recuperative care and health-related social needs (HRSN) services, including housing transition supports. As part of this effort, the state identified local and state organizations that currently deliver similar services across Kentucky to help determine a baseline funding level for these activities.

Based on this assessment, the total amount of state funds allocated to housing and housing-related supports is \$7,224,575.

***See attached worksheet for the analysis of historical state expenditures on housing and related housing expenditures.**

Development of a Formal MOE Plan

To solidify its commitment, Kentucky will develop a formal MOE plan, emphasizing recuperative care as a cost-saving measure that reduces hospital length of stay, reduces emergency department (ED) admissions, and prevents unnecessary hospital readmissions. The plan will specify MOE requirements for both medical and social services, including clinical assessments, care coordination, medication management, and on-site behavioral health services. It will align with hospital medical care policies, ensure uninterrupted funding, and detail mechanisms to maintain funding stability across state budget cycles.

Integration of MOE into Kentucky's Budgeting Processes

Integrating MOE into Kentucky's budgeting process will require alignment with the state's annual and biennial budget processes. Medicaid managed care organizations (MCOs) will be required to allocate dedicated funds for recuperative care stays without reductions due to federal funding. A braided funding model may incorporate state Medicaid dollars, hospital partnerships, and local health department contributions. Kentucky Department of Medicaid Services (DMS) will request that recuperative care HRSN expenditures are designated as a separate line item in the state budget for traceability.

Implementation of Tracking and Reporting Systems

Tracking and reporting systems will be developed to monitor spending against MOE requirements. Financial reporting mechanisms will be implemented to track expenditures, while service utilization metrics — such as reduced ED admissions, reduced hospital readmission rates, reduced length of stays, and increased post-discharge health outcomes — will measure effectiveness. Kentucky's Cabinet for Health and Family Services (CHFS) agencies and MCOs will be required to report quarterly or annually on Recuperative care HRSN-related expenditures. Performance audits will assess quality outcomes, cost-effectiveness, and compliance with MOE requirements, while an internal compliance monitoring system will identify any potential reductions in state funding.

Submission of Annual MOE Reports to CMS

As required per STC 58, Kentucky will submit an annual report to CMS that will include a breakdown of expenditures and utilization reviews detailing the number of Medicaid beneficiaries accessing Recuperative care services. The data will include Recuperative care-specific quality data related to reduced ED admissions, reduced hospital readmission rates, reduced length of stay, and increased post-discharge health outcomes. Additionally, it will include a comparison of baseline funding before and after the demonstration period. If fluctuations in funding occur — such as increased hospital referrals — Kentucky will explain their impact on MOE compliance and outline corrective measures.

Adjustment of Funding Strategies as Needed

If Kentucky's spending falls below the required MOE level, the state will adjust its budget to restore funding to the baseline. Adjustments may be based on hospital discharge trends and patient length-of-stay data. In the event of increased demand, the state will explore alternative funding sources, including hospital-provider partnerships. Should CMS modify the demonstration requirements, the MOE funding calculations will be adapted accordingly to sustain service delivery.

Analysis of Historical State Expenditures on Recuperative Care HRSN Services Over a Multi-Year Period (3-5 Years)*

Scope of Recuperative Care HRSN Services

Kentucky will conduct a historical expenditure analysis of Recuperative care HRSN services over a five-year period, if available, to establish a reliable funding baseline. The first step is to define the scope of Recuperative care HRSN services by identifying all state-funded programs that provide these services. The services include Short-Term Pre-Procedure Housing for individuals requiring preparatory support before a procedure, and Short-Term Post-Transition Housing, which provides rehabilitative services after hospitalization without requiring 24/7 ongoing clinical monitoring. Non-recurring funding sources, such as pandemic relief funds and temporary pilot programs, will be excluded. Programs will be assessed to determine whether they are fully state-funded or receive federal or local matching contributions.

Collect Financial Data from Relevant Sources

Financial data will be collected from multiple sources, including Kentucky Medicaid budget reports, legislative appropriations data, MCO spending reports, hospital discharge and referral data, county and state health department reports, and social services funding records. Each dataset will include annual expenditure amounts, breakdowns by service type, and the number of Medicaid beneficiaries served per year.

The primary sources include:

- Kentucky Medicaid budget and financial reports (Medicaid agency reports on direct Recuperative care funding).
- Legislative appropriations data (Kentucky budget office allocations for Recuperative care services, if applicable).
- MCO spending reports (if Recuperative care is reimbursed via Medicaid managed care).
- Hospital discharge and referral data (tracks Medicaid beneficiaries referred to Recuperative care facilities).
- County and state health department reports (state-supported Recuperative Care initiatives and housing programs).
- Social Services funding records (direct state-funded transitional housing linked with medical respite care).

Each dataset will provide:

- Annual expenditure amounts for Recuperative care HRSN services.
- Breakdown by service type (e.g., respite housing, case management, medical coordination, and transportation).
- Number of Medicaid beneficiaries served per year.

Standardize Data for Consistency

To ensure consistency, expenditures will be standardized by adjusting for inflation using the Consumer Price Index or a similar factor. Accounting methods will be standardized across different reporting years, and services will be classified under uniform categories such as Short-Term Pre-Transition Housing and Short-Term Post-Transition Housing. Any data gaps will be addressed through interpolation techniques where necessary.

Calculate Multi-Year Averages and Trends

Using five years, if available, of historical data, annual expenditure trends will be analyzed to identify increases or reductions in spending. The baseline funding level will be calculated as the average annual expenditure over the period with weighted adjustments for service expansions. Seasonal and policy-driven variations will also be considered, such as Medicaid expansion or temporary emergency funding injections, which should not be included in the baseline.

Table 1: Computation of Analysis

<p>A. Determine Annual Expenditure Trends</p>	<p>Compute year-over-year growth rates in spending:</p> $\text{Growth Rate} = \frac{(\text{Expenditure}_{\text{Year X}} - \text{Expenditure}_{\text{Year(X-1)}})}{\text{Expenditure}_{\text{Year(X-1)}}} \times 100$ <p>Identify any increases or reductions in spending within specific Recuperative care categories as an outcome.</p>
<p>B. Calculate the Baseline Funding Level</p>	<p>Compute the average annual expenditure as follows:</p> $\text{Baseline MOE} = \frac{\text{Total Spending Over Last X Years}}{X}$ <p>If service expansions occurred, use a weighted average to account for policy-driven increases.</p>
<p>C. Identify Seasonal or Policy-Driven Variations</p>	<p>Check for policy changes (e.g., Medicaid expansion covering more Recuperative care services) that may have temporarily increased spending.</p> <p>Account for emergency funding injections (e.g., COVID-19 federal funding for respite care) that should <i>not</i> be included in the baseline calculation.</p>

Validate the Baseline with Stakeholders

Stakeholder validation will be conducted by sharing findings with CHFS leadership, Medicaid finance teams, hospital associations, and Recuperative care providers to ensure data accuracy. Results will be compared with federal and state funding projections for cross-verification. Any known policy shifts — such as new Medicaid-covered Recuperative care initiatives or legislative budget amendments — will be factored into the final analysis.

Finalize and Document the Baseline Funding

Finally, Kentucky will finalize and document the baseline funding level through a formal expenditure report, which will include historical spending trends, service inclusion/exclusion justifications, and projected funding needs for the Medicaid demonstration period. This report will be submitted to CMS, ensuring that Medicaid-funded Recuperative care services remain

financially sustainable, that federal funds supplement rather than replace state investments, and that budgeting and reporting align with CMS expectations.

By implementing this structured approach, Kentucky ensures that MOE compliance is maintained, state investments in Recuperative care remain intact, and long-term financial planning supports the sustainability of Medicaid HRSN Recuperative care initiatives.

Agency/Department Name	Program Area	Budget Code	Program Description	Total Program budget	One-time costs (Infrastructure/ costs not ongoing/etc.)	Amount proposed for MOE tracking-go forward amount	Explanation for the amount proposed to be included in the MOE
729T-Department for Behavioral Health and Intellectual Disabilities	Mental Health	729P - Mental Health	KY Housing Corporation - Housing Inspection for Priority Populations	\$60,000.00	\$0.00	\$60,000.00	
729T-Department for Behavioral Health and Intellectual Disabilities	Mental Health	729P - Mental Health	Wellsprings Inc - Supportive Housing	\$1,045,000.00	\$0.00	\$1,045,000.00	State generated funds that pay for Supportive Housing Services
729T-Department for Behavioral Health and Intellectual Disabilities	Mental Health	729P - Mental Health	Seven Counties - Community Based Housing	\$75,000.00	\$0.00	\$75,000.00	State generated funds that pay for Community based housing
729T-Department for Behavioral Health and Intellectual Disabilities	Mental Health	729P - Mental Health	Homeless Prevention Project	\$96,500.00		\$96,500.00	State generated funds that pay for Homeless Prevention
729T-Department for Behavioral Health and Intellectual Disabilities	Mental Health	729P - Mental Health	KY River Community Care - Housing Support	\$1,561,000.00	\$0.00	\$1,561,000.00	Included in the BHDID Mental Health Block Grant MOE
729T-Department for Behavioral Health and Intellectual Disabilities	Mental Health	729P - Mental Health	New Beginnings Bluegrass - Supportive Housing Services	\$1,565,000.00	\$0.00	\$1,565,000.00	Included in the BHDID Mental Health Block Grant MOE
729T-Department for Behavioral Health and Intellectual Disabilities	Mental Health	729P - Mental Health	University of KY - CKRC Management and Operations - Personal care homes - Transitional Living Services	\$762,000.00	\$0.00	\$762,000.00	Included in the BHDID Mental Health Block Grant MOE
729T-Department for Behavioral Health and Intellectual Disabilities	Mental Health	729P - Mental Health	Olmstead Wraparound	\$800,000.00		\$800,000.00	Included in the BHDID Mental Health Block Grant MOE
729T-Department for Behavioral Health and Intellectual Disabilities	Substance Use Disorder	729N - Substance Use Disorder	KY Housing Corporation - Housing Inspection for Priority Populations	\$6,500.00	\$0.00	\$6,500.00	Included in the BHDID SUD Block Grant MOE
729T-Department for Behavioral Health and Intellectual Disabilities	Substance Use Disorder	729N - Substance Use Disorder	The Healing Place - Emergency Shelter	\$900,000.00	\$0.00	\$900,000.00	Included in the BHDID SUD Block Grant MOE
729T-Department for Behavioral Health and Intellectual Disabilities	Substance Use Disorder	729N - Substance Use Disorder	PennyRoyal Reg MH MR BD - Genesis Residential Program	\$100,000.00	\$0.00	\$100,000.00	Included in the BHDID SUD Block Grant MOE
729T-Department for Behavioral Health and Intellectual Disabilities	Substance Use Disorder	729N - Substance Use Disorder	Oxford House - Substance Use Recovery Housing	\$253,575.00	\$0.00	\$253,575.00	Included in the BHDID SUD Block Grant MOE
Louisville Continuum of Care		State grant funds	The fund is primarily used for matching funds for federal housing programs and homeless prevention aid	\$550,000.00	\$550,000.00	\$0.00	Excluded-One time
Department of Corrections		Appropriation: Transitional and Reentry Housing	Substance use treatment and early intervention services that includes transitional residence and outpatient services	\$11,608,550.00	\$11,608,550.00	\$0.00	Excluded - One-time
Department of Corrections		Appropriation: Transitional Housing Grants	Provide grants to nonprofit organizations that support individuals who are incarcerated by helping prepare them for release and transition back into the community.	\$11,608,550.00	\$11,608,550.00	\$0.00	Excluded - One-time
Total				\$30,991,675.00	\$23,767,100.00	\$7,224,575.00	

Agency/Department Name	Program Area	Budget Code	Program Description	Total Program budget	One-time costs	Amount	Explanation for the amount
729T-Department for Behavioral Health and Intellectual Disabilities	Mental Health	729P - Mental Health	KY Housing Corporation - Housing Inspection for Priority Populations	\$ 60,000	\$ -	\$ 60,000	
729T-Department for Behavioral Health and Intellectual Disabilities	Mental Health	729P - Mental Health	WellSprings Inc - Supportive Housing	\$ 1,045,000.0	\$ -	\$ 1,045,000.0	State generated funds that pay for Supportive Housing Services
729T-Department for Behavioral Health and Intellectual Disabilities	Mental Health	729P - Mental Health	Seven Counties - Community Based Housing	\$ 75,000.0	\$ -	\$ 75,000.0	State generated funds that pay for Community based housing
729T-Department for Behavioral Health and Intellectual Disabilities	Mental Health	729P - Mental Health	Homeless Prevention Project	\$ 96,500.0		\$ 96,500.0	State generated funds that pay for Homeless Prevention
729T-Department for Behavioral Health and Intellectual Disabilities	Mental Health	729P - Mental Health	KY River Community Care - Housing Support	\$ 1,561,000.0	\$ -	\$ 1,561,000.0	Included in the BHDID Mental Health Block Grant MOE
729T-Department for Behavioral Health and Intellectual Disabilities	Mental Health	729P - Mental Health	New Beginnings Bluegrass - Supportive Housing Services	\$ 1,565,000.0	\$ -	\$ 1,565,000.0	Included in the BHDID Mental Health Block Grant MOE
729T-Department for Behavioral Health and Intellectual Disabilities	Mental Health	729P - Mental Health	University of KY - CKRC Management and Operations - Personal care homes - Transitional Living Services	\$ 762,000.0	\$ -	\$ 762,000.0	Included in the BHDID Mental Health Block Grant MOE
729T-Department for Behavioral Health and Intellectual Disabilities	Mental Health	729P - Mental Health	Olmstead Wraparound	\$ 800,000.0		\$ 800,000.0	Included in the BHDID Mental Health Block Grant MOE
729T-Department for Behavioral Health and Intellectual Disabilities	Substance Use Disorder	729N - Substance Use Disorder	KY Housing Corporation - Housing Inspection for Priority Populations	\$ 6,500.0	\$ -	\$ 6,500.0	Included in the BHDID SUD Block Grant MOE
729T-Department for Behavioral Health and Intellectual Disabilities	Substance Use Disorder	729N - Substance Use Disorder	The Healing Place - Emergency Shelter	\$ 900,000.0	\$ -	\$ 900,000.0	Included in the BHDID SUD Block Grant MOE
729T-Department for Behavioral Health and Intellectual Disabilities	Substance Use Disorder	729N - Substance Use Disorder	PennyRoyal Reg MH MR BD - Genesis Residential Program	\$ 100,000.0	\$ -	\$ 100,000.0	Included in the BHDID SUD Block Grant MOE
729T-Department for Behavioral Health and Intellectual Disabilities	Substance Use Disorder	729N - Substance Use Disorder	Oxford House - Substance Use Recovery Housing	\$ 253,575.0	\$ -	\$ 253,575.0	Included in the BHDID SUD Block Grant MOE
Louisville Continuum of Care		State grant funds	The fund is primarily used for matching funds for federal housing programs and homeless prevention aid	\$ 550,000.0	\$ 550,000.0		Excluded-One time
Department of Corrections		Appropriation: Transitional and Reentry Housing	Substance use treatment and early intervention services that includes transitional residence and outpatient services	\$ 11,608,550.0	\$ 11,608,550.0	\$ -	Excluded - One-time
Department of Corrections		Appropriation: Transitional	Provide grants to nonprofit organizations that	\$ 11,608,550.0	\$ 11,608,550.0	\$ -	Excluded - One-time
			Total	\$ 30,991,675.0	\$ 23,767,100.0	\$ 7,224,575.0	