1915(c) Service Authorization Crosswalk

Home and Community Based Wavier (HCB)

Kentucky 1915(c) Home and Community Based Waiver Services

Education for Case Managers

Updated: December 2, 2019

WELCOME TO THE 1915(c) SERVICE AUTHORIZATION CROSSWALKS

The 1915(c) Service Authorization Crosswalks provide case managers with an overview of the 1915(c) waiver service offerings available to participants. Crosswalks include the following eight (8) elements for each waiver service:

1. **Service**: Name of the service
2. **Applicable 1915(c) Waivers**: A list of all 1915(c) waivers the service applies to (*if the crosswalk contains more than one waiver service)*
3. **Summary at a Glance**: A brief description of the service and limits
4. **Definition**: The service as defined in the 1915(c) Home and Community Based Services (HCBS) waiver specific Kentucky Administrative Regulation (KAR)
5. **Limitations**: Any limits associated with the service, such as volume limits, conflicts with other services, variation based upon a specific waiver
6. **Duplication of Service Risk***:* Limitations on this service where it cannot be billed concurrently with another service
7. **Cabinet-level Review/Approval***:* Indication that the service requires approval by the Department for Medicaid Services (DMS) or its designee prior to service delivery
8. **Service Indicators***:* Examples of rationale that support use of the service

Crosswalks contain the service definition and limitations for each service as indicated in the 1915(c) waiver applications and the KARs, both found on the Division of Community Alternatives website. There are five (5) crosswalks:

1. Acquired Brain Injury Waivers (ABI, ABI-LTC) Crosswalk
2. Home and Community Based Waiver (HCB) Crosswalk
3. Michelle P. Waiver (MPW) Crosswalk
4. Supports for Community Living Waiver (SCL) Crosswalk
5. Model II Waiver (MIIW) Crosswalk

Case managers will find the HCB Crosswalk on the following pages. The additional crosswalks are found on the Division of Community Alternatives website.

Service Name	**Adult Day Health Care (S5100)**
Summary at a Glance	Skilled nursing services, one meal per day and snacks, registered nurse (RN) supervision, regularly scheduled daily activities, crisis services, and routine personal and healthcare needs for waiver participants aged twenty-one (21) years or older.
Definition	Adult day health care (ADHC) services include basic and ancillary services for waiver participants who are twenty-one (21) years or older. Basic services include skilled nursing services provided by an RN or licensed practical nurse (LPN), including ostomy care, urinary catheter care, decubitus care, venipuncture, insulin injections, tracheotomy care, or medical monitoring; meal service corresponding with hours of operation with a minimum of one (1) meal per day, snacks, RN supervision, regularly scheduled daily activities, crisis service, routine personal and healthcare needs, and equipment essential to the provision of the ADHC services. Transportation is not covered under the ADHC element. ADHC is not available in the participant directed services (PDS) option.
Limitations	This service is limited to fifty (50) hours per calendar week. Fixed upper payment limit of: $2.83 per unit for Level I services; $3.43 per unit for Level II services except for specialized respite, which shall be $10.00 per unit for Level II.
Duplication of Service Risk	**Waiver Service**: Yes **State Plan Service**: Yes **Other Service**: No
Requires Cabinet-Level Review	No
Service Indicators	ADHC is the most appropriate setting to meet the participant's needs. Participant can benefit from socialization and structured activities. Participant has expressed a willingness to engage in social activities with others. Participant requires skilled care services that are included in ADHC. Participant is able to access services that are within a reasonable distance and best meet the specific needs of the participant.

	Relief to the caregiver to ease caregiver strain and/or burnout.

Service Name	**Attendant Care (S5108 / 580)**
Summary at a Glance	Provide hands-on assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs), managing medical appointments, and other tasks participants would normally do for themselves if they did not have a disability.
Definition	Attendant Care services are provided through traditional providers and enable waiver participants to accomplish tasks that they normally would do for themselves if they did not have a disability. Attendant Care may include hands-on assistance (actually performing a task for the participant), reminding, observing, and/or guiding a waiver participant in ADLs (such as bathing, dressing, toileting, transferring and maintaining continence) and IADLs (more complex life activities such as personal hygiene, light housework, laundry, meal planning and preparation, transportation, grocery shopping, money management, and assistance with medication administration). This service may also include assisting the waiver participant in managing his/her medical care including making medical appointments and accompanying the participant during medical appointments but does not include the provision of direct medical services. The provision of home health medical services through the state plan does not prohibit the provision of attendant care waiver services. Attendant care services may only be used to meet the needs as defined on the person-centered service plan (PCSP). Attendant Care cannot duplicate State Plan services or other waiver services. Attendant Care shall not replace the natural support system. Natural Supports are defined as a non-paid person, persons, or a community resource, which can provide, or has historically provided assistance to the participant or due to the familial relationship, would be expected to provide assistance.
Limitations	Determined by the independent assessment and identified on the PCSP. Maximum daily allowance for Attendant Care alone or in combination with Adult Day

	is $200 per day based on a seven (7) day week. The amount of Attendant Care services is based on the assessment and included on the PCSP. Fixed upper payment limit of $24.00 per hour.
Duplication of Service Risk	**Waiver Service**: Yes **State Plan Service**: Yes **Other Service**: No
Requires Cabinet-Level Review	No
Service Indicators	Strong support for keeping a participant integrated with family/community/support systems. Personal care/homemaker/ADHC not to occur at the same time, however, the services can occur on the same day. Risk factors to indicate a participant requires attendant care could include (not an all-inclusive list): • Engages in risk behaviors • "Sundowner" (experiencing increased confusion during evening hours) Assess for less invasive measures that would assure participant safety other than attendant care (i.e. taking handles/burners off stove).

Service Name	**Conflict-Free Case Management (T1016 / 590)**
Summary at a Glance	Assist participants who receive waiver services in gaining access to needed waiver, State Plan, and other community services. Case management shall be conflict free, meaning the case management provider must not also provide another waiver service to the same participant.
Definition	Case Management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet participant and family comprehensive needs through communication and available resources to promote quality cost effective outcomes. Case management services shall assist participants who receive waiver services in gaining access to needed waiver, State Plan and other community services. Case managers shall be responsible for monitoring the services included in the participant's PCSP. Case managers will work closely with the

	participant to assure the participant has access to available supports, services, and resources and that ongoing need are met. Case managers will also work closely with the DMS independent assessors. Case management involves face-to-face and related contacts to make arrangements for activities which assure the following: (1) The health, safety and welfare of the participant is met (2) The ongoing needs of the participant are determined and reflected in the PCSP (3) The supports and services needed by the participant are identified and implemented (4) Housing and employment (when applicable) issues are addressed (5) Appointments and meetings are scheduled (6) The quality of the supports and services as well as the health and safety of the participants are monitored and (7) Benefits are managed as needed. Case management functions include: *Collaboration *Implementation of the PCSP *Knowledge of all programs and resources *Education of participant on programs and resources available to them *Knowledge of participant's strengths and weaknesses *Referral to services *Coordination of services *Monitoring activities and services *Reporting of incidents *Facilitation of the service team *Identification of barriers to participant's needs *Input from all disciplines and team members involved in the participant's care *Advocacy for the participant not the program or provider *Monitoring of health, safety and welfare Case Management shall be conflict-free. Conflict-free means a provider, including any subsidiary, partnership, not-for-profit, or for profit business entity that has a business interest in the provider who renders case management to a participant, must not also provide another waiver service to that same participant unless the provider is the only willing and qualified provider in the geographical area (within thirty (30) miles from the participant's residence). Case managers will assure that participants have freedom of choice of providers in a conflict-free climate. Agencies providing case management

	services to a participant may not provide other waiver services to that same participant. Case management shall not include direct services. Case managers or their designees must be available for on-call services.
Limitations	This service is limited to one (1) unit per participant per month, (one (1) unit of service is defined as one (1) calendar month). The participant contact shall be monthly. At a minimum, the case manager shall conduct one (1) direct face-to-face contact every other month with telephonic contact on alternate months. The face to face contact must be conducted in the home at least three (3) times per year. Fixed upper payment limit of $100.00.
Duplication of Service Risk	**Waiver Service**: No **State Plan Service**: No **Other Service**: No
Requires Cabinet-Level Review	No
Service Indicators	Participant has been approved for waiver and requires case manager for PCSP development and ongoing monitoring. A specific situation/event has occurred in which participant may require additional outreach.

Service Name	**Environmental and Minor Home Adaptations (S5165 / T1999 / 290)**
Summary at a Glance	Physical adaptations to the home required for the participant's health, welfare, and safety, or to enable to participant to function with greater independence in the home.
Definition	Physical adaptations to the home, required by the participant's PCSP, which are necessary to ensure the health, welfare, and safety of the participant or which enable the participant to function with greater independence in the home, and without which, the participant would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems, which are necessary to accommodate the medical equipment and supplies

	necessary for the welfare of the participant. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this service. All services shall be provided in accordance with applicable State or local building codes. All environmental and minor home adaptations must undergo a Cabinet-level review and approval prior to service delivery. All providers for environmental and minor home adaptations shall be licensed and insured as verified by the case manager. Environmental and minor home adaptations shall also include the installation and monthly support of personal emergency response systems. Must have 24/7 access to an RN for consultation.
Limitations	Reimbursement for environmental and minor home adaptations shall be limited to $2,500 per participant per year. The case manager shall be responsible for assisting the participant to access other State Plan services, natural supports or services available through other funding streams if their needs exceed this limit.
Duplication of Service Risk	**Waiver Service**: No **State Plan Service**: Yes **Other Service**: Yes
Requires Cabinet-Level Review	Yes
Service Indicators	Modification is necessary for health and safety and/or participant ability to navigate independently throughout residence. Must meet safety/codes compliance. Confirm whether or not the goods or services can be covered through the State Plan or through another resource. Potential reduction in the reliance on In-Home worker/caregiver and/or increase participant independence. Select the lowest of the three (3) required estimates. State Plan options are explored before waiver service is used.

Service Name	**Goods and Services (999 / T1999)**
Summary at a Glance	Purchase of goods or services utilized to reduce the need for personal care or enhance the participant's independence in the home or community.
Definition	The purchase of goods and services must be individualized and may be utilized to reduce the need for personal care or enhance the independence within the home or community of the program participant. All items purchased must be included on the PCSP. Services must be clinically necessary and be supported by clinical documentation. As a Medicaid-funded service, this definition will not cover experimental goods and services inclusive of items which may be defined as restrictive under G.S. 122C-60. Examples of services and supports provided under Goods and Services may include nutritional and incontinent supplies and interpreter support. Reimbursement for environmental and minor home adaptations shall be limited to $2,500 per participant per year. The case manager shall be responsible for assisting the participant to access other State Plan services, natural supports, or services available through other funding streams if their needs exceed this limit.
Limitations	Participants shall not receive goods and services through both the traditional and PDS option. Goods and services cannot exceed $3,500.00 per year without DMS approval.
Duplication of Service Risk	**Waiver Service**: No **State Plan Service**: Yes **Other Service**: Yes
Requires Cabinet-Level Review	Yes (Any submission of $500 or more must be approved by DMS or its designee prior to service delivery.)
Service Indicators	Confirm whether or not the goods or services can be covered through the State Plan or through another resource. Goods or services are supportive of participant's goals as identified on the PCSP and support participant's overall HCBS needs.

Service Name	**Home and Community Supports (S5108)**
Summary at a Glance	Utilize PDS to accomplish independent tasks not typically provided by natural supports. Includes hands-on assistance in ADLs and IADLs.
Definition	Home and Community Direct Support Services enable waiver participants who elect to utilize PDS to accomplish tasks that they normally would do for themselves if they did not have a disability and would not typically be provided by natural supports. Home and Community Supports may include hands-on assistance (actually performing a task for the participant), reminding, observing, and/or guiding a waiver participant in ADLs (such as bathing, dressing, toileting, transferring and maintaining continence) and IADLs (more complex life activities such as personal hygiene, light housework, laundry, meal planning and preparation, transportation, grocery shopping, money management, and assistance with medication administration). This service may also include assisting the waiver participant in managing his/her medical care including making medical appointments and accompanying the participant during medical appointments. Home and Community Support Services may only be used to meet the needs as defined on the PCSP. Home and Community Support Services cannot duplicate State Plan services or other waiver services and shall not replace the natural support system. Natural Supports are defined as a non-paid person, persons, or community resource, which can provide or has historically provided assistance to the participant or due to the familial relationship, would be expected to provide assistance.
Limitations	Determined by the independent assessment and identified on the PCSP. Maximum daily allowance for Home and Community Support Services alone or in combination with Adult Day or Attendant Care cannot exceed $200. Home and Community Support Services can be provided if the participant is also receiving Adult Day Services or Attendant Care if the service is identified as a need via the independent assessment, the service is listed on the PCSP and the service is not provided at the same time as another service. Home and Community Support Services cannot exceed forty-five (45) hours per week. Travel to and from the waiver participant's home is excluded.

	Unit amount is defined as fifteen (15) minutes. Upper payment limit of $2.88 per unit.
Duplication of Service Risk	**Waiver Service**: Yes **State Plan Service**: Yes **Other Service**: No
Requires Cabinet-Level Review	No
Service Indicators	Participant requires assistance with chores such as light housework, laundry, meal planning/preparation, grocery shopping that are separate from the overall family routine. Service affords the family/caregiver the ability to provide additional supports to the participant.

Service Name	**Home Delivered Meals (S5170)**
Summary at a Glance	Provide meals to participant who has a need for a home delivered meal based on a deficit in an activity of daily living or independent activity of daily living identified during the assessment process.
Definition	A home delivered meal shall: • Meet at least one-third (1/3) of the recommended daily allowance per meal and meet the requirements of the current version of the Dietary Guidelines for Americans published by United States Department of Agriculture and the United States Department of Health and Human Services • Be provided to a participant who is unable to prepare his or her own meals and for whom there are no other persons available to do so including natural supports • Be furnished in accordance with menus that are approved in writing by a licensed dietitian • Take into consideration the participant's medical restrictions; religious, cultural, and ethnic background; and dietary preferences • Be individually packaged heated meals • Be provided for inclement weather, holidays, or emergencies if prior approval is provided by the Cabinet and if the meals are individually packaged if not heated; Are shelf stable; or have components separately packaged if the

	components are clearly marked as components a single meal; and • **Not**: Supplement or replace meal preparation activities that occur during the provision of attendant care services or any other similar service; supplement or replace the purchase of food or groceries; include bulk ingredients, liquids, and other food used to prepare meals independently or with assistance; be provided while the participant is hospitalized, residing in an institutional setting, or while in attendance at an ADHC center; or duplicate a service provided through other programs operated by any governmental agency.
Limitations	Limited to one (1) unit of service per day and five (5) units per week. One (1) unit of service equals one (1) hot meal. Upper payment limit of $7.50 per hot meal.
Duplication of Service Risk	**Waiver Service**: No **State Plan Service**: No **Other Service**: Yes Note: If home delivered meals not an option, potential for community congregate meals, churches, etc.
Requires Cabinet-Level Review	No
Service Indicators	Determine if congregate meal options are available through the community. Limited to one (1) meal per day; case manager to ensure nutrition/meal assistance provided for other daily meals as needed. During on-going monitoring, case manager to ask/watch for appropriate use. I.E. if participant is not consuming the meal, seek alternatives to the home delivered meals. Participant has an assessed need for assistance with meal preparation.

Service Name	**Non-Specialized Respite Care (S5108 / T1005)**
Summary at a Glance	Short-term care due to absence or need for relief of non-paid primary caregiver.

Definition	Non-Specialized Respite services are defined as short term care which is provided to a waiver participant due to the need for relief of the primary caregiver who normally provides care for the participant. Non-Specialized Respite services cannot be utilized to provide respite to a paid caregiver. Services must be provided at a level to appropriately and safely meet the support needs of the waiver participant and that the respite provider has the appropriate training and qualifications. Respite care services shall be required to be of a skill level beyond normal babysitting. Non-Specialized services cannot replace the natural support system. Natural Supports are defined as a non-paid person, persons, or community resource, who can provide, or has historically provided assistance to the participant or due to the familial relationship, would be expected to provide assistance.
Limitations	Non-Specialized Respite alone or combined with Specialized Respite cannot exceed $4,000 per year unless approved by the Cabinet. Limits are based solely on the capitated yearly rate and not on the number of days, hours or sequence of service hours. Upper payment limit $2.75 per unit.
Duplication of Service Risk	**Waiver Service**: Yes **State Plan Service**: No **Other Service**: No
Requires Cabinet-Level Review	No
Service Indicators	Provide necessary relief to allow caregivers to take care of personal matters or engage in tasks for other members of the household. Signs/evidence of family/caregiver burnout, including but not limited to caregiver lack of self-care and increased agitation between caregiver and participant. Caregiver is responsible for twenty-four (24) hour care of participant.

Service Name	**Participant Directed Coordination Services (T2040)**
Summary at a Glance	Coordination of participant's PCSP.

	Provide guidance to participant in understanding roles and responsibilities of an employer in PDS.
Definition	Participant Directed Coordination (PDC) includes the coordination of the participant's PCSP, providing guidance to the participant in understanding the role and responsibility of an employer in PDS, and management and distribution of funds in the participant's approved participant-directed budget. The provider shall ensure person-centered planning principles are applied in the implementation of the PCSP. The provider shall perform the employer responsibilities of payroll processing which shall include: issuance of paychecks, withholding federal, state and local tax, and making tax payments to the appropriate tax authorities, and issuance of W-2 forms. The provider shall be responsible for performing all fiscal accounting procedures including issuance of expenditure reports to the participant, their representative, and the service advisor. The provider shall maintain a separate account for each participant while continually tracking and reporting funds, disbursements, and the balance of the participant's budget. The provider shall process and pay invoices for participant-directed goods and services approved in the participant's PCSP.
Limitations	Providers of PDC cannot provide any other waiver service to the participant and must demonstrate the ability through experience as a financial management entity for state or federal participant directed programs. PDC is defined as one (1) unit per participant per month and must include monthly face-to-face contact. PDC services are limited to participants opting to participant direct some or all of their non-medical services. Upper payment limit of $325.00 per unit.
Duplication of Service Risk	**Waiver Service**: No **State Plan Service**: No **Other Service**: No
Requires Cabinet-Level Review	No
Service Indicators	Participant is approved under the HCB waiver for PDS.

Service Name	**Specialized Respite (T1005 / 660 / 662)**
Summary at a Glance	Short term care provided to a waiver participant due to the need for relief of the primary caregiver or the sudden absence or illness of the primary caregiver who normally provides care for the participant.
Definition	Specialized Respite services are defined as short term care which is provided to a waiver participant due to the need for relief of the primary caregiver or the sudden absence or illness of the primary caregiver who normally provides care for the participant. Specialized Respite Service direct care staff must have twenty-four (24) hour access to an RN for consultation and emergency situations. Respite services cannot be utilized to provide respite to a paid caregiver. Services must be provided at a level to appropriately and safely meet the support needs of the waiver participant and that the respite provider has the appropriate training and qualifications. Specialized Respite care services shall be required to be of a skill level beyond normal babysitting. Specialized Respite can be provided in conjunction with PDS respite but not at the same time. Respite services shall only be provided by licensed home health agencies or ADHC agencies and can be provided in the following locations: • The home of the participant or • An adult day health care center licensed by the state of Kentucky or • Combination of home and adult day health care center
Limitations	Reimbursement for Specialized Respite services shall be limited to no more than $4,000 per participant per year. The case manager shall be responsible for assisting participants to access other State Plan services, natural supports or services available through other funding streams if their needs exceed this limit. Specialized Respite services can be provided twenty-four/seven (24/7) but shall not exceed $200 per day. Specialized Respite services alone or combined with Specialized Respite cannot exceed $4,000 per year without Cabinet approval. Limits are based solely on the capitated yearly rate and not on the number of days, hours or sequence of service hours. Specialized Respite Service direct

	care staff must have twenty-four (24) hour access to an RN for consultation and emergency situations. Upper payment limit of: $4.00 per unit for Level I; $10.00 per unit for Level II
Duplication of Service Risk	**Waiver Service**: Yes Note: Respite cannot be billed concurrently with other services. **State Plan Service**: No **Other Service**: No
Requires Cabinet-Level Review	Yes
Service Indicators	Participant meets any of the items listed in the service definition and there is an emergent absence or illness of the primary caregiver Signs/evidence of family/caregiver burnout, including but not limited to caregiver lack of self-care and increased agitation between caregiver and participant.