

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Major Changes

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

No significant changes were made to Model II waiver. The following clarifications were made to offer easier interpretation of program policy and improved compliance. Specifically, the state made the following revisions:

- ? Updated performance measures for consistency and to promote standardization across waiver programs
- ? Clarified that the waiver does not cover services that could be provided under a state health plan, state-funded programs, other Medicaid programs, bundled services offered in inpatient or institutional settings, or special education services
- ? Clarified that the limit for all MIW services is 64 units (16 hours) per day to align the waiver with Kentucky Administrative Regulations
- ? Clarified that providers are required to provide training on HCBS settings requirements, Access Rule requirements, and person-centered planning requirements
- ? Included guidance to establish standards for continuity of care for waiver participants whose service provider was added to the abuse registry
- ? Confirmed CMS requirements to certify waiver program compliance with the HCBS Settings requirements
- ? Clarified that entities and/or individuals responsible for service plan development may not provide other direct waiver services to the participant in alignment with Kentucky Administrative Regulations.
- ? Confirmed CMS requirements for monitoring safeguards to reduce the risk of conflicts of interest for providers responsible for person-centered care planning activities
- ? Clarified that reconsideration and administrative requests may be postmarked or timestamped by fourteen (14) calendar days from the date of the written notice of adverse action
- ? Updated cost estimates and projects for future waiver years.

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

1. Request Information (1 of 3)

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

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

Model Waiver II

C. Type of Request: renewal

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

3 years 5 years

Original Base Waiver Number: KY.40146

Waiver Number: KY.40146.R08.00

Draft ID: KY.003.08.00

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

Model Waiver

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

10/01/25

Approved Effective Date: 10/01/25

PRA Disclosure Statement

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: July 31, 2027). The time required to complete this information collection is estimated to average 163 hours per response for a new waiver application and 78 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

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

Hospital

Select applicable level of care

Hospital as defined in 42 CFR § 440.10

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

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

Nursing Facility

Select applicable level of care

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

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

NF served in Hospital

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

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

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

1. Request Information (3 of 3)

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

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

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

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

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

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

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

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

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

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

A program operated under section 1932(a) of the Act.

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

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

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

A program authorized under section 1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

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

Goals

Waiver recipients:

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

Objectives

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

Organizational Structure

The Department for Medicaid Services (the Department) exercises administrative discretion in the operation of the waiver and in setting policies, rules, and regulations related to the waiver.

3. Components of the Waiver Request

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

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

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

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

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

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

Yes. This waiver provides participant direction opportunities. Appendix E is required.

No. This waiver does not provide participant direction opportunities. Appendix E is not required.

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

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

H. Quality Improvement Strategy. Appendix H contains the quality improvement strategy for this waiver.

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

federal financial participation.

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

4. Waiver(s) Requested

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

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

Not Applicable

No

Yes

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

No

Yes

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

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

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

5. Assurances

In accordance with 42 CFR § 441.302, the state provides the following assurances to CMS:

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

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

Appendix C.

- B. Financial Accountability.** The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR § 441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the

participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

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

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

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

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

F. FFP Limitation. In accordance with 42 CFR Part 433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. If a provider certifies that a particular legally liable third-party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

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

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

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

The Department for Medicaid Services (the Department) issued the HCB waiver renewal application for public comment from March 13, 2025, to April 13, 2025. To inform providers, participants, and community partners and collect feedback, the Department used the following methods:

1. **Email Updates:** The Department issued the full renewal waiver application, along with an educational summary document of proposed updates via email on March 13, 2025. The Department sent email reminders about the public comment period on April 3, 2025 and on April 10, 2023.
2. **Web and Social Media:** The draft waiver application and summary of updates were posted to the Department's Division of Long-Term Services and Supports website from March 13, 2025, through April 13, 2025. Notices about the start of the public comment period along with reminders were posted to the Department's social media channels.
3. **Dedicated Email Box:** The Department used a widely publicized email box to receive comments and questions from providers, participants, and community partners. The Department also offered options for submitted comments via phone or U.S. Mail.
4. **Advocacy Organizations:** Several well-known advocacy organizations shared the Department's notices and reminders to ensure as many stakeholders as possible had the opportunity to review and comment on the draft waiver application. The public comments and responses can be found on the Department's Division of Long-Term Services and Supports website at <https://www.chfs.ky.gov/agencies/dms/dca/Pages/default.aspx>.

Based on public comment, the Department made the following updates to the MIIW waiver application:

- ? Removed language from Appendix F-2-a. stating that administrative hearings cannot be requested via email.

A second public comment period was held from June 2 to July 1, 2025, to allow individuals a non-electronic option to review the waiver applications and submit public comment. Printed copies of the public comment notice, waiver applications, and summaries were posted in DCBS Family Support Offices across the state.

The public comments and responses from the non-electronic public comment period can be found at <https://www.chfs.ky.gov/agencies/dms/dca/Pages/default.aspx>.

No changes were made to the waiver application as a result of the second public comment period.

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

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

7. Contact Person(s)

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

Last Name:

Hancock

First Name:

Carmen

Title:

Director, Division of Long-Term Services and Supports

Agency:

Department for Medicaid Services, Cabinet for Health and Family Services

Address:

Address 2:

275 East Main Street

6W-B

City:

Frankfort

State:

Kentucky

Zip:

40621

Phone:

(502) 564-0762

Ext:

TTY

Fax:

(502) 564-0249

E-mail:

carmen.hancock@ky.gov

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

Kentucky

Zip:

Phone:

Ext:

TTY

Fax:

E-mail:

8. Authorizing Signature

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

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

Signature:

Carmen Hancock

State Medicaid Director or Designee

Submission Date:

Jul 18, 2025

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

Last Name:

Hancock

First Name:

Carmen

Title:

Division Director

Agency:

Department for Medicaid Services

Address:

275 E. Main St.

Address 2:

6W-B

City:

Frankfort

State:

Kentucky

Zip:

40601

Phone:

(502) 330-3280

Ext:

TTY

Fax:

(502) 564-0249

E-mail:

Attachments

carmen.hancock@ky.gov

Attachment #1: Transition Plan

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

Replacing an approved waiver with this waiver.

Combining waivers.

Splitting one waiver into two waivers.

Eliminating a service.

Adding or decreasing an individual cost limit pertaining to eligibility.

Adding or decreasing limits to a service or a set of services, as specified in Appendix C.

Reducing the unduplicated count of participants (Factor C).

Adding new, or decreasing, a limitation on the number of participants served at any point in time.

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

Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

Not applicable.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

The waiver is operated by the state Medicaid agency.

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

The Medical Assistance Unit.

Specify the unit name:

Division of Long-Term Services and Supports

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the state Medicaid agency. Thus this section does not need to be completed.

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

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the state. Thus, this section does not need to be completed.

Appendix A: Waiver Administration and Operation

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

Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

The Department contracts with Gainwell Technologies as a fiscal agent to pay claims through the Medicaid Management Information System (MMIS). The Department also has a Memorandum of Agreement (MOA) through the Department, with DCBS for review of financial eligibility for the waiver population. The Department contracts with Therap to deliver electronic visit verification (EVV) services.

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

Appendix A: Waiver Administration and Operation

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

Not applicable

Applicable - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

Local/Regional non-state public agencies perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the state and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

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

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

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

Appendix A: Waiver Administration and Operation

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

DMS - Division of Long-Term Services and Supports

Appendix A: Waiver Administration and Operation

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

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

Appendix A: Waiver Administration and Operation

- 7. Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR § 431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.* Note: Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care evaluation, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care evaluation tool. States should ensure that any use of an evaluation tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment		
Waiver enrollment managed against approved limits		
Waiver expenditures managed against approved levels		
Level of care waiver eligibility evaluation		
Review of Participant service plans		
Prior authorization of waiver services		
Utilization management		
Qualified provider enrollment		
Execution of Medicaid provider agreements		
Establishment of a statewide rate methodology		
Rules, policies, procedures and information development governing the waiver program		
Quality assurance and quality improvement activities		

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:

Percentage of contract requirements fulfilled by contracted entities as determined through contract monitoring N = Number of contract requirements fulfilled by contracted entities as determined through contract monitoring. D=Number of contract requirements for contracted entities.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Records in Medicaid Partner Portal System

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

Data Aggregation and Analysis:

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

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

Performance Measure:

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

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Medicaid Partner Portal System

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

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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 150px; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 150px; margin-top: 5px;"></div>

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

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

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

The Department provides written feedback and as needed meetings to address any problems and needed corrections.

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age					
				Maximum Age Limit			No Maximum Age Limit		
Aged or Disabled, or Both - General									
		Aged							
		Disabled (Physical)							
		Disabled (Other)							
Aged or Disabled, or Both - Specific Recognized Subgroups									
		Brain Injury							
		HIV/AIDS							
		Medically Fragile							
		Technology Dependent		0					
Intellectual Disability or Developmental Disability, or Both									

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
		Autism			
		Developmental Disability			
		Intellectual Disability			
Mental Illness					
		Mental Illness			
		Serious Emotional Disturbance			

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

Participants must meet the Nursing Facility Level of Care regulation as defined in the 907 KAR 1:022 and 907 KAR 1:595 and are ventilator dependent at least 12 or more hours a day and require 24-hour per day high intensity specialty nursing care or are on an active weaning program ordered by and under the management of a physician.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

Not applicable. There is no maximum age limit

The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.

Specify:

Appendix B: Participant Access and Eligibility

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

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

No Cost Limit. The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

Cost Limit in Excess of Institutional Costs. The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

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

A level higher than 100% of the institutional average.

Specify the percentage:

Other

Specify:

Institutional Cost Limit. Pursuant to 42 CFR § 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

Cost Limit Lower Than Institutional Costs. The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

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

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

The following dollar amount:

Specify dollar amount:

The dollar amount (select one)

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

Specify the formula:

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

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

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

can be assured within the cost limit:

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

- ☒ **The participant is referred to another waiver that can accommodate the individual's needs.**
- ☒ **Additional services in excess of the individual cost limit may be authorized.**

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

Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a	
Waiver Year	Unduplicated Number of Participants
Year 1	<div>100</div>
Year 2	<div>100</div>
Year 3	<div>100</div>
Year 4	<div>100</div>
Year 5	<div>100</div>

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

- ☒ **The state does not limit the number of participants that it serves at any point in time during a waiver year.**
- ☐ **The state limits the number of participants that it serves at any point in time during a waiver year.**

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	<input type="text"/>
Year 2	<input type="text"/>
Year 3	<input type="text"/>
Year 4	<input type="text"/>
Year 5	<input type="text"/>

Appendix B: Participant Access and Eligibility

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

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

Not applicable. The state does not reserve capacity.

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

Purpose(s) the state reserves capacity for:

Purposes	
Kentucky Transitions/Money Follows the Person	

Appendix B: Participant Access and Eligibility

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

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

Kentucky Transitions/Money Follows the Person

Purpose (*describe*):

DMS will reserve 10 slots for the purpose of allowing persons who are ventilator dependent and institutionalized to be reintegrated into the community and the person's home through the use of the Money Follows the Person grant.

Describe how the amount of reserved capacity was determined:

The amount of reserved capacity was determined using 10% of the slots for the Money Follows the Person grant. There are 100 slots available in the waiver of which less than 50 are currently used.

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

Waiver Year	Capacity Reserved
Year 1	10

Waiver Year	Capacity Reserved
Year 2	10
Year 3	10
Year 4	10
Year 5	10

Appendix B: Participant Access and Eligibility

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

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

The waiver is not subject to a phase-in or a phase-out schedule.

The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity.

Select one:

Waiver capacity is allocated/managed on a statewide basis.

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

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

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

The waiver provides for the entrance of all eligible participants until maximum capacity is reached.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

Section 1634 State

SSI Criteria State

209(b) State

2. Miller Trust State.

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

No

Yes

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

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

Parents and Other Caretaker Relatives (42 CFR § 435.110)

Pregnant Women (42 CFR § 435.116)

Infants and Children under Age 19 (42 CFR § 435.118)

SSI recipients

Aged, blind or disabled in 209(b) states who are eligible under 42 CFR § 435.121

Optional state supplement recipients

Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

100% of the Federal poverty level (FPL)

% of FPL, which is lower than 100% of FPL.

Specify percentage:

Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in section 1902(a)(10)(A)(ii)(XIII) of the Act)

Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in section 1902(a)(10)(A)(ii)(XV) of the Act)

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

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

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

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

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

Specify:

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

No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR § 435.217. Appendix B-5 is not submitted.

Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR § 435.217.

Select one and complete Appendix B-5.

All individuals in the special home and community-based waiver group under 42 CFR § 435.217

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

Check each that applies:

A special income level equal to:

Select one:

300% of the SSI Federal Benefit Rate (FBR)

A percentage of FBR, which is lower than 300% (42 CFR § 435.236)

Specify percentage:

A dollar amount which is lower than 300%.

Specify dollar amount:

Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR § 435.121)

Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR § 435.320, § 435.322 and § 435.324)

Medically needy without spend down in 209(b) States (42 CFR § 435.330)

Aged and disabled individuals who have income at:

Select one:

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR § 435.217 group effective at any point during this time period.

Spousal impoverishment rules under section 1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under section 1924 of the Act.

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or section 1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time period after September 30, 2027 (or other date as required by law).

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law) (select one).

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

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

Use spousal post-eligibility rules under section 1924 of the Act.

(Complete Item B-5-b (SSI State) and Item B-5-d)

Use regular post-eligibility rules under 42 CFR § 435.726 (Section 1634 State/SSI Criteria State) or under § 435.735 (209b State)

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Spousal impoverishment rules under section 1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

b. Regular Post-Eligibility Treatment of Income: Section 1634 State and SSI Criteria State after September 30, 2027 (or other date as required by law).

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

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

The following standard included under the state plan

Select one:

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

(select one):

300% of the SSI Federal Benefit Rate (FBR)

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

Specify the percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the state plan

Specify:

The following dollar amount

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

The following formula is used to determine the needs allowance:

Specify:

Other

Specify:

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

Not Applicable

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

Specify:

Specify the amount of the allowance (select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

iii. Allowance for the family (select one):

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

Other

Specify:

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

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

Select one:

Not Applicable (see instructions) *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

The state does not establish reasonable limits.

The state establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

- c. Regular Post-Eligibility Treatment of Income: 209(b) State or after September 30, 2027 (or other date as required by law).**

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules after September 30, 2027 (or other date as required by law)

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

i. Allowance for the personal needs of the waiver participant

(select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

A percentage of the Federal poverty level

Specify percentage:

The following dollar amount:

Specify dollar amount:

If this amount changes, this item will be revised

The following formula is used to determine the needs allowance:

Specify formula:

Other

Specify:

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

Select one:

Allowance is the same

Allowance is different.

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR § 435.726 or 42 CFR § 435.735:

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

Select one:

Not Applicable (see instructions) *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

The state does not establish reasonable limits.

The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

- e. Regular Post-Eligibility Treatment of Income: Section 1634 State or SSI Criteria State ? January 1, 2014 through September 30, 2027 (or other date as required by law).**

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

- f. Regular Post-Eligibility Treatment of Income: 209(b) State ? January 1, 2014 through September 30, 2027 (or other date as required by law).**

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

- g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules ? January 1, 2014 through September 30, 2027 (or other date as required by law).**

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

The provision of waiver services at least monthly

Monthly monitoring of the individual when services are furnished on a less than monthly basis

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

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

Directly by the Medicaid agency

By the operating agency specified in Appendix A

By an entity under contract with the Medicaid agency.

Specify the entity:

Other

Specify:

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

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

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

1. Has medical care needs which can be met in a community-based setting;
2. Meets nursing facility (NF) level of care requirements as defined in 907 KAR 1:022 and 907 KAR 1:595;
3. Be ventilator dependent for 12 hours or more daily or be on an active weaning program;
4. Has service needs which can be met through community-based services;
5. Meet the target group definitions described in section B-1-a

The Department will utilize clinical documentation and verification to determine level of care. The Department will also utilize the Department-approved functional assessment tool to support development of the Person-Centered Service Plan (PCSP) as defined in Appendix D of this waiver application. The MAP-351A assessment ensures that nursing facility level of care requirements are met. It includes information such as the individual's abilities to perform ADLs/IADLs, number of hours the ventilator is required, medical history, and other care needs such as medications, oxygen, etc.

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

The same instrument is used in determining the level of care for the waiver and for institutional care under the state plan.

A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.

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

The tool used for institutional care collects the data to support that an individual requires institutional care and meets the criteria outlined in the Nursing Facility Level of Care regulation. The MAP 351A collects the data to determine if an individual meets institutional level of care while also collecting the data to identify their needs and available supports in the community, their home and their environment. This allows for a determination of what support needs must be met for the individual to stay and be safely supported in their home and community. Additionally, applicants may be asked to submit other documents and/or medical records supporting the need for 1915(c) waiver services.

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

In order to be considered for 1915(c) waiver services, all applicants must apply using the Department-approved system and must submit clinical documentation and verification. In addition to stating the applicant would require institutionalization if they did not have 1915(c) waiver services, the documentation must include physician's order verifying ventilator usage for 12 hours or more per day. The applicant may also be required to submit other documents and/or medical records supporting the need for 1915(c) waiver services. Once the Department receives the application, it is evaluated using the following process:

- 1.The application is reviewed for the targeted waiver(s);
- 2.The application is reviewed for level of care;
- 3.Once it is determined the applicant meets level of care, the Department reserves capacity for the participant and notifies them to pick a service provider via a letter. The letter includes a number for the Department Waiver Help Desk, where the participant can receive assistance in picking a service provider if needed. If there is no open slot in the waiver, the participant is placed on a waiting list until a slot becomes available;
- 4.After the applicant's slot is reserved, the Department for Community Based Services (DCBS) reviews the applicant's case and determines if they meet financial eligibility requirements for 1915(c) waiver services. For applicants on a waiting list, this financial eligibility determination will not take place until they receive a slot in the waiver. If financial eligibility is denied, the slot is forfeited and the applicant may appeal their financial eligibility determination through DCBS; and
- 5.Once financial eligibility is met, the applicant undergoes a functional assessment conducted by the appropriate entity. The functional assessment determines the applicant's service needs, which is used to develop the person-centered service plan (PCSP)

DMS monitors progress from application to receipt of services. If the individual does not initiate services within one hundred twenty (120) days after waiver enrollment, DMS contacts the individual or their representative and the individual's chosen agency to follow up.

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

Every three months

Every six months

Every twelve months

Other schedule

Specify the other schedule:

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

The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.

The qualifications are different.

Specify the qualifications:

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

A task is sent to the functional assessor electronically through the Department-approved system sixty (60) calendar days prior to the re-evaluation due date. The task remains on the assessor's dashboard until the assessment is uploaded or the program is closed. DMS uses reports to monitor re-assessments that are due and their status. If the provider agency does not submit the re-evaluation in a timely manner it will not receive payment for services rendered.

- j. Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR § 441.303(c)(3), the state assures that written and/or

electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR § 92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

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

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

Number and Percent of applicants whose LOC review was conducted within 60 days of capacity reserved in the waiver. N = Number of applicants whose LOC review was conducted within 60 days of capacity reserved in the waiver. D = Number of applicants with capacity reserved in the waiver.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Medicaid Waiver Management Application reports

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:

Percent of waiver participants whose initial and subsequent LOC was appropriately determined according to the approved description. N = Number of waiver waiver participants whose initial and subsequent LOC was appropriately determined according to the approved description. D = Total number of LOC determinations

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Level of Care Documentation in Medicaid Waiver Management Application

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

Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

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

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

No

Yes

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

Appendix B: Participant Access and Eligibility**B-7: Freedom of Choice**

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

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

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

All waiver participants are informed of their choice of institutional care or waiver programs and available services by their RN Supervisor. This information is provided at the initial person-centered planning meeting and at least annually thereafter. An electronic copy of this signed form is retained in the Department-approved system.

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix C: Participant Services

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

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

Service Type	Service	
Other Service	Skilled services provided by a Licensed Practical Nurse	
Other Service	Skilled Services provided by a Registered Nurse	

Service Type	Service		
Other Service	Skilled services provided by a Respiratory Therapist		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Skilled services provided by a Licensed Practical Nurse

HCBS Taxonomy:

Category 1:

05 Nursing

Sub-Category 1:

05020 skilled nursing

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Skilled nursing services by an LPN are defined as the provision of medically necessary complex skilled nursing care in the home by an LPN. The purpose is to assess, monitor, and provide skilled nursing care as defined in KRS 314.011 in the home. Services must be skilled and non-custodial in nature. These services differ in nature, scope, supervision arrangements, or provider type from skilled nursing services in the state plan as Model II providers specialize in ventilator services where state plan services do not.

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

Reimbursement shall be based on a fixed fee for a unit of service provided. A unit of service is 15-minutes. This service is limited to 64 units per day, which is equivalent to 16 hours per day.

Skilled Services by an LPN must be approved by the Department or its designee prior to service delivery.

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

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Private Duty Nursing Agency
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Skilled services provided by a Licensed Practical Nurse

Provider Category:

Agency

Provider Type:

Private Duty Nursing Agency

Provider Qualifications

License (*specify*):

by Office of the Inspector General 902 KAR 20:370

Certificate (*specify*):

Certified by the Department or its designee

Other Standard (*specify*):

The agency must meet certified waiver provider qualifications as defined in 907 KAR 7:005 and 907 KAR 1:595. Agency staff who come into direct contact with waiver participants must meet the following qualifications:

- ? A licensed practical nurse (LPN) as defined in KRS 314.011(9).
- ? Completes Department-approved, waiver-specific training and is monitored for competency on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered thinking.
- ? Has the ability to:
 - o Communicate effectively with a participant in the participant's preferred manner of communication and with the participant's family;
 - o Read, understand, and implement written and oral instructions;
 - o Perform required documentation;
 - o Participate as a member of the participant's person-centered team if requested by the participant; and
 - o Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant's person-centered service plan (PCSP).
- ? Undergoes pre-employment screenings as described in C-2-a and b of this appendix.
- ? Is certified in CPR and First Aid.

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of the Inspector General
The Department or its designee

Frequency of Verification:

At least every 2 years or more frequently if necessary

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Skilled services provided by a Licensed Practical Nurse

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License (specify):

Office of the Inspector General as regulated by 902 KAR 20:081.

Certificate (specify):

Certified by the Department or its designee

Other Standard (specify):

The agency must meet certified waiver provider qualifications as defined in 907 KAR 7:005 and 907 KAR 1:595.

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

- ? A licensed practical nurse (LPN) as defined in KRS 314.011(9).
- ? Completes Department-approved, waiver-specific training and is monitored for competency on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered thinking.
- ? Has the ability to:
 - o Communicate effectively with a participant in the participant's preferred manner of communication and with the participant's family;
 - o Read, understand, and implement written and oral instructions;
 - o Perform required documentation;
 - o Participate as a member of the participant's person-centered team if requested by the participant; and
 - o Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant's person-centered service plan (PCSP).
- ? Undergoes pre-employment screenings as described in C-2-a and b of this appendix.
- ? Is certified in CPR and First Aid.

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of the Inspector General
The Department or its designee

Frequency of Verification:

At least every 2 years or more frequently if necessary

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Skilled Services provided by a Registered Nurse

HCBS Taxonomy:

Category 1:

05 Nursing

Sub-Category 1:

05020 skilled nursing

Category 2:

Sub-Category 2:

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Category 3:**Sub-Category 3:**

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Category 4:**Sub-Category 4:**

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

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Skilled nursing services by an RN are defined as the provision of medically necessary complex skilled nursing care in the home by an RN. The purpose is to assess, monitor and provide skilled nursing care as defined in KRS 314.011 in the home. Services must be skilled and non-custodial in nature. These services differ in nature, scope, supervision arrangements, or provider type from skilled nursing services in the state plan as Model II providers specialize in ventilator services where state plan services do not.

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

Reimbursement shall be based on a fixed fee for a unit of service provided. A unit of service is 15-minutes. This service is limited to 64 units per day, which is equivalent to 16 hours per day.
 Skilled Services by an RN must be approved by the Department or its designee prior to service delivery.
 These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency
Agency	Private Duty Nursing Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Skilled Services provided by a Registered Nurse

Provider Category:

Agency

Provider Type:

Home Health Agency

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

Office of the Inspector General as regulated by 902 KAR 20:081

Certificate (*specify*):

Certified by the Department or its designee

Other Standard (*specify*):

The agency must meet certified waiver provider qualifications as defined in 907 KAR 7:005 and 907 KAR 1:595.

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

- ? A registered nurse (RN) as defined in KRS 314.011(5).
- ? Completes Department-approved, waiver-specific training and is monitored for competency on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered thinking.
- ? Has the ability to:
 - o Communicate effectively with a participant in the participant's preferred manner of communication and with the participant's family;
 - o Read, understand, and implement written and oral instructions;
 - o Perform required documentation;
 - o Participate as a member of the participant's person-centered team if requested by the participant; and
 - o Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant's person-centered service plan (PCSP).
- ? Undergoes pre-employment screenings as described in C-2-a and b of this appendix.
- ? Is certified in CPR and First Aid.

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

Office of the Inspector General
The Department or its designee

Frequency of Verification:

At least every 2 years or more frequently if necessary

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type:** Other Service**Service Name:** Skilled Services provided by a Registered Nurse**Provider Category:**

Agency

Provider Type:

Private Duty Nursing Agency

Provider Qualifications

License (*specify*):

Office of Inspector General as regulated by 902 KAR 20:370

Certificate (*specify*):

Certified by the Department or its designee

Other Standard (*specify*):

The agency must meet certified waiver provider qualifications as defined in 907 KAR 7:005 and 907 KAR 1:595.

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

? A registered nurse (RN) as defined in KRS 314.011(5).

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

? Has the ability to:

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

o Read, understand, and implement written and oral instructions;

o Perform required documentation;

o Participate as a member of the participant's person-centered team if requested by the participant; and

o Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant's person-centered service plan (PCSP).

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

? Is certified in CPR and First Aid.

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of the Inspector General
The Department or its designee

Frequency of Verification:

At least every 2 years or more frequently if necessary

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Skilled services provided by a Respiratory Therapist

HCBS Taxonomy:

Category 1:

05 Nursing

Sub-Category 1:

05020 skilled nursing

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Skilled services by an RT are those that specialize in the promotion of optimal pulmonary function and health. This includes assessment of the participant's respiratory function, a diagnostic evaluation, monitoring and rehabilitation of the participant's pulmonary disorder. It involves the use and management of therapeutic medical gases and their apparatus and ventilator support. Services are provided by a licensed RT.

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

Reimbursement shall be based on a fixed fee for a unit of service provided. A unit of service is 15-minutes. This service is limited to 64 units per day, which is equivalent to 16 hours per day. These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Private Duty Nursing Agency

Provider Category	Provider Type Title
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Skilled services provided by a Respiratory Therapist

Provider Category:

Agency

Provider Type:

Private Duty Nursing Agency

Provider Qualifications

License (*specify*):

Office of Inspector General as regulated by 902 KAR 20:370

Certificate (*specify*):

Certified by the Department or its designee

Other Standard (*specify*):

The agency must meet certified waiver provider qualifications as defined in 907 KAR 7:005 and 907 KAR 1:595.

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

? A respiratory therapist as defined in KRS 314A.010(3)(a).

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

? Has the ability to:

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

o Read, understand, and implement written and oral instructions;

o Perform required documentation;

o Participate as a member of the participant's person-centered team if requested by the participant; and

o Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant's person-centered service plan (PCSP).

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

? Is certified in CPR and First Aid.

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of the Inspector General

The Department or its designee

Frequency of Verification:

At least every 2 years or more frequently if necessary

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Skilled services provided by a Respiratory Therapist

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License (*specify*):

Office of the Inspector General as regulated by 902 KAR 20:081

Certificate (*specify*):

Certified by the Department or its designee

Other Standard (*specify*):

The agency must meet certified waiver provider qualifications as defined in 907 KAR 7:005 and 907 KAR 1:595.

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

? A respiratory therapist as defined in KRS 314A.010(3)(a).

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

? Has the ability to:

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

o Read, understand, and implement written and oral instructions;

o Perform required documentation;

o Participate as a member of the participant's person-centered team if requested by the participant; and

o Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant's person-centered service plan (PCSP).

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

? Is certified in CPR and First Aid.

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of the Inspector General

The Department or its designee

Frequency of Verification:

At least every 2 years or more frequently if necessary

Appendix C: Participant Services

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

Not applicable - Case management is not furnished as a distinct activity to waiver participants.

Applicable - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

As a waiver service defined in Appendix C-3. *Do not complete item C-1-c.*

As a Medicaid state plan service under section 1915(i) of the Act (HCBS as a State Plan Option). *Complete item C-1-c.*

As a Medicaid state plan service under section 1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c.*

As an administrative activity. *Complete item C-1-c.*

As a primary care case management system service under a concurrent managed care authority. *Complete item C-1-c.*

As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management). *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants and the requirements for their training on the HCBS settings regulation and person-centered planning requirements:

Case management is provided by the same provider agency that supplies services, however, the individual who fulfills the case management responsibilities is not the same individual who provides direct care to the participant. The provider agency will be required to provide training on HCBS settings requirements, HCBS access rule requirements, and person-centered care planning requirements.

d. Remote/Telehealth Delivery of Waiver Services. Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.

Service
Skilled services provided by a Licensed Practical Nurse
Skilled Services provided by a Registered Nurse
Skilled services provided by a Respiratory Therapist

1. Will any in-person visits be required?

Yes.

No.

2. *By checking each box below, the state assures that it will address the following when delivering the service remotely/via telehealth.*

The remote service will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc. *Explain:*

--

How the telehealth service delivery will facilitate community integration. *Explain:*

How the telehealth will ensure the successful delivery of services for individuals who need hands on assistance/physical assistance, including whether the service can be rendered without someone who is physically present or is separated from the individual. *Explain:*

How the state will support individuals who need assistance with using the technology required for telehealth delivery of the service. *Explain:*

How the telehealth will ensure the health and safety of an individual. *Explain:*

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

No. Criminal history and/or background investigations are not required.

Yes. Criminal history and/or background investigations are required.

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

A. All providers or provider agency employees with contact with participants are required to undergo a background investigation at hiring and repeated as appropriate.

B. Kentucky offers employers two (2) options for conducting pre-employment background investigations.

i. The Kentucky Applicant Registry and Employment Screening (KARES) system: KARES is an electronic interface and nationwide background investigation and registry system. KARES enables automatic abuse registry checks, including continuous assessment (i.e., ongoing registry checks after employment date), as well as fingerprint-based background checks through Kentucky State Police (KSP) and the Federal Bureau of Investigation (FBI).

ii. If KARES is not used, pre-employment background investigations must be conducted using all four (4) of the following:

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

If a potential employee has resided or worked out of state within the last twelve (12) calendar months the other state's equivalency of all checks must be completed and results provided for that timeframe

C. All agency employees who have contact with participants, are also required to pass a six-panel drug screening prior to employment.

D. Provider agencies are responsible for conducting pre-employment background screenings on agency employees. The following disqualifies an agency employee from providing services:

1. A prior conviction for an offense as described in KRS 17.165(1) through (3);
2. A prior felony conviction or diversion program that has not been completed;
3. A drug conviction, felony plea bargain, or amended plea bargain within the past five (5) years;
4. Employees with a drug related conviction or an amended plea bargain within the past five (5) years must prove completion of all court ordered treatment and/or diversion programs. The employing provider agency must conduct a random, six-panel drug screening within the following frequency depending on the timeframe since conviction:
 - a. Every ninety (90) days for employees who are three (3) years or less removed from his/her conviction,
 - b. Every 180 days for employees three (3) to five (5) years removed from his/her conviction, and
 Random drug screenings are not required for employees who are over five (5) years removed from his/her conviction
5. Failing to pass a six-panel drug test;
6. Has a conviction for abuse, neglect, or exploitation (ANE) as defined in Appendix G;
7. Has substantiated finding of abuse, neglect or exploitation through adult protective services (APS) or child protective services (CPS);
8. Prior substantiated case of Medicaid fraud by the Office of Medicaid Fraud and Abuse Control, the Office of the Inspector General (OIG) or Office of the Attorney General(OAG); or
9. Employees who have a driving under the influence conviction, amended plea bargain, or diversion in the past year shall not transport participants

All employees must also undergo a risk assessment for tuberculosis per Department of Public Health guidelines found in 902 KAR 20:205

During a provider's initial certification and at each subsequent certification, the Department reviews employee's files to ensure background checks were completed timely and accurately.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

No. The state does not conduct abuse registry screening.

Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; (c) the process for ensuring that mandatory screenings have been conducted; and (d) the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

All employees of traditional service providers with contact with the participant must submit to a screening using KARES or a combination of other State registries at the time of hire.

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

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

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

For licensed providers who conduct screenings using the AOC, CAN, and Caregiver Misconduct Registry, the agency must also check, at random, twenty-five (25) percent of existing employees using the registries each year. Existing employees are those who have been employed by the agency for one (1) year or more. The Department reviews the findings of this check upon recertification of the provider and at provider billing reviews.

If the provider agency receives a new alert or identifies a waiver services provider on the abuse registry during the annual review process the agency will:

1. Terminate the employee, effective immediately
2. Initiate a backup plan to implement a temporary service provider for the participant immediately, which will enable continuity of care for the participant
3. Notify the Department with the name of the direct care/service provider, date of the infraction identified, and the name(s) of any waiver participants who had contact with the provider on or after the infraction date within 72 hours of discovery;
4. Notify the participant that the direct care service professional is no longer eligible to provide care and work with the participant to assign a new service provider; the name and contact details of the assigned temporary service provider; details regarding any updates to waiver service delivery dates or times; and
5. Participants will be contacted to select a new provider in accordance with the Department process for replacing an HCBS service provider that is no longer available; and
6. Update the individual's PCSP as needed within 30 days.

Appendix C: Participant Services

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

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

Appendix C: Participant Services

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

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law or regulations to care for another person (e.g., the parent (biological or

adoptive) of a minor child or the guardian of a minor child who must provide care to the child). At the option of the state and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. *Select one:*

No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.

Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.

Specify: (a) the types of legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar services provided by a legally responsible individual is "*extraordinary care*", exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; (c) the state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and, (g) the procedures that are used to implement required state oversight, such as ensuring that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

- e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

The state does not make payment to relatives/legal guardians for furnishing waiver services.

The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

Specify the types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted judgement on behalf of the individual. Specify the procedures that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.

Specify the controls that are employed to ensure that payments are made only for services rendered.

Other policy.

Specify:

- f. Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR § 431.51:

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

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

- g. State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act.** Specify whether the state chooses the option to provide waiver HCBS in acute care hospitals. *Select one:*

No, the state does not choose the option to provide HCBS in acute care hospitals.

Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions. *By checking the boxes below, the state assures:*

The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;

The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;

The HCBS must be identified in the individual's person-centered service plan; and

The HCBS will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.

And specify: (a) The 1915(c) HCBS in this waiver that can be provided by the 1915(c) HCBS provider that are not duplicative of services available in the acute care hospital setting; (b) How the 1915(c) HCBS will assist the individual in returning to the community; and (c) Whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization. If yes, please specify the rate methodology in Appendix I-2-a.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

Percent of existing providers who continue to meet certification and licensure requirements and adhere to other standards following initial enrollment. N=Number of existing providers who continue to meet certification and licensure requirements and adhere to other standards following initial enrollment. D=Number of existing providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:

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

Data Source (Select one):**Other**

If 'Other' is selected, specify:

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

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

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

b. Sub-Assurance: The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

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

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

Performance Measure:

The State does not contract with non-licensed or non-certified providers, therefore this measure is not applicable.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Not applicable

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

Other Specify: <input type="text" value="Not applicable"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text" value="not applicable"/>
	Other Specify: <input type="text" value="Not applicable"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text" value="Not applicable"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text" value="Not applicable"/>

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

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

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

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

Performance Measure:

Percent of providers in which 90% of staff have successfully completed mandatory training in accordance with state requirements and the approved waiver. N = Number of providers in which 90% of staff have successfully completed mandatory training in accordance with state requirements and the approved waiver. D = Total number of providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Desk review or onsite review of employee records

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

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

The State currently verifies that 100% of all waiver providers are certified and/or licensed prior to rendering services. Providers who have completed the OIG process to receive a license are eligible to become a Medicaid provider. The States OIG monitors and re-licenses them on a three (3) year basis. If a provider's license is revoked, the Department or its designee is notified by the OIG. The Department or its designee certifies licensed and non-licensed providers. The State does not contract with non-licensed or non-certified providers. The State implements its policies and procedures and provides for training as needed related to policy changes through letters, the Department website or by attending the various associations of each of the provider entities.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

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

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

- a. Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

Not applicable- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Applicable - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

Limit(s) on Set(s) of Services. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.

Furnish the information specified above.

Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.

Furnish the information specified above.

Budget Limits by Level of Support. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.

Furnish the information specified above.

Other Type of Limit. The state employs another type of limit.

Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 §§ CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings in which 1915(c) HCBS are received. *(Specify and describe the types of settings in which waiver services are received.)*

Services are provided in the participant's home.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and in the future as part of ongoing monitoring. *(Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which waiver HCBS are received.)*

Providers are monitored for compliance with federal Final Rule as part of the certification and monitoring process. Providers are monitored every two (2) years or more frequently if necessary. As part of the certification and recertification, providers are asked specific questions regarding federal Final Rule.

3. By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:

The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in

the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board. *(see Appendix D-1-d-ii)*

Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

Facilitates individual choice regarding services and supports, and who provides them.

Home and community-based settings do not include a nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.

Provider-owned or controlled residential settings. *(Specify whether the waiver includes provider-owned or controlled settings.)*

No, the waiver does not include provider-owned or controlled settings.

Yes, the waiver includes provider-owned or controlled settings. (By checking each box below, the state assures that each setting, *in addition to meeting the above requirements*, will meet the following additional conditions):

The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

Each individual has privacy in their sleeping or living unit:

Units have entrance doors lockable by the individual.

Only appropriate staff have keys to unit entrance doors.

Individuals sharing units have a choice of roommates in that setting.

Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

Individuals have the freedom and support to control their own schedules and activities.

Individuals have access to food at any time.

Individuals are able to have visitors of their choosing at any time.

The setting is physically accessible to the individual.

Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan *(see Appendix D-1-d-ii of this waiver application)*.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Person-Centered Service Plan (PCSP)

- a. Responsibility for Service Plan Development.** Per 42 CFR § 441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals. Given the importance of the role of the person-centered service plan in HCBS provision, the qualifications should include the training or competency requirements for the HCBS settings criteria and person-centered service plan development. *(Select each that applies):*

Registered nurse, licensed to practice in the state

Licensed practical or vocational nurse, acting within the scope of practice under state law

Licensed physician (M.D. or D.O)**Case Manager** (qualifications specified in Appendix C-1/C-3)**Case Manager** (qualifications not specified in Appendix C-1/C-3).*Specify qualifications:***Social Worker***Specify qualifications:***Other***Specify the individuals and their qualifications:***Appendix D: Participant-Centered Planning and Service Delivery****D-1: Service Plan Development (2 of 8)**

- b. Service Plan Development Safeguards.** Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant. Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in service plan development. *By checking each box, the state attests to having a process in place to ensure:*

Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;

An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;

Direct oversight of the process or periodic evaluation by a state agency;

Restriction of the entity that develops the person-centered service plan from providing services without the

direct approval of the state; and

Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

- c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The State regulations include the participant's freedom of choice of service providers as well, as participation in the development of the PCSP. Participants may select family members and/or other significant others to participate in the development of the PCSP. The participant or legal guardian shall sign the PCSP indicating their participation in the development. The provider is required to ensure the participant has been informed of their rights to choose provider agencies. Each provider is aware of their licensure requirements and the Department requirements to include and involve the participant and their family/caregiver in the care planning process. This is applied by each provider and reviewed and discussed with the providers and also the participants during on-site surveys. In addition, the Department website provides current and helpful information regarding the Model II waiver program and its services, processes, benefits, etc. to participants, providers, other consumers, the public, etc. and Department staff provides information and assistance as requested of participants and providers.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

- d. i. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; (g) how and when the plan is updated, including when the participant's needs changed; (h) how the participant engages in and/or directs the planning process; and (i) how the state documents consent of the person-centered service plan from the waiver participant or their legal representative. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The enrollment notice sent to the participant advises the participant and the participant's legal guardian and/or authorized representative, if applicable, that they must select an enrolled MIIW provider to complete their functional assessment and begin the person-centered service planning process. Once the provider is selected, they must associate themselves in the Department-approved system and complete the assessment and begin the person-centered planning process.

The functional assessor must contact the individual to schedule the functional assessment. The assessment must be completed and uploaded in the Department-approved system.

The functional assessor is responsible to verbally advise the participant and the participant's legal guardian and/or authorized representative, if applicable, or informal supports who attend the assessment, of next steps to initiate services, expressly advising them of the need to schedule their person-centered service planning meeting with their provider.

After completion and upload of the functional assessment, an RN supervisor with the participant's chosen provider agency who will not provide direct care to the participant must conduct an initial home visit and begin the Person-Centered Services Plan (PCSP).

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

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

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

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

Once the person-centered planning team is confirmed, the RN Supervisor completes the primary activities:

- a. The team collectively reviews the findings of the participant's functional assessment. This process includes documenting any non-Medicaid paid or unpaid supports including information on the access and limitations of said supports, and Medicaid State Plan services. For annual review meetings, the team should also review the participant's current PCSP;
- b. The team works collectively under the leadership of the participant and the participant's legal guardian or authorized representative, if applicable, to complete an additional review of the participant's person-centered planning needs and wishes to establish goals and objectives that enhance health, safety, and welfare, community-based independence, community participation, and quality of life. Not all goals and objectives must be accomplished using 1915(c) waiver funded services;
- c. The process of setting goals should include education and team support for the participant and the participant's legal guardian or the participant's authorized representative, if applicable. Goals and objectives must be:
 - ? Stated Clearly: The goal or objective should be understandable to the participant and in his/her own words,
 - ? Measurable: There should be markers of progress toward achieving a goal or objective that can be identified and quantified,
 - ? Attainable: The goal or objective should be broken into small and actionable steps. Barriers to achieving the goal or objective should be identified and a plan put in place to help mitigate those barriers,
 - ? Relevant: The goal or objective should be important to the participant. Steps toward the goal or objective should

help the participant develop and use available resources to achieve it, and

? Time-Bound: There should be a defined period for when the participant is expected to achieve the goal or objective, keeping in mind that reaching the goal or objective can take time and several steps. There should also be an agreed upon schedule in place for checking progress

d. The RN Supervisor will provide detailed information to participants about available non-waiver services that may assist in reaching their goals and objectives; and

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

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

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

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

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

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

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

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

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

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

Once the assessment is complete and the participant chooses a service provider, the participant and the participant's legal guardian and/or authorized representative, if applicable, begins the process of developing the PCSP with the RN Supervisor's assistance. Upon acceptance of a new participant, the RN Supervisor must conduct an initial home visit to begin the person-centered planning process.

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

B. Redetermination of the Person-Centered Service Plan every 6 months

A participant's PCSP is redetermined every 6 months. Prior to the reviewing and modifying the PCSP, the following activities must occur:

- a. The RN Supervisor is to attend and must review the annual functional assessment, which is housed in the Department-approved system.
- b. The functional assessor is not to use information provided by an RN Supervisor that directly conflicts with assessment feedback provided by the participant.

The person-centered service planning can begin forty-five (45) calendar days prior to the end of the current LOC period. The PCSP must be completed and uploaded to the Department-approved system seven (7) calendar days prior to the end of the current LOC period. The LOC period is defined as the period spanning 182 calendar days from the date a participant is allocated a waiver spot in the Department-approved system. Person-centered service planning and development of the PCSP should follow the steps described under "Process for Developing a Person-Centered Service Plan" in this section.

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

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

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

- a. Inpatient admission to an institutional care setting with changes at discharge in functional ability from previous assessment including:
 - i. Decreased functional ability in one or more activities of daily living, and/or
 - ii. Decreased functional ability in three or more instrumental activities of daily living.
- b. A change in care setting that increases the participant's level of care, including transitions between community-based settings such as moving from a participant's own home to a residential setting;
- c. Long-term change in access to or ability of an unpaid caregiver(s); and/or
- d. Observed or reported changes that result in the inability of the participant to meet goals and objectives based on the current PCSP, and/or do not provide a level of service sufficient to address health, safety, or welfare concerns.

3. The RN Supervisor is responsible to initiate the event-based assessment in the Department-approved system.

4. The RN Supervisor will be responsible to review the updated assessment and share information about the assessment outcomes with the participant and the participant's legal guardian or authorized representative, if applicable. The RN Supervisor will work with the participant, and any members of the participant's person-centered team as requested by the participant, to modify the PCSP to address any requested or necessary modifications.

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

ii. HCBS Settings Requirements for the Service Plan. *By checking these boxes, the state assures that the following will be*

included in the service plan:

The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.

For provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:

A specific and individualized assessed need for the modification.

Positive interventions and supports used prior to any modifications to the person-centered service plan.

Less intrusive methods of meeting the need that have been tried but did not work.

A clear description of the condition that is directly proportionate to the specific assessed need.

Regular collection and review of data to measure the ongoing effectiveness of the modification.

Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

Informed consent of the individual.

An assurance that interventions and supports will cause no harm to the individual.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

- e. Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

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

1. Medical diagnoses that may require emergency intervention,
2. Behaviors that could harm the participant's health, safety, and welfare or harm the health, safety, and welfare of others, and
3. Any other identified or observable risks that could adversely affect the environment, health, safety, and welfare of the participant or pose a risk of harm to service providers.

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

Back-up arrangements vary between individuals and their specialized needs. The agency discusses possibilities with the family to develop this plan. This could include natural supports/support network, state plan provider's wrap around services, physician's office assistance, etc. The arrangement is then entered into the Department-approved system. This is a requirement as the person-centered service plan cannot be submitted until this arrangement is entered into the system. The arrangements are reviewed both during the certification/re-certification review and during quality review random samplings between the review periods to ensure regulatory compliance.

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

- f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The participant's RN Supervisor who works for the participant's chosen provider agency but will not provide direct care to the participant is required to provide information about available services including, but not limited to:

?Medicaid State Plan funded services, non-Medicaid paid or unpaid supports that may support the participant's home and community-based needs,

?Traditional options,

?Services available on their 1915(c) waiver and how they can assist the participant to advance goals as specified in the PCSP,

?Available service providers in the area, and/or

?Understanding of freedom of choice.

The service provider is responsible for assisting the participant and the participant's legal guardian or authorized representative, if applicable, in choosing his or her providers of services specified in the PCSP. This assistance may include telephonic or on-site visits with participants and their families, assisting them in accessing the provider listing, answering questions about providers, and informing them or demonstrating use of the Partner Portal system and information housed within. Service providers are trained by the Department to respond to participant inquiries regarding choice of provider in a manner that avoids conflict of interest and/or conveys personal, subjective opinion.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR § 441.301(b)(1)(i):

Upon completion of the PCSP, it is the responsibility of the service provider to submit the PCSP through the Department-approved system for review and service authorization. A service authorization shall not be issued without appropriate review and approval.

Once the complete PCSP is submitted, it will undergo system checks and, if indicated, it will be reviewed by the Department. If the PCSP is approved, the participant will receive a letter in the mail. A copy of the notification is also available in the Department-approved system. If the determination results in an adverse decision, the participant will receive an adverse decision notice, which informs of what was denied, why it was denied, and their right to an informal reconsideration and a fair hearing, via certified mail. The service provider is responsible for notifying providers of approval or denial of the completed PCSP.

The Department reviews PCSPs during the certification/re-certification review period, completes surveys with all participants/families to ensure all regulatory compliance is met, and completes random sampling quality review checks between the review period.

DMS reviews of 100% of MIIW providers annually and 100% of the MIIW recipients are reviewed during those surveys. Comprehensive monitoring tools are utilized to conduct each survey. The monitoring tools include a review of all areas of the MIIW program and service benefits and requirements. Any areas of non-compliance that may be identified are reported to the provider and a Corrective Action Plan is requested from the provider by DMS. Corrective Action Plans, when applicable, are reviewed approved/denied as appropriate and follow-up reviews are conducted on-site with the providers to ensure the effectiveness of corrective actions when they were necessary.

Appendix D: Participant-Centered Planning and Service Delivery

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

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update, when the individual's circumstances or needs change significantly, or at the request of the individual, to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

Every three months or more frequently when necessary

Every six months or more frequently when necessary

Every twelve months or more frequently when necessary

Other schedule

Specify the other schedule:

- i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR § 92.42. Service plans are maintained by the following (*check each that applies*):

Medicaid agency

Operating agency

Case manager

Other

Specify:

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

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

- a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan, participant health and welfare, and adherence to the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5); (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The participant's RN Supervisor who is with the participant's chosen agency but does not provide direct care to the participant is responsible for the coordination and monitoring of all the participant's waiver services included in the PCSP and will assist in identifying and connecting the participant with non-waiver services.

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

?Progress toward PCSP goals, including any changes in goals or objectives,

?Satisfaction with services delivered via the PCSP,

?Confirming any new needs and addressing whether PCSP modification may be necessary,

?Review of utilization and cost of utilization,

?Any concerns with health, safety, and welfare, and/or risk mitigation needs, and/or

?Review of access to any additional community-based supports, including non-Medicaid funded services, to address where additional assistance or linkage may be needed

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

All contact and monitoring activities, observations, and outcomes must be documented via monthly case notes housed in the Department-approved system.

- b. Monitoring Safeguard.** Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for monitoring the implementation of the service plan except, at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

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

Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation. *(Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation).*

Due to the providers' licensure requirements with the Office of the Inspector General, Model II providers are limited to one individual outside of their Certificate of Need (CoN) area. This, and the waiver's certification requirements, limits the number of providers in an area. However, participants are free to choose a different entity to conduct and complete their initial and 6-month level of care assessment. The state requires person-centered service plan development and monitoring functions be administratively separate from service provision. Compliance with this requirement is monitored by the state during certification/recertification reviews or at any time a participant or their representative expresses a concern and during random sampling quality review checks.

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. *By checking each box, the state attests to having a process in place to ensure:*

Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;

An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;

Direct oversight of the process or periodic evaluation by a state agency;

Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and

Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

- a. Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.**

Performance Measures

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

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

Performance Measure:

Percent of service plans that address the participant's personal goals either by provision of waiver services or through other means. N = Number of service plans that address the participant's personal goals either by provision of waiver services or through other means. D = Number of approved service plans.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

Performance Measure:

Percent of service plans that address the participant's assessed needs including health and safety risk factors. N = Number of service plans that address the participant's assessed needs including health and safety risk factors. D = Number of approved service plans.

Data Source (Select one):**Record reviews, off-site**

If 'Other' is selected, specify:

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

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

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

Data Aggregation and Analysis:

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

- b. Sub-assurance:** *Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual.*

Performance Measures

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

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

- c. Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.**

Performance Measures

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

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

Performance Measure:

Percent of participants with a plan revision/update within 6 months of the previous plan. N = Number of participants with a plan revision/update within 6 months of the previously approved plan. D = Waiver participants enrolled for at least 6 months.

Data Source (Select one):

Other

If 'Other' is selected, specify:

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

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
Other	Annually	Stratified

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

Data Aggregation and Analysis:

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

Performance Measure:

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

Data Source (Select one):**Record reviews, off-site**

If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

d. Sub-assurance: Participants are afforded choice between/among waiver services and providers.

Performance Measures

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

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

Performance Measure:

Percent of records that demonstrate correct type, amt, scope and freq of services were provided according to the duration specified in the PCSP. N= number of records that demonstrate that correct type, amt, scope and freq of services for the specified duration were provided according to the PCSP. D=Number of records.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Review of person centered service plans and other documentation in the Medicaid Waiver Management Application and claims data from the MMIS

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

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

Data Aggregation and Analysis:

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

- e. *Sub-assurance: The state monitors service plan development in accordance with its policies and procedures.*

Performance Measures

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

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

Performance Measure:

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

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Medicaid Waiver Management Application acknowledgement page

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

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

Data Aggregation and Analysis:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

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

Identified individual problems are researched and addressed by the Department or its designee. If issues are noted, the Department will follow the policies and procedures as noted in 907 KAR 7:005 and 907 KAR 1:595.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability (from Application Section 3, Components of the Waiver Request):

Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.

No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied,

suspended, reduced or terminated. The state provides notice of action as required in 42 CFR ?431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Participants are first informed of their right to an administrative hearing, the reconsideration, and the grievance processes during the initial face-to-face visit through distribution of the waiver welcome packet. Verification that the participant has been informed of their rights to an administrative hearing is obtained by signature of the participant on the Department-approved form. A participant may request assistance to submit a request for an administrative hearing. If the participant does not have a service provider, or would prefer assistance from another party, the following entities may assist participants with filing an administrative hearing request:

1. Office of the Ombudsman,
2. Kentucky Protection and Advocacy,
3. Office of Legal Support, or
4. By calling the Medicaid Waiver Help Desk

Materials provided to the participant include the participant's rights and process to request an administrative hearing in the event of one (1) of the following adverse actions:

- a. Not providing a participant the choice of home and community-based services as an alternative to institutional care,
- b. Denying a participant the service(s) of their choice, service delivery option of their choice, or the provider(s) of their choice, or
- c. Actions to deny, suspend, reduce, or terminate services

All administrative hearings are handled by the Hearing and Appeals Branch of the Cabinet for Health and Family Services (the Cabinet).

Participants who are denied level of care, suspension, reduction, or termination of services are issued written notification of appeal rights at the time of adverse action. These rights are contained as a part of the adverse action notices issued by the Department or its designee. When this function is conducted by a designee, the Department or its designee will develop all templates and perform oversight activities to ensure timeliness and that the adverse action notice includes the following:

- ? Appropriate denial or change information,
- ? Administrative hearing rights,
- ? Instructions for reconsideration or administrative hearing, and
- ? Contact information to request assistance with a request for appeal

All administrative hearing rights are outlined in 907 KAR 1:563 which requires written notification of appeal rights to the participant and stipulates that participants must request, in writing, an administrative hearing within thirty (30) calendar days of the date of the notification. Services will continue as previously indicated in the person-centered service plan (PCSP) prior to the adverse action if the request for an administrative hearing is made within ten (10) calendar days. The notices are generated electronically at the time of an adverse action, delivered, via certified mail, to the participant and the participant's legal guardian or authorized representative, if applicable, delivered electronically to the RN Supervisor, and recorded electronically in the Department-approved system.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

- a. **Availability of Additional Dispute Resolution Process.** Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

No. This Appendix does not apply

Yes. The state operates an additional dispute resolution process

- **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

A reconsideration is an optional process that provides the participant an opportunity to resolve the adverse action outside of the administrative hearing process while still retaining the option to pursue an administrative hearing in the future. The reconsideration is also the most efficient and quickest way to resolve an adverse action.

The participant may request an administrative hearing immediately following an adverse action notice or after they have pursued the reconsideration process. Furthermore, the reconsideration process is not a pre-requisite for an administrative hearing. Participants are first informed of the reconsideration process during the initial functional assessment, at the same time they are informed of the administrative hearing, and complaint and grievance process. Additionally, participants are informed of those processes annually upon re-assessment and in any adverse action notice.

The Department provides for a reconsideration process. This process is operated by the Department or its designee. This reconsideration process is summarized in the following steps:

1. The provider, participant, or the participant's legal guardian/authorized representative acting on the participant's behalf can request a reconsideration.
 - a. A reconsideration request must be made in writing and can be submitted to the Department via U.S. Mail or by email. Participants with a disability that prevents them from submitting a request in writing can call the Department Division of Long-Term Services and Supports for assistance; and
 - b. Reconsideration requests postmarked or dated and timestamped more than fourteen (14) calendar days from the date of the written notice of adverse action are considered invalid

The individual making the request will receive an out of timeframe letter notifying them that the request was not made in the proper timeframe

If a reconsideration request is made after the fourteen (14) calendar day timeframe ends, the provider, participant, or the participant's legal guardian/authorized representative acting on the participant's behalf can still request an administrative hearing.

The out of timeframe letter will explain the right to an administrative hearing and the process for requesting one as described in Appendix F-1; and

A request for an administrative hearing must be made in writing and postmarked or dated and timestamped within thirty (30) calendar days of the initial written notice of adverse action.

2. The Department or its designee will conduct the reconsideration, render a determination, and send a letter to the provider, participant and participant's legal guardian or authorized representative, if applicable, within the timeframe set forth in 907 KAR 1:595. If the adverse action is upheld, the letter will be sent via certified mail. If the adverse action is overturned, the letter will be postmarked within the timeframe referenced in 907 KAR 1:563.

3. If the reconsideration determination upholds or modifies the original decision resulting in an adverse action, the participant, the participant's legal guardian or the participant's authorized representative may request an administrative hearing. Information on how to request an administrative hearing is included in the reconsideration determination letter. The participant has thirty (30) calendar days from the reconsideration determination to request an administrative hearing. The request must be received or postmarked within thirty (30) calendar days of the reconsideration determination letter. If the request is received or postmarked within ten (10) calendar days, previously approved services of the reconsideration determination letter, services will continue until receipt of the final order. Administrative Hearings are handled by the Hearing and Appeals Branch of the Cabinet as described in section F-1.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

No. This Appendix does not apply

Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

- **Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:

Participants have the opportunity to register grievances and complaints concerning the provision of services by waiver providers.

The grievances and complaints system shall be operated by the Department for Medicaid Services (the Department).

Filing a grievance or complaint is not a pre-requisite or substitution for a reconsideration or administrative hearing.

- **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Waiver participants may register any grievance or complaint regarding waiver service provision or RN Supervisors by contacting the Department via the Medicaid Waiver Help Desk, via email, or via mail. A complaint or grievance can be submitted at any time. Participants are informed that filing a grievance or complaint is not a pre-requisite or substitution for a fair hearing. Complaints and grievances are documented in a central database administered by the Department. All complaints and grievances are tracked and trended by the Department to identify if additional provider trainings and participant education opportunities should be developed and conducted.

A complaint is an expression of dissatisfaction from the participant regarding some aspect of their 1915(c) waiver service delivery or experience that does not require follow up as determined by the categorization process described below.

A grievance is an expression of dissatisfaction from the participant due, in part or in full, to the failure of the Department, or a provider to adhere to established operating procedures, regulations, and waiver requirements. Grievances may require the Department follow up and resolve as determined by the categorization process described below.

Upon receiving a complaint or grievance, the Department will immediately assess and categorize the gravity of the grievance or complaint and determine if an immediate response, timely response or acknowledgement of the grievance or complaint is required.

1. An immediate response is necessary if a participant's health, safety, or welfare are jeopardized. Grievances will be addressed and the appropriate parties notified immediately of learning of the event. The Department will contact the participant via his/her preferred method of communication once the grievance is resolved and throughout the investigation as necessary;

2. The Department will provide a timely response if a grievance requires action to be taken but does not put the health, safety, or welfare of the participant in jeopardy. These responses will be addressed as soon as possible. Some action, including opening an investigation and notifying the appropriate parties, must be taken within seven (7) calendar days of receiving the grievance. Resolution of the grievance is dependent on the nature of the grievance and resolution is not required to occur within seven (7) calendar days. The Department will contact the participant via his/her preferred method of communication once the grievance is resolved; or

3. If no action is necessary, the Department will document the complaint within the Department-approved system

During this complaint/grievance assessment, the Department will determine if other agencies are responsible for licensure, certification, or monitoring of the provider and will notify or involve these agencies as appropriate. The Department will also determine if the grievance/complaint meets the definition of a critical incident as specified in Appendix G. If a critical incident has occurred, the Department will alert the appropriate parties and follow the process described in Appendix G of this waiver application.

Lastly, the Department will require all waiver service providers to implement policies and procedures to address participant complaints and grievances independently from the State complaint/grievance process. The providers are required to educate all participants regarding the procedure and provide adequate resolution in a timely manner. The provider grievances and appeals are monitored by the Department through certification and on-site monitoring during surveys, investigations, and technical assistance visits.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program. *Select one:*

Yes. The state operates a Critical Event or Incident Reporting and Management Process (*complete Items b through e*)

No. This Appendix does not apply (*do not complete Items b through e*)

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

--

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Commonwealth is responsible to provide a reporting process and investigation of cases of abuse, neglect, and exploitation (ANE) of waiver participants using 907 KAR 1:595 and the following Kentucky statutes and administrative regulations:

??Abuse? as defined in KRS 209.020(8) and 922 KAR 5:070,

??Sexual Abuse? as defined in KRS 600.020(58),

??Exploitation? as defined in KRS 209.020(9) and 922 KAR 5:070, and

??Neglect? as defined in KRS 209.020(16) and 922 KAR 5:070.

The Department for Medicaid Services (the Department) requires the following additional incident types to be reported:

?Serious injury -requiring treatment beyond first aid

?Death other than by natural causes, and

?Events that serve as indicators of risk to participant health and welfare (e.g., unplanned inpatient hospitalizations, medication errors, use of restraints or behavioral interventions).

The Department will continually monitor incident trends and patterns and may require additional incident types beyond those listed above as needed.

For organizational and prioritization purposes, the Department classifies incidents into non-critical incidents and critical incidents. Critical incidents are serious in nature and pose immediate risk to health, safety, or welfare of the waiver participant or others. Non-critical incidents are minor in nature and do not create a serious consequence or risk for waiver participants. Other sections of this appendix describe the process for categorizing and investigating these incidents.

Identification of the individuals/entities that must report critical events and incidents:

Any individual who witnesses or discovers a critical or non-critical incident is responsible to report it. This includes, but is not limited to, all persons as defined in KRS 209.030(2) and KRS 620.030.

The timeframes within which critical and non-critical incidents must be reported:

Any individual who witnesses or discovers an incident should immediately take steps to ensure the participant's health, safety, and welfare, and notify the necessary authorities, including calling law enforcement and reporting any suspected ANE or financial exploitation to the Department for Community Based Services (DCBS). DCBS is part of the Cabinet for Health and Family Services (the Cabinet) and operates both Adult and Child Protective Services (APS and CPS).

For critical incidents, the participant's legal guardian/authorized representative shall be notified immediately following notifications to law enforcement and/or APS/CPS, unless he/she has suspected involvement. The Department defines ?immediately? as making the notification as soon as possible but no later than eight (8) hours after the incident. The participant's RN Supervisor shall also be notified immediately. A critical incident report shall be submitted to the Department via the Department-approved system within eight (8) hours of the time the incident is witnessed or discovered, and no later than the next business day if it is witnessed or discovered outside of regular business hours. The provider agency must begin its investigation into the critical incident immediately upon witnessing or discovering the incident and submit a full, written investigative report to the Department within ten (10) business days.

For non-critical incidents, the participant's legal guardian and/or authorized representative shall be notified within twenty-four (24) hours upon witness or discovery of the incident. The Department shall be notified via an incident report entered into the Department-approved system or other approach approved by the Department. A non-critical incident shall be submitted within twenty-four (24) hours to the Department via the Department approved system of the time the incident is witnessed or discovered and no later than two (2) business days if witnessed or discovered outside of regular business hours. The provider agency shall identify the root cause and conduct risk mitigation. The provider agency describes its risk mitigation strategy on its initial report to the Department.

The Department or its designee reviews critical and non-critical incident summary data generated by the Department-approved system to identify systemic issues and conduct follow-up activities as warranted.

The method of reporting:

DCBS operates both a telephone hotline and an online system for reporting suspected ANE of an adult or child. Reporters can reach the Child Protection Hotline, toll-free, at 1-877-597-2331 to report suspected ANE of both an adult or child. The phone line is staffed twenty-four (24) hours a day, seven (7) days a week including weekends and holidays. Reporters can also contact their local DCBS office to report suspected ANE.

There is also an online system for reporting suspected ANE. This system is available for reporting non-emergency situations that do not require an urgent response. The website is monitored from 8:00 a.m. to 4:30 p.m. EST, Monday through Friday. Reports are not reviewed on evenings, weekends, or State holidays. If a child or adult is at immediate risk of abuse or neglect that could result in serious harm or death, it is considered an emergency and should be reported to local law enforcement or 911.

Any person making such a report shall provide the following information, if known:

?The name, age, and address or location where the child or adult can be found and/or any other person responsible for their care,

?The nature and extent of the ANE, including any evidence of previous ANE,

?The identity of the suspected perpetrator,

?The name and address of the reporter, if they choose to be identified, and

?Any other information that the person believes might be helpful in establishing the cause of the abuse, neglect, or exploitation

Those who witness or discover a non-critical or critical incident shall report it to the Department using the Department-approved system. It is the provider's responsibility to contact all pertinent entities including but not limited to the RN Supervisor, law enforcement, and protective services.

- c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

It is a responsibility of the Model II waiver provider to ensure that the participant and their caregiver are educated about ANE and the methods available to report ANE.

During the provider's initial visit with the participant, information and resources are provided to the participant, the participant's legal guardian and/or authorized representative, if applicable, and anyone else designated by the participant regarding strategies to identify, prevent, report, and intervene in any instances or potential instances of ANE. Participants and their caregivers are asked to attest to their knowledge and training on ANE and critical incidents annually. A copy of contact information for appropriate protection agencies must be provided and explained to each participant and/or legal guardian/authorized representative, if applicable. Training and communication must be provided to the participant in a manner that is appropriate for their learning style.

Depending upon the individual needs of each participant, additional training or information shall be made available and related needs addressed in the participant's person-centered service plan (PCSP).

The Department requires all providers to complete training on ANE identification and reporting. The Department monitors training completion during on-site visits by random sampling of employee records.

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The Department (DMS), or its designee receives the reports for all types of critical events or incidents. Additionally, all incidents are reported to the case manager, direct service provider and any applicable family members/guardians. The following agencies are also notified in certain circumstances:

Law enforcement ? if criminal activity is involved.

Adult/Child Protective Services (APS/CPS) - if suspected Abuse/Neglect/Exploitation (A/N/E)

Medical provider ? hospitalization or medication error

The response below describes the Department's role in reviewing and responding to critical and non-critical incidents. The Department cooperates with other investigative agencies, including APS/CPS, operating agencies, and law enforcement, to complete investigative activities in a timely manner with minimal stress to the participant.

The entity that receives reports of each type of critical event or incident:

Shall notify the Department of any incident, critical or non-critical, via an incident report uploaded to the Department-approved system or other approach approved by the Department. Shall report to DCBS suspected ANE.

The entity that is responsible for evaluating reports and how reports are evaluated:

Upon receiving the report, the Department becomes responsible for evaluating reports. The Department evaluates and classifies the report as a non-critical or critical incident. The Department may upgrade or downgrade an incident based on the report.

A. A non-critical incident shall:

1. Be reviewed by the Department and appropriately classified as a critical or non-critical incident. The Department reserves the right to escalate any categorical non-critical incident to a critical incident as circumstances require;
2. Be minor in nature and not create a serious consequence or risk for participants;
3. Not require an on-site Department or its designee investigation and consist of only desk review, telephonic interview, etc.; and/or
4. Be reported on by the provider to the Department and monitored for future follow-up and intervention as appropriate

B. A critical incident shall:

1. Be reviewed by the Department or its designee and appropriately classified as a critical or non-critical incident and the investigative process will be initiated as appropriate;
2. Be serious in nature;
3. Pose immediate risk to health, safety, or welfare of the participant, co-residing participants, or others;
4. Be investigated and reported on by the provider to the Department. An investigation report must be completed within ten (10) business days of the incident; and/or
5. Warrant an on-site Department investigation as needed

The timeframes for conducting and completing an investigation:

Individuals who witness or discover an incident shall immediately ensure the participant's health, safety, and welfare, and contact the proper authorities, including law enforcement and/or APS/CPS.

For both critical and non-critical incidents, the participant's legal guardian/authorized representative and RN Supervisor shall be notified as soon as the above steps have been taken.

Once these steps have been taken, the provider agency initiates an investigation into the incident based on its classification as follows:

Non-Critical Incidents

The provider agency is expected to identify the root cause and conduct risk mitigation. The provider agency describes its

risk mitigation strategy on its initial report to the Department.

The Department reviews the non-critical incident report. Based on the report's findings, the Department may require more information or escalate the incident to a critical incident. If the non-critical incident is escalated to a critical incident, the critical incident processes below will apply.

Critical Incidents

Provider agencies must initiate investigations of critical incidents immediately upon witnessing or discovering the incident. The Department shall be notified, via an incident report entered into the Department-approved system, the same day if the incident is witnessed or is discovered during business hours and the next business day if it is witnessed or is discovered outside of business hours. The Department or its designee conducts a review of the critical incident. The Department or its designee may intervene when deemed necessary and conduct an investigation within fourteen (14) business days of notification if the incident involves physical abuse and neglect that results in death or potentially life-threatening or serious injury or illness. APS/CPS and/or law enforcement investigations may take longer. The Department will maintain a memorandum of understanding with APS/CPS regarding the results of investigations and will take appropriate action based on the outcome. The provider must upload a complete, investigative report on the critical incident within ten (10) business days of witness or discovery to the Department-approved system. This report only includes provider findings.

All waiver providers are expected to meet the standards set forth in their provider agreement with the Department, with Department ANE training, Department waiver certification, and/or OIG licensure regarding ANE/critical incident investigations and reporting.

The entity that is responsible for conducting investigations and how investigations are conducted:

Providers conduct and upload investigations on critical incidents to the Medicaid Waiver Management Application within seven calendar days.

In opening and initiating an investigation, the Department or its designee contacts and coordinates with APS/CPS, law enforcement, and other responsible agencies immediately if needed. the Department or its designee must conduct investigations in coordination with these parties, as they are identified as involved in a case, to ensure the participant's health, safety, and welfare.

The Department or its designee must also assist and support investigations in accordance with Kentucky statute and administrative regulations, including 922 KAR 1:330, 922 KAR 5:070, KRS 620.030, and KRS 209.030.

The Department or its designee will conduct an investigation using methods determined appropriate and will intervene immediately to address imminent health, safety, or welfare concerns of a participant as deemed necessary, based on the reporting and investigatory information obtained. As part of the investigation, the Department or its designee may interview parties involved in the incident including provider staff, participants, witnesses, or other parties. In addition, the Department or its designee may request and review medical reports, claims data, police reports, and other pertinent documentation to support the Department's investigation. If necessary, the Department or its designee may also conduct an on-site investigation to inspect the participant's environment at home or in a provider facility. If the investigation report results in documentation of regulatory non-compliance, a findings letter including citations, impositions of a corrective action plan (CAP), and/or sanctions is generated and sent to the provider agency via mail.

The participant or family/legal representative, as appropriate, as well as other relevant parties (the provider licensing and regulatory authority) are notified of the investigation within thirty (30) days of close of the investigation.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Department is responsible to oversee reporting of and response to critical incidents affecting waiver participants. The Department or its designee will conduct an investigation and will intervene to address imminent health, safety, or welfare concerns of a participant as deemed necessary. Department tracks and trends all incident reports. The Department or its designee may conduct follow-up monitoring visits, technical assistance, or provider training as needed, based on trend analysis. Trend analysis and oversight is conducted quarterly and monitors the following data elements:

- ?Nature of the incident,
- ?Frequency of incidents,
- ?Adherence to time standards,
- ?CAP status,
- ?High frequency providers,
- ?Recurring participants, and
- ?Rate of unreported incidents identified via MMIS claims data

All incident reports are submitted through the Department-approved system or other approach approved by the Department. The Department samples a select number of providers and verifies through certification surveys, monitoring visits, or investigations that critical incidents were appropriately addressed and that the provider agency is following up appropriately.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

The state does not permit or prohibits the use of restraints

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

Kentucky recognizes that person-centered thinking and planning is key to prevention of risk of harm for all participants. It is the responsibility of all RN Supervisors to utilize person-centered thinking as a means of crisis prevention.

Kentucky is dedicated to fostering a restraint-free environment in all waiver programs. The Department prohibits the use of mechanical or chemical restraints, seclusion, manual restraints, including any manner of prone (breast-bone down) or supine (spine down) restraint.

The Department also prohibits the use of chemical restraints. The Department defines a chemical restraint as the use of a medication, either over the counter or prescribed, to temporarily control behavior or restrict movement or functioning of a participant and is not a standard treatment for the participant's medical or psychiatric diagnosis.

A psychotropic per required need (PRN) is a pharmacological intervention defined as the administration of medication for an acute episodic symptom of a participant's mental illness or psychiatric condition and is not considered a chemical restraint. All administration must adhere to a physician's order that shall include drug, dosage, directions, and reason for use. The PCSP, risk mitigation form, and behavior support plan, if applicable, shall incorporate the protocol for use of a psychotropic PRN and is applicable to participants in Department-approved provider sites. These are reviewed annually as part of the person-centered planning process or more often if needed.

The Department is responsible for oversight of the person-centered planning process which includes monitoring of case management reports, incident reports, and complaints. The continuous quality improvement process reveals trends, patterns, and remediation necessary to ensure proper implementation of the PCSP and participant safety.

A participant has the right to be free of any physical or chemical restraints. Any interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior must be reviewed on an annual basis. Although the state trains on not utilizing restraints, if restrictive intervention has been utilized by agency, an agency is then responsible to submit a critical incident.

State laws, regulations, and policies will be made available to CMS upon request through the Medicaid agency or the operating agency.

The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one):***The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The state of Kentucky does not authorize the use of restraints or seclusion. Should a restraint be used then the provider agency is required to complete an incident report. If a restraint or seclusion is used then the incident is reported to APS/CPS, the incident is investigated, and substantiated or not substantiated. If the report is substantiated then the perpetrator is placed on the Kentucky Board of Nursing Abuse Registry. DMS investigates all unauthorized use of restraints of seclusion upon receipt of the incident report. Incident reports are monitored upon receipt and quarterly for use of restrictive interventions.

The use of restrictive interventions is permitted during the course of the delivery of waiver services Complete Items G-2-b-i and G-2-b-ii.

- i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

- c. Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

The state does not permit or prohibits the use of seclusion

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The Department or its designee is responsible for detecting the unauthorized use of seclusion, as described in section G-2-a. The Department or its designee incorporates oversight into on-site monitoring and review of critical incidents. Incident reports are monitored upon receipt and quarterly for use of seclusion.

The use of seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-c-i and G-2-c-ii.

- i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the state has established

concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

- a. Applicability.** Select one:

No. This Appendix is not applicable (*do not complete the remaining items*)

Yes. This Appendix applies (*complete the remaining items*)

- **Medication Management and Follow-Up**

- i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Entity (entities) that have responsibility for monitoring medication regimens:

Licensed waiver providers are responsible for monitoring participant medication regimens in residential and day service settings.

The methods for conducting monitoring of medication regimens:

Waiver providers are required to follow the guidelines indicated below for administration of medication:

Unless the employee is a licensed or registered nurse, ensure that staff administering medication:

1. Have the Department-approved training on cause and effect and proper administration and storage of medication, documentation requirements, and appropriate disposal. Training must occur at time of hire, annually, and as needed. Attendance and competency must be documented and maintained in provider personnel records;
2. Document all medication administered, including self-administered, over-the-counter drugs, on a medication administration record (MAR), with the date, time, and initials of the person who administered the medication and supervisor's validation of appropriate administration and documentation through a process approved by the Department or its designee. The Department or its designee reviews during the certification processes. The Department or its designee conducts certification every two (2) years or more frequently if necessary; and
3. Ensure the medication shall:
 - a. Be kept in a locked cabinet or storage unit,
 - b. Be kept in a pharmacy labeled container or original package with participant's name and expiration date,
 - c. Be properly disposed of as needed,
 - d. If a controlled substance, be kept under double lock, and
 - e. Documented by a cumulative monthly log with drug name and dosage with a daily medication count verified by two individuals with signature, title, date, and time

In addition, waiver providers are required to have policy and procedures for on-going monitoring of medication administration, which must be approved by the Department or its designee.

Frequency of medication regimen monitoring:

Licensed waiver providers are responsible for monitoring medication logs daily to ensure that medications are administered according to physician order, Department requirements and policies and procedures.

Documented by a cumulative monthly log with drug name and dosage with a daily medication count verified by two individuals with signature, title, date, and time

- ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

The Department or its designee is responsible for oversight of medication management practices by licensed waiver providers. This oversight begins with review and approval of providers' policy and procedures for on-going monitoring of medication administration. The Department or its designee assesses medication administration policies, practices, and record-keeping, and necessary interventions employed, as part of the certification and on-site monitoring process, which occurs at least every two (2) years. In addition, all medication errors must be reported through the Department-approved system, as defined in G-1-d. A provider agency supervisor should verify appropriate administration of medication on a frequency approved by the Department or its designee during the provider certification and re-certification process.

Providers deemed non-compliant with medication management requirements may receive technical assistance, CAPs, or sanctions depending on the frequency and severity of the non-compliant action. The Department or its designee conducts additional evaluation and investigation for any medication error classified as a critical incident and any recurrent non-critical incidents classified as a critical incident.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

Not applicable. *(do not complete the remaining items)*

Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*

- **State Policy.** Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Licensed waiver providers may be responsible for medication administration. Those who choose to be responsible receive training on medication administration. G-3-b-I of this appendix describes the Department policy regarding medication regimen reviews. In addition to these monitoring standards, the Commonwealth provides guidance to providers through State law, regulations, and policies. State laws, regulations, and policies will be made available to CMS upon request through the Medicaid agency or the operating agency.

- **Medication Error Reporting.** *Select one of the following:*

Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).

Complete the following three items:

- (a) Specify state agency (or agencies) to which errors are reported:

All errors are reported to the Department through the Department-approved system and investigated in accordance with section G-1-D of this appendix.

- (b) Specify the types of medication errors that providers are required to *record*:

A medication error occurs when a participant receives an incorrect drug, dose, form, quantity, route, concentration, or rate of administration from a provider. A medication error is also defined as the variance of the administration of a drug on a schedule other than intended in the prescription instructions. Therefore, a missed dose or a dose administered more than one hour before or after the scheduled time constitutes a medication error. Providers must record two (2) levels of medication errors while a participant is in their care as follows:

Non-critical: Errors in prescribed medication or medication management by direct service providers that result in no or minimal adverse consequences and require no treatment or intervention other than monitoring or observation. For provider assisted medications (e.g., administering or cueing), medication errors only relate to medications included on the Medication Administration Record (MAR).

Critical: Errors in prescribed medication or medication management by waiver providers that result in a significant adverse reaction requiring medical attention in an emergency room, urgent care center, or hospital. For provider assisted medications (e.g., administering or cueing), medication errors only relate to medications included on the Medication Administration Record (MAR).

(c) Specify the types of medication errors that providers must *report* to the state:

All medication errors as defined in section G-3-c-iii-b must be reported to the State. Providers must report non-critical errors following the non-critical incident timeframes set forth in section G-1-B. Providers must report critical errors following the critical incident timeframes set forth in section G-1-B.

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.

Specify the types of medication errors that providers are required to record:

- **State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The Department or its designee is responsible for monitoring waiver providers' performance in the administration of medication. This oversight begins with review and approval of provider policy and procedures for on-going monitoring of medication administration. The Department or its designee assesses medication administration policies, practices, and record-keeping, and necessary interventions employed, as part of the certification, on-site monitoring, and incident reporting process, which occurs as deemed necessary by the Department or its designee. In addition, all medication errors must be reported through the Department-approved system and will be followed up on as warranted.

The Department reviews individuals' records during the re-certification process to ensure proper medication administration. This includes reviewing the current physician-signed plan of treatment, MARs/eMARs, prescription dates, and surveys with the individuals/families to ensure regulatory compliance. The staff reviewers conduct and complete a checklist and review of medication administration policies and procedures and logs. The Department or its designee work to analyze data of any identified patterns or trends to support need for agency trainings. Random sampling quality reviews are also conducted between the re-certification process to ensure case notes align with the current physician-signed plan of treatment.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.

i. Sub-Assurances:

- Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.***

Performance Measures

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

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

Performance Measure:

Percent of ANE and death incidents with appropriate action completed by providers as required by the department. N = number of ANE and death incidents with appropriate action completed by providers as required by the department. D = Number of ANE and death incidents with provider action required by the department.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Model II internal tracking tool

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

Data Aggregation and Analysis:

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

Performance Measure:

Percent of potential abuse, neglect, exploitation & unexplained death incidents rptd in required timeframe. N=Number of potential abuse, neglect, exploitation & unexplained death incidents rept in required timeframe. D=# of critical incident reports of potential abuse, neglect, exploitation & unexplained death.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Medicaid Waiver Management Application critical incident reporting module

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

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

Data Aggregation and Analysis:

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

Performance Measure:

Percent of participants (or families/legal guardians) receiving info on how to identify and report abuse, neglect, exploitation & unexplained death. N= # of participants (or families/legal guardians) receiving info on how to identify and report abuse, neglect, exploitation and unexplained death. D= # of participants.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Medicaid Waiver Management Application acknowledgement page

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 250px; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 250px; margin-top: 5px;"></div>

Performance Measure:

Percent of potential abuse, neglect, exploitation & unexplained death incidents reviewed/investigated in the required timeframe. N=# of incident reports of potential abuse, neglect, exploitation & unexplained death reviewed/investigated in the required timeframe. D = Number of critical incident reports of potential abuse, neglect, exploitation & unexplained death received.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Medicaid Waiver Management Application critical incident reporting module

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 120px; margin-top: 5px;"></div>
Other Specify:	Annually	Stratified Describe Group:

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

Data Aggregation and Analysis:

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

Performance Measure:

Percent of abuse, neglect, exploitation incidents referred to appr entities (ex. Law Enforcement, APS/CPS) for follow-up. N=# of abuse, neglect, exploitation incidents ref to appr entities (Law Enforcement, APS/CPS) for follow-up. D=# of abuse, neglect, exploitation incidents.

Data Source (Select one):**Record reviews, off-site**

If 'Other' is selected, specify:

Medicaid Waiver Management Application critical incident reporting module

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

Data Aggregation and Analysis:

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

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

Performance Measure:

Percent of employees who received training on abuse, neglect, exploitation and preventable deaths. N = Number of employees who received training on A/N/E and preventable deaths. D = Number of employee records

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Employee Records

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

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

Data Aggregation and Analysis:

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

- b. Sub-assurance:** *The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

Performance Measures

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

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

Performance Measure:

Percent of critical incidents where investigation included root cause analysis. N =

Number of critical incidents where root cause was identified. D = Number of critical incidents received.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Medicaid waiver Management Application critical incident reporting

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 250px; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 250px; margin-top: 5px;"></div>

Performance Measure:

Percent of critical incidents that were reviewed and corrective measures were appropriately taken. N = Number of critical incidents that were reviewed, and corrective measures were appropriately take. D = Number of critical incidents

Data Source (Select one):**Record reviews, off-site**

If 'Other' is selected, specify:

Medicaid Waiver Management Application critical incident reporting

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 120px; margin-top: 5px;"></div>
Other Specify:	Annually	Stratified Describe Group:

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

Data Aggregation and Analysis:

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

- c. *Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.*

Performance Measures

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

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

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

Performance Measure:

Number and Percent of reported critical incidents where use of restrictive interventions followed policies and procedures. N= Number of critical incident reports where the use of restrictive interventions were reported and investigated in the appropriate time frame D= Number of critical incident reports listing use of restrictive interventions.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Medicaid Waiver Management Application critical incident reporting

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 200px; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 200px; margin-top: 5px;"></div>

- d. *Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

Performance Measures

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

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

Performance Measure:

Percent of participants who received information and support to access Medicaid State Plan services identified in their PCSP. N= Number of participants who received information and support to access Medicaid State Plan services identified in their PCSP. D= Number of participants with Medicaid State Plan services identified in their PCSP.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Participant Survey

Responsible Party for data collection/generation	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
---	---	---

<i>(check each that applies):</i>		
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

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

Licensed provider agencies are reviewed every three (3) years by the OIG. Licensed and certified agencies are reviewed by the Department or its designee, which includes the monitoring of employees records for criminal checks and abuse registry checks.

The Department or its designee performs first line monitoring and identifies deficiencies of the Model II waiver provider. This monitoring includes, but not limited to reviewing complaint logs, MARs, policies and procedures of providers for grievances and complaints, etc. During the monitoring the Department or its designee will review the procedures the provider uses to train employees and ensure the health, safety, and welfare of the participants and that incidents are reported appropriately. The Department or its designee monitors the complaint process by examining complaint logs and the results of client satisfaction surveys. Providers must ensure that waiver participants have access to agency staff and know their RN Supervisor's name and contact information.

The Department or its designee monitors the complaint process by examining complaint logs and the results of client satisfaction surveys.

Providers must ensure that waiver participants have access to agency staff and know their RN Supervisor's name and contact information.

The Department requires providers to make the toll-free Fraud and Abuse Hotline telephone number of the Office of Inspector General available to agency staff, waiver participants and their caregivers or legal representatives, and other interested parties. The purpose of this telephone Hotline is to enable complaints or other concerns to be reported to the Office of Inspector General.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Licensed provider agencies are reviewed every three (3) years by the OIG. Licensed and certified agencies are reviewed by the Department or its designee. Should an enrolled provider not meet requirements to provide services, OIG would notify Program Integrity. The Department or its designee performs first line monitoring and audit reviews. All documentation concerning the monitoring process for providers is kept for a period of five (5) years after last claim is processed or expiration of the contract, whichever is sooner.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of health and welfare that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under Section 1915(c) of the Social Security Act and 42 CFR § 441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver quality improvement strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a quality improvement strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the quality improvement strategy.

Quality Improvement Strategy: Minimum Components

The quality improvement strategy (QIS) that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the QIS spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the QIS. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement**a. System Improvements**

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Department or its designee collects data from a variety of sources to help understand the effectiveness and quality of its current waiver operations. The data collected provides meaningful insights and informs decisions related to process and systems improvement. The Department has defined its quality-related operational elements including data aggregation, measurement, and reporting activities which promotes consistent, rigorous quality management approaches that are institutionalized within Cabinet operations and culture. The Department determined what data should be collected based on several factors including; relevance to participant health and welfare, reliability of data, importance to the Department operational goals, ease and feasibility of data collection, among other factors. The information collected includes data from: LOC determinations; service authorizations, service and expenditure reports; individual plans and outcomes; incident reports; consumer surveys; monitoring visits; progress toward achieving corrective action plan goals; recertification reviews.

The Department analyzes the aggregate data based on established performance targets related to each data point. The Department evaluates data collected against these performance targets to identify performance gaps. As gaps are identified, the Department evaluates program-wide data in a manner that enables the Department staff to observe overarching trends and to "drill down" to observe differences among various geographies, waivers, subpopulations, etc. so that the Department can begin to understand potential root causes of performance patterns and variations. Subsequently, the Department identifies opportunities to improve operational processes based on performance gaps and trends. The Department prioritizes the process improvement to address performance gaps and trends based on the measure. The Department strategically identifies opportunities to enhance operational processes based on how the process can improve participant health and welfare, strengthen compliance with federal regulations and guidance, and improve efficiencies of staff resource use, among other factors.

Implementation of system improvements is dependent on the performance gap. The Department will assess the performance gap and identify the root cause to be addressed. The Department, or its designee, will develop a tailored implementation plan, identify needed staff, determine the steps, sequence, and timeline for system improvement so performance gaps can be addressed in a timely manner.

Results are typically communicated to agencies monthly, quarterly, annually and as needed. Providers, participants, families, other interested parties and the public receive notification of policy changes or technical assistance resulting from the data findings as needed. These activities occur through letters or policy documents, virtual or in-person meetings, or email notifications. Case managers and providers are also expected to share policy change information with participants. Results are typically communicated to agencies monthly, quarterly, annually and as needed. Providers receive information through monthly touchpoints while participants, families, other interested parties and the public receive notification of policy changes or technical assistance resulting from the data findings as needed. These activities occur through letters or policy documents, virtual or in-person meetings, or email notifications. Case managers and providers are also expected to share policy change information with participants. Results are typically communicated to agencies monthly, quarterly, annually and as needed. Providers, participants, families, other interested parties and the public receive notification of policy changes or technical assistance resulting from the data findings as needed. These activities occur through letters or policy documents, virtual or in-person meetings, or email notifications. Case managers and providers are also expected to share policy change information with participants.

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Quality Improvement Committee	Annually
Other Specify:	Other Specify:

Responsible Party(<i>check each that applies</i>):	Frequency of Monitoring and Analysis(<i>check each that applies</i>):
<input type="text"/>	<input type="text"/>

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The Department continually monitors system design changes by evaluating the performance data pre- and post-implementation of system changes. The Department establishes performance goals when implementing systems redesign and regularly tracks the progress towards meeting these goals. The Department will monitor the implementation of system improvements through regularly scheduled meetings, progress towards key milestone, and continuous monitoring of performance measures. The Department reserves the right to increase the frequency or number of measures collected during system change implementation to identify unforeseen impacts of the system change plan. Department can modify its design changes based on outcomes indicated by its performance data. As new performance gaps arise, the Department prioritizes additional systems changes to address these gaps. The Department or its designee creates reports to track progress of these systems improvements and discusses progress with the appropriate parties. This process continues as the Department improves its operations to meet its program-wide goals.

- ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

The Cabinet is shifting its approach to re-orient its quality management activities from the current compliance focus to one that recognizes the importance of both regulatory compliance and quality improvement to promote improved participant outcomes and other performance improvements. The Department is creating a quality strategy that mirrors this shift in approach. The Department has selected performance measures that allows the Department the ability to understand the effectiveness and quality of its current waiver operations. The data collected provides meaningful insights and informs decisions related to process and systems improvement. The Department regularly reviews each of its 1915(c) waiver operations and identifies opportunities to modify existing measures or add measures to appropriately monitor its operational effectiveness. In addition, the Department performs a formal annual review of its quality strategy and revises, as needed.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

- a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):

No

Yes (*Complete item H.2b*)

- b. Specify the type of survey tool the state uses:

HCBS CAHPS Survey :

NCI Survey :

NCI AD Survey :

Other (*Please provide a description of the survey tool used*):

Participants are surveyed during provider certification to determine satisfaction. The tool was developed by the State to review community involvement and quality of life.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Department directly conducts post payment annual billing reviews of 100% of the Model II waiver active providers during the on-site monitoring reviews. These audits shall include a post-payment review of Medicaid reimbursement to the provider agency for services rendered to a waiver participant. The Department Nurse Reviewer shall utilize reports generated from the Medicaid Management Information System (MMIS) reflecting each service billed by the waiver provider. Comparison of payments to participant records, documentation and approved person-centered service plan shall be conducted. If any payments were issued without the appropriate documentation or not in accordance with approved POC, the Department will initiate recoupment of the monies.

The review team follows an annually prepared review schedule to ensure that 100% of the providers are reviewed. Provider reviews are conducted on-site. Monitoring tools that are updated at least annually to ensure that all current and regulatory requirements and indicators related to performance measures are on the tools to guide the review of clinical records and the documentation of all services provided. The clinical documentation is also utilized to review the services reimbursed by the Department to ensure that services billed to and reimbursed by DMS are accurate and appropriate.

Monitoring/reviews are completed annually by the Department for 100% of enrolled providers and 100% of the members served in the Model II waiver. The Department may reflect in the monitoring report that a Corrective Action Plan (CAP) is needed. The Department requests a CAP, if needed. The enrolled provider submits a response to the CAP with supporting evidence of the implementation of the corrective action.

The Auditor of Public Accounts conducts annual audits of the Model II waiver program in accordance with the Single Audit Act. The audit encompasses the prior fiscal year.

Providers may choose to have an independent audit of their financial statements but they are not required to do so.

All services in this waiver are have been required to use Electronic Visit Verification (EVV) since January 1, 2024. Staff includes EVV records (service checklist, notes, visit information) as part of the utilization review.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.

i. Sub-Assurances:

- a. Sub-assurance: The state provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

Performance Measures

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

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

Performance Measure:

Percent of waiver service claims submitted and paid for services rendered on the participants person-centered service plan and only for services rendered. N= Number of waiver service claims that were submitted and paid for services rendered on the participant's person-centered service plan and only for services rendered. D= Number of waiver service claims submitted and paid.

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

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

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Data Aggregation and Analysis:

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

Performance Measure:

**Percent of claims coded and paid for in accordance with the established reimbursement methodology specified in the approved waiver. N =Number of claims coded and paid in accordance with the established reimbursement methodology in the approved waiver
 D =Number of claims coded and paid.**

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:

Number and percent of rates that remain consistent with the approved rate methodology throughout the five year waiver cycle. N=Number of rates that remain consistent with rate methodology throughout the five year waiver cycle. D=Number of rates used throughout the five year waiver cycle.

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

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

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Data Aggregation and Analysis:

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

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

The Department reviews and adds Edits/Audits to the Medicaid Management Information System (MMIS) periodically for program compliance and as policy is revised to ensure claims are not paid erroneously.

The Department reviews the CMS-372 report for accuracy prior to submission.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

The Department or its designee provides technical assistance to certified providers on an ongoing basis. Providers found out of compliance submit and are held to a corrective action plan (CAP). The Department or its designee performs trainings upon request of providers and provides technical assistance whenever requested. Should an enrolled provider fail to meet their CAP, the Department may terminate the provider's enrollment as a waiver provider.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Provider rates are established under a fee-for-service system. DMS established rates for most services through an independent cost study conducted by Guidehouse Consulting to determine costs associated with each service component. The following services were included in the rate study: Skilled services provided by a Licensed Practical Nurse, Skilled Services provided by a Registered Nurse, Skilled services provided by a Respiratory Therapist. The methodology for the rate study is consistent with the efficiency, economy, and quality of care requirements described in §1902(a)(30)(A) of the SSA. From March-May 2022, Guidehouse administered a statewide provider cost and wage survey, requesting that providers across each of the Commonwealth's six 1915(c) home and community-based services waivers report wage and other cost information for the first quarter (January-March) of 2022, as well as other program characteristics to support rate setting. Guidehouse had administered a similar survey in February-May 2019, collecting data from provider Fiscal Year 2018.

Guidehouse employs an independent rate build-up approach, which considers median direct wages, payroll taxes, benefits, and employee-related expenses, as well as provider administrative and program support expenses, along with representative productivity rates for each service. This approach establishes a base rate that reflects wages of the direct care staff providing the service, as well as direct supervisory costs. Employee-related expenses, administrative and overhead expenses, and program support costs are calculated as a percentage of direct care wages, and then factored into the rate as a multiplier of the base wage rate. The rates also incorporate service-specific productivity factors, as well as facility, equipment, transportation, training and supply costs unique to certain types of services. The data informing the rates derive from the provider cost and wage surveys, as well as benchmarks from the federal Bureau of Labor Statistics and the Medical Expenditure Panel Survey as well as other state and regional wage benchmarks.

Stakeholders were afforded opportunities for feedback throughout the process, as a part of the announcement of the independent rate study, during and following release of the provider cost survey, and following public notice of this waiver amendment. The public comment process includes informing stakeholders of the change, then releasing educational summary documents of rates and the proposed waiver amendment itself for 30 days and allowing stakeholders to submit comments in writing or via email, as described in further detail in section 6I. Stakeholders were informed of public comment and responses to public comment through DMS' website, a dedicated email, on DMS' social media accounts. Along with general public comment opportunities, the rate study was subject to monthly review and feedback from an advisory Rate Study Work Group, composed of provider representatives, advocacy groups, Legislators, and other state agency stakeholders.

DMS conducted a thorough review of benchmark rates in 2023. The Legislature allocated funding to cover 70% of the benchmark rate recommendations in 2024.

Rates are not tiered and do not vary by provider geographic location.

Providers were notified of rates through a provider letter via email in June 2024. Rates can be found on the fee schedule publicly at the following link: <https://www.chfs.ky.gov/agencies/dms/Pages/feesrates.aspx> In addition to being able to view the fee schedule posted online, participants receive education from case managers regarding payment rates for services and also receive written notification of rate changes and education from case managers.

DMS will review rates every five years, or more frequently as necessary, to ensure rates are adequate to maintain the provider pool.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Billings for Model II waiver services shall flow directly from the waiver providers to the Medicaid Management Information System (MMIS).

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

- c. Certifying Public Expenditures** (select one):

No. state or local government agencies do not certify expenditures for waiver services.

Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)

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Certified Public Expenditures (CPE) of Local Government Agencies.

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

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Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

All MIIW providers shall be enrolled with the Department's Division of Program Integrity, Provider Enrollment, and have a signed contract on file. The Medicaid Management Information System (MMIS) has edits and audits established to prevent non-enrolled provider claims from processing and to ensure the individual is eligible on the date of service, services billed were on the approved PCSP and services were rendered. The Department conducts audits of 100% of the MIIW providers annually to ensure the following three checks are met: individual was eligible on date of service, services billed were included in the approved PCSP, and services were rendered. These audits shall include a post-payment review of Medicaid reimbursement to the provider agency for services rendered to MIIW participants. The Department shall utilize reports generated from MMIS reflecting each service billed by the waiver provider. Comparison of payments to participant records, documentation and approved PCSPs shall be conducted. Overpayments or inappropriate billings are recouped using the AR process through the MMIS, which retains monies from future payments. DMS subtracts the amount noted for recoupment from the federal funds that are drawn down.

Services subject to EVV include: all skilled services provided. The department requires the agency to collect visit data through either a mobile device or IVR as an alternative. Model II providers have hard edits in the MMIS that requires a visit for each claim paid as of 01/01/2025. The Department requires each agency to have an alternative back up manual method in case of natural disaster or in need of an emergency event.

Each agency should have policies and procedures related to EVV. The policies and procedures for EVV should outline:

- ? The process for onboarding and training new staff.
- ? Addressing issues with EVV usage among staff or participants.
- ? The process for reviewing visits and correcting errors or issues.
- ? A backup, paper process for PDS employees in case of an EVV system outage or in the event of a natural disaster.
- ? The process for auditing the agency's current EVV users, ensuring accuracy, and making updates as necessary (this should occur at a minimum of every 90 days).

It is the agency's responsibility to review visits entered in EVV and to resolve errors. DMS acknowledges that employee errors, connectivity issues, or system outages may result in slightly less than 100% compliance. Those situations will be taken into consideration as DMS monitors EVV usage.

- e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (select one):

Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, waiver services are made through an approved MMIS.

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.

The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.

The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

No. The state does not make supplemental or enhanced payments for waiver services.

Yes. The state makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-

Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

No. *State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.*

Yes. *State or local government providers receive payment for waiver services. Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

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

The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:

No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR § 447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. Select one:

No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR § 447.10.

Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of section 1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

This waiver is a part of a concurrent section 1915(b)/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

This waiver is a part of a concurrent section 1115/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.

In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

Appropriation of State Tax Revenues to the State Medicaid Agency

Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Other State Level Source(s) of Funds.

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

Not Applicable. There are no local government level sources of funds utilized as the non-federal share.

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

--

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. *Services Furnished in Residential Settings. Select one:*

No services under this waiver are furnished in residential settings other than the private residence of the individual.

As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.

b. *Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Do not complete this item.

--

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:

No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

Yes. Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

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Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:

No. The state does not impose a co-payment or similar charge upon participants for waiver services.

Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

Nominal deductible

Coinsurance

Co-Payment

Other charge

Specify:

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)**

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)**

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)**

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration**J-1: Composite Overview and Demonstration of Cost-Neutrality Formula**

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	22236.21	69683.73	91919.94	262671.69	18456.18	281127.87	189207.93
2	23774.70	71675.60	95450.30	270112.18	18978.98	289091.16	193640.86
3	25384.55	73687.39	99071.94	277763.42	19516.58	297280.00	198208.06
4	27063.11	75774.67	102837.78	285631.40	20069.41	305700.81	202863.03
5	28820.09	77921.08	106741.17	293772.25	20637.90	314410.15	207668.98

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (1 of 9)**

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Nursing Facility	
Year 1	100		100
Year 2	100		100
Year 3	100		100

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Nursing Facility	
Year 4	100		100
Year 5	100		100

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

- b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

DMS developed the ALOS estimate using 372 report data from 10/1/22 - 9/30/23. The average length of stay for participants on this waiver is 271 days per the 372 report and we anticipate ALOS remaining at that level for all five waiver years. The average length of stay is expected to remain static or minimally increase in future years. Based on historical information, the ALOS only minimally changes from year to year.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

- c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

DMS developed Factor D estimates, including users and average units per user for Waiver Year (WY) 1 using 372 report data from 10/1/22 - 9/30/23. For all services, DMS multiplied the total number of units by 4 to calculate projections for 15-minute units (the 372 report reflects 1 hour units in effect at the time of the report).

DMS elected to use the Q3 2024 CMS Market Basket Index for Skilled Nursing Facilities in place of trended 372 report data due to inconsistent annual trends in service utilization likely due to the COVID-19 pandemic.

DMS trended the data forward using the CMS Market Basket Index (released Q3 2024) for Skilled Nursing Facilities (SNF) to align with the SNF level of care requirement for this waiver. Based on the Market Basket, DMS used a 9.9% factor to trend from the midpoint of the 372 period to the midpoint of WY1. DMS trended WYs 2-5 by applying the Market Baskets from midpoint of the WY1 to midpoint of WY2 (2.8%). DMS applied the percentage increase to estimated users and average units per user to align with projected growth of the program. DMS rounded the average units per user estimates up to the nearest whole number.

The average cost per unit estimates for WY1-5 reflect the methodology described in Appendix I. DMS did not apply the CMS Market Basket increase to payment rates as payment rates are formalized in Kentucky Administrative Regulations and do not receive an annual adjustment.

DMS did not have utilization data for the following services per the 372 report: Skilled Services Provided by a Respiratory Therapist. This service has low historical utilization rates. DMS has no intention of phasing this service out of the waiver at this time but elected to estimate 0 users and units per user given historical data in recent 372 reports. If DMS experiences an increase in utilization for this service, we will plan to submit an amendment to align with that trend.

- ii. Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

DMS developed Factor D' estimates for Waiver Year 1 using 372 report data from 10/1/22 - 9/30/23. DMS trended the 372 report Factor D? value forward to Waiver Year 1 (10/1/25 - 9/30/26) by applying the CMS Market Basket Index for Skilled Nursing Facilities from midpoint of the 372 report to midpoint of WY1 (9.9%). DMS trended the WY1 Factor D? value forward to WYs 2-5 by applying the CMS Market Basket Index for Skilled Nursing Facilities from midpoint of the WY1 to midpoint of WY2 (2.8%).

- iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

DMS developed Factor G estimates for Waiver Year 1 using 372 report data from 10/1/22 - 9/30/23. DMS trended the 372 report Factor G value forward to Waiver Year 1 (10/1/25 - 9/30/26) by applying the CMS Market Basket Index for Skilled Nursing Facilities from midpoint of the 372 report to midpoint of WY1 (9.9%). DMS trended the WY1 Factor G value forward to WYs 2-5 by applying the CMS Market Basket Index for Skilled Nursing Facilities from midpoint of the WY1 to midpoint of WY2 (2.8%).

- iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

DMS developed Factor G' estimates for Waiver Year 1 using 372 report data from 10/1/22 - 9/30/23. DMS trended the 372 report Factor G' value forward to Waiver Year 1 (10/1/25 - 9/30/26) by applying the CMS Market Basket Index for Skilled Nursing Facilities from midpoint of the 372 report to midpoint of WY1 (9.9%). DMS trended the WY1 Factor G' value forward to WYs 2-5 by applying the CMS Market Basket Index for Skilled Nursing Facilities from midpoint of the WY1 to midpoint of WY2 (2.8%).

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “manage components” to add these components.

Waiver Services	
Skilled services provided by a Licensed Practical Nurse	
Skilled Services provided by a Registered Nurse	
Skilled services provided by a Respiratory Therapist	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. **Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Skilled services provided						1680072.72
<p>GRAND TOTAL: 2223620.79</p> <p>Total Estimated Unduplicated Participants: 100</p> <p>Factor D (Divide total by number of participants): 22236.21</p> <p>Average Length of Stay on the Waiver: <input type="text" value="271"/></p>						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
by a Licensed Practical Nurse Total:						
Skilled services provided by a Licensed Practical Nurse	15 minute	19	7636.00	11.58	1680072.72	
Skilled Services provided by a Registered Nurse Total:						543548.07
Skilled Services provided by a Registered Nurse	15 minute	9	3777.00	15.99	543548.07	
Skilled services provided by a Respiratory Therapist Total:						0.00
Skilled services provided by a Respiratory Therapist	15 minute	0	0.00	13.36	0.00	
<p>GRAND TOTAL: 2223620.79</p> <p>Total Estimated Unduplicated Participants: 100</p> <p>Factor D (Divide total by number of participants): 22236.21</p> <p>Average Length of Stay on the Waiver: 271</p>						

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Skilled services provided by a Licensed Practical Nurse Total:						1818523.20
Skilled services provided by a Licensed Practical Nurse	15 minute	20	7852.00	11.58	1818523.20	
Skilled Services provided by a Registered Nurse Total:						558946.44
Skilled Services provided by a Registered Nurse	15 minute	9	3884.00	15.99	558946.44	
Skilled services provided by a Respiratory Therapist Total:						0.00
Skilled services provided by a Respiratory Therapist	15 minute	0	0.00	13.36	0.00	
<p>GRAND TOTAL: 2377469.64</p> <p>Total Estimated Unduplicated Participants: 100</p> <p>Factor D (Divide total by number of participants): 23774.70</p> <p>Average Length of Stay on the Waiver: 271</p>						

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (7 of 9)****d. Estimate of Factor D.**

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Skilled services provided by a Licensed Practical Nurse Total:						1963678.50
Skilled services provided by a Licensed Practical Nurse	15 minute	21	8075.00	11.58	1963678.50	
Skilled Services provided by a Registered Nurse Total:						574776.54
Skilled Services provided by a Registered Nurse	15 minute	9	3994.00	15.99	574776.54	
Skilled services provided by a Respiratory Therapist Total:						0.00
Skilled services provided by a Respiratory Therapist	15 minute	0	0.00	13.36	0.00	
<p>GRAND TOTAL: 2538455.04</p> <p>Total Estimated Unduplicated Participants: 100</p> <p>Factor D (Divide total by number of participants): 25384.55</p> <p>Average Length of Stay on the Waiver: 271</p>						

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (8 of 9)****d. Estimate of Factor D.**

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Skilled services provided by a Licensed Practical Nurse Total:						2115272.28
<p>GRAND TOTAL: 2706310.65</p> <p>Total Estimated Unduplicated Participants: 100</p> <p>Factor D (Divide total by number of participants): 27063.11</p> <p>Average Length of Stay on the Waiver: 271</p>						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Skilled services provided by a Licensed Practical Nurse	15 minute	22	8303.00	11.58	2115272.28	
Skilled Services provided by a Registered Nurse Total:						591038.37
Skilled Services provided by a Registered Nurse	15 minute	9	4107.00	15.99	591038.37	
Skilled services provided by a Respiratory Therapist Total:						0.00
Skilled services provided by a Respiratory Therapist	15 minute	0	0.00	13.36	0.00	
<p style="text-align: center;">GRAND TOTAL: 2706310.65</p> <p style="text-align: center;">Total Estimated Unduplicated Participants: 100</p> <p style="text-align: center;">Factor D (Divide total by number of participants): 27063.11</p> <p style="text-align: center;">Average Length of Stay on the Waiver: 271</p>						

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Skilled services provided by a Licensed Practical Nurse Total:						2274277.26
Skilled services provided by a Licensed Practical Nurse	15 minute	23	8539.00	11.58	2274277.26	
Skilled Services provided by a Registered Nurse Total:						607731.93
Skilled Services provided by a Registered Nurse	15 minute	9	4223.00	15.99	607731.93	
Skilled services provided by a Respiratory Therapist Total:						0.00
Skilled services provided by a Respiratory Therapist	15 minute	0	0.00	13.36	0.00	
<p style="text-align: center;">GRAND TOTAL: 2882009.19</p> <p style="text-align: center;">Total Estimated Unduplicated Participants: 100</p> <p style="text-align: center;">Factor D (Divide total by number of participants): 28820.09</p> <p style="text-align: center;">Average Length of Stay on the Waiver: 271</p>						