Kentucky Department for Medicaid Services
Acquired Brain Injury Long Term Care Renewal
Official Response to Formal Public Comment from September 2 – October 2, 2022

Between September 2, 2022, and October 2, 2022, the Department for Medicaid Services (DMS) received formal public comments regarding the renewal of Kentucky's Acquired Brain Injury Long Term Care (ABI LTC) waiver. ABI LTC is a 1915(c) Home and Community Based Services (HCBS) waiver that provides services to individuals with an acquired brain injury who have reached a plateau in their recovery and need maintenance services to live safely in the community.

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

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

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

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
Covered Services				
CS7	Provider	**Occupational Therapy (OT), Speech Therapy (ST), and Physical Therapy (PT) – Service Type** Commenter noted OT is listed in the proposed waiver renewal as a statutory service and says this appears to be an error.	Thank you for bringing this to our attention. OT should be listed as an Extended State Plan Service.	DMS will update the service type for OT to reflect it is an Extended State Plan Service.
CS1	Provider Participant	**Medicaid State Plan OT, ST, and PT – Frequency and Duration of Visits** Commenters say Medicaid state plan OT, ST, and PT do not allow the same frequency and duration of visits as waiver OT, ST, and PT and, as a result, state plan therapies will not adequately address the needs of brain injury survivors or allow for the provision of therapies in a community setting. "When I was receiving speech therapy under the state plan it was 30 minutes every two weeks. I did not make progress	Participants can receive up to twenty (20) Medicaid state plan OT, ST, and/or PT sessions without prior authorization and visits are not limited to a specific duration. Medicaid state plan OT, ST and PT visits are billed based on the appropriate HCPCS code as outlined on the fee schedule. If multiple modalities are provided in a single visit, all appropriate HCPCS codes can be billed. The person-centered planning team is responsible to determine the frequency and duration of services based on the participant's assessment, observed needs, and goals and objectives and should be able to identify in advance whether 20 visits will meet the participant's needs. If the participant	

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		because it was like starting all over again each time I went." "My therapists took me out to help me learn how to function at the grocery store and bank, as well as how to navigate the environment, find an apartment, and pass the driving test. Each of my sessions was at least an hour and a half 5 days per week. This is what I needed." "Under the proposed changes, clients would be reduced to much shorter sessions. These longer sessions are necessary in order for clients to achieve cognitive, communication, ADL, and social skills training and implement these skills/strategies in home, community as well as the clinical settings." "How would the therapist be able to take them out in the community when we are only able to see them 1-2x a week for one hour each visit. In one hour, our therapist and participant would not be able to provide quality therapy services for proper transfer training, making a list for shopping, picking appropriate items in community of list and problem solving,	will need more than 20 visits, the OT, ST, and/or PT provider should begin the prior authorization process as soon as possible to avoid disruption to a participant's services. Many submitted comments indicate therapists routinely accompany participants into the community to complete activities of daily living or instrumental activities of daily living such as grocery shopping, apartment hunting, or learning to drive. It is important to note that while OT, ST, and PT strategies can be taught in the community, therapists should not be providing long-term assistance to participants in completing these activities. Once the therapist establishes the care plan, natural supports or non-clinical providers should observe the skills and strategies that need to be worked on as modeled by the therapist in order to help execute the plan. Conversely, natural supports and non-clinical service providers should be giving the therapist feedback so interventions can be adjusted as necessary to best support the participant. The goal of OT, PT, and ST for ABI LTC participants is to obtain the highest possible level of functioning and should not be used as a substitute for	

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		loading all of the items up, getting home and unloading the items, placing the items in appropriate places with strategies, and then completing budgeting tasks of balancing money." "Our higher functioning participants working on grocery shopping, house searching, budgeting, jobs, etc. If therapy transitions to state plan the therapist cannot possibly address/improve anything once a week in hour long sessions."	24-hour supervision, socialization, or community access.	
CS2	Provider Participant	**Medicaid State Plan OT, ST, and PT – Prior Authorization Process** Commenters say the prior authorization process under the Medicaid state plan for additional OT, ST, and PT visits takes too long, results in delays in care, and will be cumbersome for participants to navigate. "When my 20 visits under state Medicaid were used, my therapists had to get approval for more sessions. This caused me to go for 12 weeks without therapy while we waited. That	To assure continuity of care, all providers who deliver services to a participant, regardless of whether it is covered through the waiver or the Medicaid state plan, should attend person-centered team meetings. The person-centered planning team is responsible to determine the frequency and duration of services based on the participant's assessment, observed needs, goals, and objectives and should be able to identify in advance whether 20 visits will meet the participant's needs. If the participant will need more than 20 visits, the OT, ST, and/or PT provider should begin the prior authorization process as soon as possible to avoid disruption to a	

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		was a major setback with all of my therapies. " "I worry that my brain injury clients may have difficulty with keeping up with these recert requests due to executive functioning deficits and experience a lapse in services if this system change happens. When there are lapses of services, clients experience regressions and sometimes need to access acute health care."	participant's services. An ABI LTC participant should not be navigating this process on their own.	
CS25	Provider	**Medicaid State Plan OT, ST, and PT – Administrative Burden** Commenter is concerned the notes requirements for OT and ST under the ABI LTC waiver and the documentation requirements necessary to receive a Medicaid state plan prior authorization for OT and ST will result in additional paperwork for providers. "Will we no longer write quarterlies/annuals/bi-annuals and just write the Medicaid	If the participant will need more than 20 visits, the OT, ST, and/or PT provider should begin the prior authorization process as soon as possible to avoid disruption to a participant's services. The requirements and frequency of the Medicaid state plan prior authorization process (every 90 days) aligns with Medicare-paid rehabilitative services. Upon the effective date of this renewal, the prior authorization process for waiver OT, ST, and PT will move to this schedule as well.	

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		reports to request recertification or will we do quarterlies/annuals/bi-annuals and fill out the Medicaid reports and forms for doctors?"		
CS3	Provider Participant	**Medicaid State Plan OT, ST, and PT – Intensity** Commenters say Medicaid state plan OT, ST, and PT is not equivalent to OT, ST and PT offered under the ABI LTC waiver, is not intensive enough for acquired brain injury survivors, and will lead to increased institutionalization. "Therapy under the state plan is not intense and does not allow for community reentry." "The statement that therapies under the ABI waiver is a duplication of services of the therapy provided under extended state plan is the equivalent of saying a doctor is a doctor is a doctor and that my PCP should manage all my needs."	ABI LTC participants should be able to receive person-centered OT, ST, and/or PT under the Medicaid state plan that meets the level of intensity they require. If a participant is denied needed OT, ST, and/or PT under the Medicaid state plan, the services may be requested through the ABI LTC waiver. The case manager or support broker should provide the denial letter when requesting services through the waiver. Many submitted comments indicate extended and more frequent OT, ST, and/or PT sessions are required for ABI LTC participants because therapists accompany participants into the community to complete activities of daily living or instrumental activities of daily living such as grocery shopping, apartment hunting, or learning to drive. It is important to note that while OT, ST, and PT strategies can be taught in the community, therapists should not be providing long-term assistance to participants in completing these activities. Once the therapist establishes the care plan, natural	

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			supports or non-clinical providers should observe the skills and strategies that need to be worked on as modeled by the therapist in order to help execute the plan. Conversely, natural supports and non-clinical service providers should be giving the therapist feedback so interventions can be adjusted as necessary to best support the participant. The goal of OT, PT, and ST for ABI LTC participants is to obtain the highest possible level of functioning and should not be used as a substitute for 24-hour supervision, socialization, or community access. Waiver OT, ST and PT providers have the option to enroll as Medicaid state plan providers. This will allow OT, ST, and PT providers under the waiver to continue to serve their ABI LTC participants and will expand the number of Medicaid state plan OT, ST, and PT providers available to ABI LTC participants. Providers can enroll in the Medicaid state plan online using the Kentucky Medicaid Partner Portal Application. Information is available at https://chfs.ky.gov/agencies/dms/provider/Pages/providerenroll.aspx. Providers who currently provide therapy services in both the HCBS waivers and the state plan (e.g. home health agencies) are already enrolled	

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			as state plan providers and no further action is needed.	
CS17	Caregiver	**Medicaid State Plan OT, ST, and PT – Provider Network** Commenter says the participant they care for will have to change service providers if required to receive Medicaid state plan OT and ST.	Participants will have access to any OT,ST, and/or PT provider enrolled in the Medicaid state plan. These providers must meet the same qualifications to provide these services as ABI LTC providers. Many ABI LTC OT, ST and PT providers are also enrolled in the Medicaid state plan. If your current provider is one of them, they can continue providing your OT, ST, or PT services or you can choose a new provider. ABI LTC OT, ST, and PT providers who are not enrolled in the Medicaid state plan can enroll at any time.	
CS11	Other Stakeholder	**Medicaid State Plan OT, ST, and PT – Medical Necessity** Commenter requests clarification on the following statement included in the Occupational and Speech Therapy definitions: "...can only be provided through the waiver when the state plan denies the services because they are not medically necessary." The commenter asks "Does 'not medically necessary' mean, inter alia, that the therapy state plan limits have	The Medicaid state plan is authorized under 1905(a) of the Social Security Act, which requires services to be medically necessary. HCBS are authorized under 1915(c) of the Social Security Act as an alternative to institutionalization. If the Medicaid state plan denies a participant needed OT ,ST or PT services, the case manager or support broker should provide the denial letter when requesting services through the waiver. Participants who receive authorization for waiver-covered OT, ST, and PT after a Medicaid state plan	

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		been reached? All Medicaid services must be medically necessary, so how could a waiver recipient ever receive these therapies through the waiver if they've been deemed not medically necessary?"	denial can continue to receive OT, ST, and PT through the waiver even after the Medicaid state plan limits reset at the start of a new calendar year.	
CS15	Provider	**Medicaid State Plan OT, ST, and PT – Travel** Commenter says receiving OT, ST, and PT under the Medicaid state plan will increase travel for participants who will have to come to the clinic more frequently to meet their therapy needs. "Many clients come from a far distance (over an hour away from the clinic), utilizing medical transportation services. They cannot simply come more days for less time, which would be a consequence of this billing change."	The regulatory definitions of both waiver-paid and Medicaid state plan-paid OT, ST, and PT do not specify where services must be provided, and participants should not experience a change in their schedule, setting, or the need to travel for these services. The person-centered planning team is responsible to determine the frequency, duration, and setting of services based on the participant's assessment, observed needs, and goals and objectives.	

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CS22	Provider	**Medicaid State Plan OT, ST, and PT – Third-Party Insurance** Commenter says most waiver participants will not qualify to receive Medicaid state plan OT, ST, or PT because they have third-party insurance. "In order for a provider to bill Medicaid as a last payer source the provider would have to become a provider for the third-party insurance and bill them first. This is just like outpatient clinics and not beneficial to providers or participants."	If a participant has third-party insurance, the third party is responsible to pay for a service before Medicaid covers it either through the state plan or the waiver. This is current policy as defined in federal regulations and would not change as a result of participants using the state Medicaid for OT, ST, and PT Both Medicaid and the waiver are the "payer of last resort" for individuals with a liable third-party payer as outlined in the Social Security Act § 1902(a)(25).	
CS26	Provider	**Medicaid State Plan OT, ST, and PT – Dually Eligible Participants** Commenter requests clarification about whether Medicaid or Medicare is the payor of last resort for participants with dual eligibility.	The commenter is correct that when a participant is dually eligible for Medicare and Medicaid, Medicaid is the payer of last resort as outlined in the Social Security Act § 1902(a)(25). This is current policy as defined in federal regulations and would not change as a result of participants using the state Medicaid for OT, ST, and PT.	
CS4	Provider Caregiver	**Medicaid State Plan OT, ST, and PT – Reimbursement Rate**	Billing waiver OT, ST, and PT is different than billing the Medicaid state plan. As the commenters state, waiver OT, ST, and PT is billed in 15-minute units. Those units are inclusive of all	

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		Commenters say Medicaid state plan reimbursement rates for OT, ST, and PT are lower than waiver reimbursement rates and will cause many OT, ST, and PT providers to lose money or go out of business. "The reimbursement for SLP services under the ABI waivers is currently $28.41 per 15 minute increment. Under the extended state plan the reimbursement for SLP services is an episode code reimbursed at $47.04. This is not even equivalent to the reimbursement for a 30 minute session under the ABI waiver. Most ABI providers hire contract SLPs to provide therapies. The rate of pay in Louisville, KY for these SLPs is between $50-65/hour. This hopefully illustrates my point that many ABI waiver businesses will not stay afloat." "Hospital based businesses who provide therapy under the state plan have a variety of payer sources to offset the low reimbursement of the extended state Medicaid plan. Businesses that only provide extended state plan services will not stay afloat."	therapeutic modalities taking place during the visit. Medicaid state plan OT, ST, and PT visits are billed based on the appropriate HCPCS code as outlined on the fee schedule. If multiple modalities are provided in a single visit, all appropriate HCPCS codes can be billed. All waiver OT, ST and PT providers have the option to enroll as Medicaid state plan providers. This will allow OT, ST, and PT providers under the waiver to continue to serve their ABI LTC participants and will expand the number of Medicaid state plan OT, ST, and PT providers available to ABI LTC participants. Additionally, waiver providers who enroll as state plan providers have the option to deliver services to any Medicaid member who may need OT, ST, and/or PT services. Providers can enroll in the Medicaid state plan online using the Kentucky Medicaid Partner Portal Application. Information is available at https://chfs.ky.gov/agencies/dms/provider/Pages/providerenroll.aspx. Providers who currently provide therapy services in both the HCBS waivers and the state plan (e.g. home health agencies) are already enrolled as state plan providers and no further action is needed.	

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		"As an administrator, I simply cannot ask therapists to spend 2-3 hours with the client while only getting reimbursed at a single occurrence/session rate not based on time." "The reimbursement rate and limited sessions set by Medicaid will see many qualified providers leave as they are unable to survive financially and sustain quality of care at limited reimbursement." "Wavier providers struggle with staffing skilled staff and if we are required to bill therapies at a lower rate, companies will not be able to afford skilled therapist." "The program is likely at risk for losing some providers due to pay cuts and also increase in paperwork occurring at the same time."		
CS12	Other Stakeholder	**Waiver OT, ST, and PT – Clarification of Definition** Commenter requests clarification on the definition of OT and ST covered by the waiver.	Per 907 KAR 3:210,OT under the waiver is “physician-ordered services in a specified amount and duration to guide a participant in the use of therapeutic, creative, and self-care activities to assist in obtaining the highest possible level of functioning” and ST is a “physician-ordered	

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		"Please also clarify that Occupational and Speech Therapy waiver services can be either habilitative or rehabilitative."	habilitative service in a specified amount and duration to assist a participant with a speech and language disability in obtaining the highest possible level of functioning."	
CS20	Provider	**Waiver OT, ST, and PT – Definition** Commenters request OT, ST, and PT in the ABI LTC waiver be redefined to state these services include cognitive brain retraining. "This differentiates that state plan and waiver therapies are different and provided to a different group of individuals and different techniques."	Thank you for your suggestion. Changes to service specifications require updates to the ABI LTC Kentucky Administrative Regulation (KAR), 907 KAR 3:210. Because of the length of time KAR amendments can take, DMS is not making any changes to the waiver application with this renewal that would require a KAR change. DMS anticipates making additional updates to the waiver and the waiver-related KAR after the 1915(c) HCBS Waiver Rate Study, which is currently underway, concludes. The public will have the opportunity to comment on any KAR or waiver application updates before they are final.	
CS5	Provider	**Waiver OT, ST, and PT – Regulatory Changes** Commenter asked why the service definition for OT, PT, and ST is not being changed in the Kentucky Administrative Regulation at this time.	It is correct that changes to ABI and ABI LTC service definitions require amending 907 KAR 3:090 and 907 KAR 3:210 respectively. The KARs will have to be amended when the 1915(c) HCBS Waiver Rate Study is complete and rate adjustments have been determined. Due to the length of time needed to receive approval for an amended KAR, DMS would not have	

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		"...If it is in the best interest of the vulnerable ABI population to amend 907 KAR 3:090, to state that clients under the ABI waivers can receive intense cognitive brain injury retraining, as so many suggested in the public comments, why is it not being done? When can it be done? What is the process to get it done?"	time to complete waiver renewal-related amendments before reopening the KAR following the rate study. DMS, in conversation with CMS, determined the best course of action is to complete the waiver renewal first before amending the KAR and submitting any waiver amendments based on the conclusion of the 1915(c) Waiver Rate Study. The rate study is currently underway. The public will have the opportunity to comment on any KAR or waiver application updates before they are final.	
CS16	Provider	**Waiver OT, ST, and PT – Prior Authorization Schedule** Commenter says the shift from requiring waiver-covered OT, ST, and PT to be prior authorized every year to every six months is causing service interruptions for ABI LTC participants and that this problem will only get worse for OT, ST, and PT covered by the Medicaid state plan. "There are frequent interruptions of service during the recertification process due to case manager paperwork requirements, scheduling the interdisciplinary team meetings,	If the participant will need more than 20 visits, the OT, ST, and/or PT provider should begin the prior authorization process as soon as possible to avoid disruption to a participant's services. The requirements and frequency of the Medicaid state plan prior authorization process (every 90 days) aligns with Medicare-paid rehabilitative services. Upon effective date of this renewal, the prior authorization process for waiver OT, ST, and PT will move to this schedule as well.	

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		requesting/waiting to receive additional physician orders, and waiting on qualification paperwork/ approval from ABIB. Just in the past 3 months, we have had several clients miss 2 or more weeks of services due to case managers requesting several times, but not receiving physician orders."		
CS19	Provider	**Medicaid State Plan and Waiver OT, ST, and PT – Duplication of Service** Commenter says ABI LTC participants can currently receive both OT, ST, and PT through the waiver for their brain injury-related needs and receive OT, ST, and PT through the Medicaid state plan for other PCSP goals and objectives. "This is just one example of how the state already allows the two different providers are able to bill two different reimbursement services."	An ABI LTC waiver participant should not be receiving OT, ST, and/or PT through the waiver and the Medicaid state plan simultaneously as it would be a duplication of service. OT, ST, and PT provided through the waiver is considered an Extended State Plan Service. This means the service should be provided by the Medicaid state plan first. If the participant exhausts their OT, ST, and PT benefit under the Medicaid state plan, these services can then be requested through the ABI LTC waiver.	
CS23	Provider	**Supervised Residential – Capacity** Commenter requests DMS permanently increase the	Making Appendix K changes permanent requires amending the ABI LTC KAR, 907 KAR 3:210. Because of the length of time KAR amendments can take, DMS is not making any	

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		capacity allowed in ABI LTC residential settings. Increased capacity is currently allowed under Appendix K.	changes to the waiver application with this renewal that would require a KAR change. DMS anticipates making additional updates to the waiver and the waiver-related KAR after the 1915(c) HCBS Waiver Rate Study, which is currently underway, concludes. The public will have the opportunity to comment on any KAR or waiver application updates before they are final.	
CS6	Provider	**Supervised Residential Level II – Provider Types** Commenter recommends adding family home providers as a provider type for Supervised Residential Level II. "This would result in further synchronization of the residential services offered across 1915(c) HCBS waivers in Kentucky, as well as, meeting an identified need in the acquired brain injury (ABI) population. This residential service model has been successful for the intellectual and developmental disabilities population and could be similarly successful for individuals with ABI."	Thank you for your suggestion. Changes to service specifications require updates to the ABI LTC KAR, 907 KAR 3:210. Because of the length of time KAR amendments can take, DMS is not making any changes to the waiver application with this renewal that would require a KAR change. DMS anticipates making additional updates to the waiver and the waiver-related KAR after the 1915(c) HCBS Waiver Rate Study, which is currently underway, concludes. The public will have the opportunity to comment on any KAR or waiver application updates before they are final.	

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CS24	Provider	**Technology Assisted Residential** Commenter requests DMS add Technology Assisted Residential to the ABI LTC waiver permanently. The service is currently available in ABI LTC under Appendix K.	Making Appendix K changes permanent requires amending the ABI LTC KAR, 907 KAR 3:210. Because of the length of time KAR amendments can take, DMS is not making any changes to the waiver application with this renewal that would require a KAR change. DMS anticipates making additional updates to the waiver and the waiver-related KAR after the 1915(c) HCBS Waiver Rate Study, which is currently underway, concludes. The public will have the opportunity to comment on any KAR or waiver application updates before they are final.	
CS9	Provider	**Goods and Services – Provider Types** Commenters request that Residential providers be added as a provider type to bill Goods and Services. "…Residential agencies have higher operating budgets and can more easily handle the cost of goods and services. Additionally, when participants have residential services on their person-centered service plan, it makes more sense for their	Thank you for your suggestion. Changes to provider types require updates to the ABI LTC KAR, 907 KAR 3:210. Because of the length of time KAR amendments can take, DMS is not making major changes to the waiver application with this renewal. DMS anticipates making additional updates to the waiver and the waiver-related KAR after the 1915(c) HCBS Waiver Rate Study, which is currently underway, concludes. The public will have the opportunity to comment on any KAR or waiver application updates before they are final.	

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		residential provider to acquire the goods."		
CS10	Provider	**Support Broker – Provider Types** Commenters request traditional case management agencies be added as a provider type for Support Broker services. "Please add if possible to allow true freedom of choice to providers. Currently some of the CMHCs have significant waiting lists for these services preventing access." "It provides PDS participants with more options (and thus is more person-centered) to choose a case manager instead of relying solely on CMHC and AAA's who often are full and cannot accept more participants."	Thank you for your feedback. Changes to provider types require updates to the ABI LTC KAR, 907 KAR 3:210. Because of the length of time KAR amendments can take, DMS is not making major changes to the waiver application with this renewal. DMS anticipates making additional updates to the waiver and the waiver-related KAR after the 1915(c) HCBS Waiver Rate Study, which is currently underway, concludes. The public will have the opportunity to comment on any KAR or waiver application updates before they are final. DMS will work with all CMHCs and ADDs to evaluate barriers to enrolling participants and provide technical assistance as needed.	
CS13	Other Stakeholder	**Waiver Services Provided in Acute Hospital Settings** Commenter appreciates the addition of language in the ABI LTC waiver allowing waiver services to be provided in acute hospital settings when the	Thank you for your comment. Waiver services provided in an acute hospital setting must: • Be needed to meet emergent, non-medical needs or risks when there is not a family	

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		hospital cannot meet the participant's health, safety, and welfare needs. Commenter has the following question: "Please confirm that communication and behavior needs are not an exhaustive list."	member or natural support available to assist. • Not duplicate services the hospital is required to provide, such as bathing or feeding. • This policy is not intended for continuing the participant's full person-centered service plan while they are hospitalized. When participants and/or their caregivers encounter a situation where receiving waiver services in an acute hospital setting may be appropriate, they or their case manager should contact DMS for further guidance.	
CS14	Other Stakeholder	**Home Delivered Meals** Commenter asks if hot, frozen, or chilled meals will be added as part of the Home Delivered Meals service. "Some ABI LTC waiver participants could benefit from this being made a permanent service. The 1915(c) HCBS Waiver Redesign Task Force's Recommendation Thirteen (13) states that all Appendix K amendments and flexibilities should become permanent."	Home Delivered Meals is not an ABI LTC service but is currently available to ABI LTC participants through Appendix K of the 1915(c) HCBS waiver application. Appendix K will remain in effect up to six months after the end of the federal public health emergency. Making Appendix K changes permanent requires amending the ABI LTC KAR, 907 KAR 3:210. Because of the length of time KAR amendments can take, DMS is not making any changes to the waiver application with this renewal that would require a KAR change. DMS anticipates making additional updates to the waiver and	

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			the waiver-related KAR after the 1915(c) HCBS Waiver Rate Study, which is currently underway, concludes. The public will have the opportunity to comment on any KAR or waiver application updates before they are final.	
CS27	Other Stakeholder	**Community Guide – Provider Types** Commenter is concerned the removal of the Community Guide service from the waiver application and the addition of the Support Broker service will reduce available provider options for ABI participants who use Participant-Directed Services because the provider types for Support Broker only include CMHCs and ADDS, whereas Community Guide provider types were Qualified Community Guide and Approved Waiver Providers. "We are concerned that limiting the provider types for support broker services will create a bottleneck for participant directed services. We are aware of current support broker	This update to the waiver application does not change the number of agencies available to provide Support Broker services to participants who choose the PDS delivery method. Community Guide and Support Broker are not the same service. Support Brokers provide case management for individuals who use PDS. Community Guides were intended to assist a participant in fulfilling the responsibilities of a PDS employer. As such, the provider qualifications for each service are different. DMS removed Community Guide from the waiver renewal to better align the waiver application with the ABI LTC KAR and reflect the services truly available for ABI LTC participants. Community Guide is not listed as a service in the ABI LTC KAR and, therefore, is not available for ABI LTC participants to receive. No participants will lose services because of the	

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		agencies that have wait lists or are not taking new clients."	Community Guide being removed from the waiver application. Conversely, Support Broker is listed as a service in the ABI LTC KAR but was not included in the waiver application. DMS added it to the renewal to better align the waiver application with the ABI LTC KAR and reflect the services truly available for ABI LTC participants. Currently, Community Mental Health Centers and Area Development Districts are the only available provider types for Support Broker services. Adding a provider type requires amending the ABI LTC KAR. DMS is not amending 907 KAR 3:210 for this renewal. Expansion of provider types will be reviewed and considered as part of the state's Enhanced FMAP Spending Plan. Any updates to provider types will be completed through a future KAR change accompanied by a waiver amendment. The public will have an opportunity to review and comment on future KAR and waiver amendments.	
Eligibility and Enrollment				
EE1	Provider	**Level of Care Documentation** Commenter thanks DMS for allowing applicants to have an	Thank you for your feedback.	

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		order stating that nursing facility level of care is needed signed by either a physician, nurse practitioner, or physician assistant. The commenter says this will increase access to the waiver.		
EE2	Other Stakeholder	**Financial Eligibility** Commenter applauds the increase in financial eligibility from 100% of the Federal Benefit Rate (FBR) to 300% of the FBR, which reduces or eliminates patient liability payments for most waiver participants.	Thank you for your feedback.	
EE3	Other Stakeholder	**Financial Eligibility** Commenter applauds the selection of 'Yes' under *4. Waiver(s) Requested, B. Income and Resources for the Medically Needy* at the beginning of the waiver application.	Thank you for your feedback.	
EE4	Other Stakeholder	**No Cost Limit** Commenter applauds selection of 'No Cost Limit' under	Thank you for your feedback. It is important to note "No Cost Limit" does not refer to the amount of services a participant receives. The CMS' Technical Application for a	

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		Individual Cost Limit in Appendix B.	§1915(c) Home and Community-Based Waiver [Version 3.6, January 2019] Instructions, Technical Guide and Review Criteria says No Cost Limit means "When an individual cost limit is not imposed, this means that no otherwise eligible individual will be denied entrance to the waiver solely based on the anticipated costs of the home and community-based services that the person may require. Again, this does not mean that the person is entitled to unlimited home and community-based services once enrolled in the waiver program. The amount of services that will be furnished to an individual is determined based on assessed needs and as specified during the development of the service plan and is subject to any other limitations specified in Appendix C."	
EE5	Provider	**Participant Termination from Service Provider** Commenter says ABI LTC providers who give a 30-day notice to a participant should not be able to terminate the participant until another provider or support is in place.	Participants should not be terminated from a provider without other services and support in place. If you encounter this situation, please contact the DMS Division of Long-Term Services and Supports Acquired Brain Injury Branch at (844) 784-5614 for assistance.	
Case Management				

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
CM1	Provider	**Use of SMART Goals** Commenter thanked DMS for defining SMART goals in the waiver application.	Thank you for your comment.	
CM2	Provider	**Deadline to Submit Person-Centered Service Plan** Commenter is concerned about the requirement for the person-centered service plan to be submitted seven days before the end of the participant's LOC year. "If there are patterns of late submission by case managers, those should be addressed by DMS... rather than blanket changes that remove autonomy from independent providers."	The completed and signed PCSP must be uploaded to the Medicaid Waiver Management Application (MWMA) seven (7) calendar days before the end of the participant's current LOC period to prevent any gaps in service for the participant. As outlined in Appendix D, the person-centered service planning process can begin forty-five (45) calendar days before the end of the LOC period to give the person-centered planning team sufficient time to complete the plan, gather the required documentation, and obtain signatures.	
CM3	Provider	**Case Management Standards** Commenter applauds the updated case management standards that align with best practices and recommends DMS require community-based organizations and provider agencies to receive the National Committee for Quality Assurance's accreditation of	Thank you for your feedback. DMS is continually evaluating different methods for improving 1915(c) HCBS waiver case management and care coordination and will consider this option during future waiver and KAR amendment processes.	

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		case management for long-term services and supports to improve quality improvement and incentivize strong care coordination policies and procedures.		
Participant Directed Services (PDS)				
PDS1	Other Stakeholder	**Legally Responsible Individuals (LRI) as PDS Employees** Commenter says the ABI LTC waiver's definition of a legally responsible individual as the parent or guardian of a minor child and the spouse of a waiver participant is a "welcome and appreciated clarification of who is an LRI."	Thank you for your feedback.	
PDS2	Other Stakeholder	**Financial Management Services – Provider Type** Commenter recommends financial management services be provided by a single entity rather than Area Development Districts (ADD) and Community Mental Health Centers (CMHC), as it is today.	Thank you for your feedback. DMS recognizes the use of multiple FMS entities can create inconsistencies in the service. DMS is currently evaluating options for streamlining and simplifying FMS for participants using PDS.	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
		"The single FMS entity may be preferable as it would provide uniformity regarding labor and tax practices as well as untangle fiscal management from case management duties."		
PDS3	Other Stakeholder	**Background Screening – Costs** Commenter recommends the cost associated with securing PDS employees be included in the reimbursement rate to financial management services agencies or the participant's PDS budget. "Many waiver recipients have limited income and cannot afford to pay for these costs out of pocket."	Thank you for your feedback. DMS understands the cost of employee background screenings is a challenge for participants using PDS and is evaluating different methods for covering PDS employee onboarding costs.	
Provider Qualifications and Training				
PQT1	Provider	**Background Screening Registry Checks** Commenter asked if the Kentucky State Police Sex Offender Registry will be added to the list of required registry checks for potential direct	DMS is evaluating background screening requirements across waiver and will consider adding this to the ABI LTC waiver in the future for consistency among 1915(c) HCBS programs.	

Reference #	Commenter Type	Comment	DMS Response	Change to the Waiver
		service providers and PDS employees.		
Other				
O1	Other Stakeholder	**1915(c) Waiver Help Desk Functions** Commenter asked if the 1915(c) Waiver Help Desk is available as a resource for all of Kentucky's 1915(c) HCBS waivers.	Yes, the 1915(c) Waiver Help Desk serves as a central contact point for providers, participants, and the public seeking information on any 1915(c) HCBS waiver in Kentucky.	