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 waivers 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.

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

1. Request Information (1 of 3)

A. The **State of** Kentucky of 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*):

Kentucky's Community Health for Improved Lives and Development (CHILD) Waiver

C. Type of Request:

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**

☐ **New to replace waiver**

Replacing Waiver Number:

Base Waiver Number:

Amendment Number
(if applicable):

Effective Date: (mm/dd/yy)

Draft ID:

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

New Waiver

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

January 1, 2026

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:

○ **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:

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:

The State of Kentucky mandatorily enrolls all children and youth into managed care who are in the custody of the State. Youth who are adopted, who age-out of care, and who are dually committed can opt-in to managed care.

The Kentucky Cabinet for Health and Family Services (CHFS) previously received approval from the Centers for Medicare and Medicaid (CMS) through a 1915(b) application for this mandatory enrollment.

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

☒ **section 1915(b)(1) (mandated enrollment 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 CHFS Community Health for Improved Lives and Development (CHILD) Waiver is focused on providing needed community-based supports to youth and children with multi-system and complex conditions who require a continuum of services to address their healthcare and social support needs. The CHILD Waiver allows children, youth, and young adults who meet the following levels of care (LOC) to enroll in the program:

- Hospital, including those classified as inpatient psychiatric facility for individuals aged 21 and under.
- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

Individuals may enroll and continue participation in the CHILD Waiver until the age of 21.

Goals

The primary goal of the CHILD 1915(c) program is to keep children, youth, and young adults with multi-system needs and complexities safe, healthy, and to the extent feasible, independent, within their communities and families. Additionally, the CHILD waiver aims to serve children, youth, and young adults regardless of custody arrangement and is dedicated to a holistic approach to addressing high-intensity needs with a support system as determined by the enrolled participant. Priority enrollment is granted to children who are in the State's custody, at risk of being unhoused or are currently unhoused or are leaving an institutional setting.

Objectives

The following are the objectives of the CHILD 1915(c) program:

- Recognize the complexity of serving children, youth, and young adults with multiple co-morbidities through a variety of services that incorporate natural support systems to keep children within their families and communities.
- Offer services not otherwise available through the Kentucky Medicaid state plan to support children, youth, and young adults.
- Create a sustainable and cost-effective program serving children, youth, and young adults with high-intensity needs outside of facility-based services.
- Streamline CHFS divisional services using a standard Medicaid authority.

Organizational Structure

The CHFS Department for Medicaid Services (DMS) holds administrative authority for the CHILD waiver. DMS delegates operational authority to the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID). Further information regarding the administrative and operational functions of each Department and contracted entities are detailed in Appendix A-7.

Service Delivery Methods

Services offered under the CHILD benefit waiver are only provided by qualified, certified Medicaid enrolled providers. Providers of services are limited to agency providers. Legally responsible individuals, relatives, parents of minor children, foster care parents, and all other guardians are prohibited from provisioning of services under this waiver. Services are only provider managed and may only be provided by certified and enrolled providers.

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

⊗ **No**

○ **Yes**

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

☐ **Geographic Limitation.** A waiver of statewideness 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 statewideness 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:

CHFS engaged stakeholders beginning in 2022 to determine gaps in service coverage for children with autism spectrum disorders, intellectual and developmental disabilities (I/DD) and related conditions, mental illness, and severe emotional disabilities. Engagement efforts included:

- Establishment of a Stakeholder Advisory Workgroup in 2022.
- In 2023, facilitation of focus groups comprised of home and community-based services (HCBS) participants, caregivers, advocacy groups, and individuals and families on an HCBS waiting list at the time of the focus groups.
- Participant surveys were released in the summer of 2023 to HCBS recipients, individuals on the State's waitlist for HCBS, family members, caregivers, and advocacy groups.
- In the fall of 2023, CHFS released provider surveys to determine potential network capacity to serve children under a specialized waiver.

CHFS notes that in addition to the stakeholder engagement efforts as enumerated above, the CHILD waiver language was developed in response to HB6 requiring the state pursue a 1915(c) program.

The above efforts resulted in the development of CHILD Waiver. In accordance with 42 CFR §441.304(f), CHFS presented opportunities for public input on the CHILD waiver design and administration as presented herein. The waiver was open for public comment between June 16 and July 15, 2025. The finalized draft of the CHILD waiver was presented to the public in the following ways:

- DMS website announcement at **[INSERT WEBSITE LINK HERE]**.
- Social media posting on the Department for Medicaid Services (DMS) website and social media channels **[INSERT SOCIAL MEDIA POSTING HERE]**.
- Email updates to stakeholders via email **[INSERT DATES OF NOTIFICATION]**.
- Informing advocacy organizations who shared information regarding the CHILD waiver and the public comment period.

CHFS received a total of **[NUMBER OF UNIQUE COMMENTS]** during the public comment period. The following summarizes the public comments received by topic area:

- **[INSERT BULLETED LIST OF PUBLIC COMMENT TOPIC AREAS]**.

A detailed list of public comments and responses can be found at: **[INSERT PUBLIC COMMENT WEBSITE LINK HERE]**.

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: Division Director of Long Term Services and Supports

Agency: Department for Medicaid Services (DMS), Cabinet for Health and Family Services

Address: 275 East Main St.

Address 2: 6W-B

City: Frankfort

State: Kentucky

Zip: 40621

Phone: 502-330-3280 **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: Adams

First Name: Crystal

Title: Division Director, Division of Developmental and Intellectual Disabilities

Agency: Department for Behavioral Health, Developmental and Intellectual Disabilities

Address: 275 E. Main St.

Address 2: 4C-F

City: Frankfort

State: Kentucky

Zip: 40621

Phone: (502) 782- 8883 **Ext:** ☐ **TTY**

Fax: (502) 564-8917

E-mail: crystal.adams@ky.gov

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:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan
Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

   ○ **The waiver is operated by the state Medicaid agency.**

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

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

DBHDID, Division of Developmental and Intellectual Disabilities (DDID)

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:

DMS has a written contract with DBHDID that is reviewed annually and is updated as needed. DMS oversees the following functions delegated to DBHDID through the written contract:

1. Utilization management.
2. Maintenance of waiting list and allocations.
3. Provider development, training, and certification.
4. Quality assurance and improvement activities.

DMS retains sole authority for the following:

1. Participant waiver enrollment.
2. Qualified provider enrollment.
3. Establishment of statewide rate methodologies.

DMS and DBHDID are jointly responsible for the following functions:

1. Execution of Medicaid provider agreements.
2. Developing rules, policies, procedures, and information governing the waiver program
3. Quality assurance and quality improvement activities.

DMS uses the following methods to ensure DBHDID performs its assigned waiver operational and

administrative functions in accordance with waiver requirements:

1. Policy and clarification is reviewed and approved by DMS.
2. DBHDID submits correspondence and reports to DMS.
3. DMS and DBHDID hold regular quarterly meetings.
4. DMS conducts an annual review of the contract to ensure DBHDID meets all requirements.

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 following entities are contracted to perform waiver operational functions on behalf of DMS and DBHDID:

- Department of Community-Based Services (DCBS): Reviews financial eligibility for the waiver enrolled population.
- CHFS' currently contracted IT vendors as follows:
  - EVV vendor: Responsible for performing the functions required under the federal CURES Act.
  - MMIS vendor: Processes and adjudicates claims for the CHILD waiver.

○ **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 is responsible for assessing the performance of contracted entities providing waiver operational functions as detailed in A-4 of this application.

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:

   DMS assesses the performance of the contracted entities bi-annually and as required by the entity's executed contract with CHFS.

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	Other State Operating 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	☒	☒	☒

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:

A1: Number and percent of requirements for each contracted entity reviewed by DMS that meet contractual obligations as determined through contract monitoring. N = Number of reviewed requirements that meet contractual obligations. D = Total number of requirements reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Reports submitted to the DMS for monitoring

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**

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):*
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: Contracted Entities	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:

A2: Number and percent of DBHDID reports meeting reporting requirements as determined through DMS review. N = Number of reviewed DBHDID reports meeting reporting requirements. D = Total number of reports reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Reports submitted to the DMS for monitoring

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 *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

A3: Number and Percent of providers with a current approved provider agreement on file. N= The number of providers with a current approved provider agreement on file. D= The number of enrolled providers.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Medicaid Partner Portal system

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

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 DMS through use of generated monthly reports. DMS monitors the 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.

Problems are identified through a review of monthly reports and further research and addressed by DMS. DMS monitors to ensure that contract objectives and goals are met as appropriate. Should the delegated entity not meet the requirements, then a corrective action plan is required and/or recoupment of funds may occur.

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:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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			☐
☒ Intellectual Disability or Developmental Disability, or Both					
☒	☒	Autism	0	21	☐
☒	☒	Developmental Disability	0	21	☐
☒	☒	Intellectual Disability	0	21	☐
☒ Mental Illness					
☐	☐	Mental Illness			☐
☒	☒	Serious Emotional Disturbance	0	21	☐

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

The CHILD waiver is specifically designed to support children and youth with high-intensity needs to live as independently as possible within their homes and communities. As such, in addition to meeting the above stated target group and the LOC criteria as specified herein, children and youth must have exhausted other services and supports enabling them to remain in a community setting (both Medicaid and non-Medicaid funded) and also demonstrate one of the following characteristics to be eligible for enrollment in the CHILD waiver:

- Is currently unhoused or is at risk-of being unhoused as a direct result of the intensity of their disability and care needs.
- Has a history (within the last year) of at least two different foster care placements as a direct result of the intensity of their disability and care needs.
- Experience with law enforcement (defined as any incident involving at least five contacts with a police department, sheriff's office, emergency services, or fire department), within the last year as a direct

result of the intensity of their disability and care needs.

- Is discharging from a PRTF, ICF/IID, or other similar institution within the next 45 calendar days and requires supports offered through the CHILD waiver.

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:

At least 120 calendar days preceding the date a participant reaching an applicable age limitation as specified in B-1-b, case managers meet with the participant and their support system (families, guardians, providers, teachers, etc.) to plan for transitioning to another program funded through Kentucky's Medicaid program. Participants who meet enrollment criteria for another approved Kentucky 1915(c) waiver or the Kentucky RISE 1915(i) State plan option will be connected with an applicable case management entity to begin a warm hand-off and to develop a plan of care. Eligibility for these programs will be established prior to meeting the age maximums of the CHILD Waiver in preparation for termination of the CHILD Waiver benefit upon reaching the age limitations; simultaneous enrollment of a participant on the CHILD Waiver and another 1915(c) waiver or the 1915(i) RISE program is controlled through Kentucky's Medicaid Waiver Management Application (MWMA).

Participants who do not meet eligibility for another 1915(c) waiver or the 1915(i) RISE program but do meet general Medicaid program requirements, will remain enrolled on the Kentucky Medicaid program and will be connected to an MCO at least 90 calendar days prior to exiting the CHILD Waiver program.

If a participant is not expected to meet Medicaid program eligibility following their enrollment on the CHILD Waiver, case managers will provide the participant and their support team with community and other State-funded resources to help support their transition from the program. Other community and State-funded resources may include (but are not limited to) those available through Kentucky's Certified Community Behavioral Health Clinics (CCBHCs), Vocational Rehabilitation, University of Kentucky – Human Development Institute (a University Center for Excellence in Developmental Disabilities), etc.

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:

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

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:

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	100
Year 2	100
Year 3	100
Year 4	100
Year 5	100

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	
Year 2	
Year 3	
Year 4	
Year 5	

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	

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:

Participants are enrolled on the CHILD Waiver based on date of waiver application. Enrollment on the CHILD Waiver is contingent on the availability of slot capacity.

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-c (209b 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-c (209b 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-c (209b 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. 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 (see instructions)**

○ **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).

The state uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR § 435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in section 1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts 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*):

◯ **The following standard under 42 CFR § 435.121**

Specify:

◯ **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 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*):

○ **The following standard under 42 CFR § 435.121**

Specify:

○ **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 § 435.735:

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 establishes the following reasonable limits:**

Specify:

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).

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 section 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:

i. Health insurance premiums, deductibles and co-insurance charges
ii. 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:

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).

The state uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR § 435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts 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*):

◯ **The following standard under 42 CFR § 435.121**

Specify:

◯ **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 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 (see instructions)**

◯ **The following standard under 42 CFR § 435.121**

Specify:

◯ **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 § 435.735:

i. Health insurance premiums, deductibles and co-insurance charges
ii. 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:

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).

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:

i. Health insurance premiums, deductibles and co-insurance charges
ii. 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-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: One

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 agency/entity**

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:

Individuals performing initial evaluations for LOC will meet the following standards:

- Hold a bachelor's degree or higher in a human services field from an accredited college or university; OR
- Hold a bachelor's degree in any other field from an accredited college or university, with at least one year of experience working with children with an I/DD (inclusive of autism), mental illness, or SED and have evidence of training in trauma-informed care; OR
- Hold a bachelor's degree in any other field from an accredited college or university, with at least two years of experience working with children in foster care or former foster children and youth; OR
- Hold a license as a Registered Nurse in accordance with State of Kentucky regulations and have at least one year of experience as a Registered Nurse. Staff with this level of experience will be supervised by a case manager supervisor who will have two or more years' experience as a case manager.

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.

Hospital - Inpatient Psychiatric Facility for Individuals Age 21 and Under LOC:

Hospital - Inpatient Psychiatric Facility for Individuals Age 21 and Under LOC is determined through administration of the Child and Adolescent Needs and Strengths (CANS) assessment tool. A participant seeking enrollment or continued enrollment on the CHILD waiver who meets a Hospital - Inpatient Psychiatric Facility for Individuals Age 21 and Under LOC must demonstrate the following criteria as outlined in KAR 200.503 and 216B.450:

- Has a serious emotional disability with a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is listed in the current edition of the DSM and that:
    - Presents substantial limitations that have persisted for at least one (1) year or are judged by a mental health professional to be at high risk of continuing for one (1) year without professional intervention in at least two (2) of the following five (5) areas: "Self-care," defined as the ability to provide, sustain, and protect his or herself at a level appropriate to his or her age; "Interpersonal relationships," defined as the ability to build and maintain satisfactory relationships with peers and adults; "Family life," defined as the capacity to live in a family or family type environment; "Self-direction," defined as the child's ability to control his or her behavior and to make decisions in a manner appropriate to his or her age; and "Education," defined as the ability to learn social and intellectual skills from teachers in available educational settings;
    - Is a Kentucky resident and is receiving residential treatment for emotional disability through the interstate compact;
    - The Department for Community Based Services (DCBS) has removed the child from the child's home and has been unable to maintain the child in a stable setting due to behavioral health needs; or
    - Is a person under twenty-one (21) years of age meeting the substantial limitation criteria and who was receiving services prior to age eighteen (18) that must be continued for therapeutic benefit.

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) LOC:

The CANS assessment to determine ICF/IID LOC for participants seeking enrollment or reenrollment on the CHILD waiver. The ICF/IID LOC criteria is defined in 907 KAR 1:022:

- Individuals must meet criteria for a diagnosis of an intellectual disability as defined by the current Diagnostic and Statistical Manual of Mental Diseases (DSM) with onset of condition prior to age eighteen OR meets criteria for a person with a related condition as defined by 42 CFR 435.1010 with onset of condition prior to age 22; AND
    - Requires physical or environmental management or habilitation; and
    - Requires a planned program of active treatment; and
    - Requires a protected environment; and
    - Unrelated to age appropriate dependencies with respect to a minor, has substantial deficits in functioning that without ongoing support, limit functioning in one or more activities of daily life (ADLs) such as communication, social participation, and independent living across multiple environment, such as home, school, work, and community.

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 instruments used for determining ICF/IID for the CHILD waiver are different than those used for the equivalent institutions because the CANS was designed to assess a participant's strengths and needs relevant to community-based services. The tool used for institutional care does not adequately reflect an individual's community, home, or environmental support systems.

All eligibility determinations from the instruments used for determining CHILD LOC eligibility are based on Kentucky's criteria for each of the respective levels of care; these outcomes are consistent with the determinations generated from the facility-based assessments.

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:

All level of care evaluations will include the administration of the CANS. DBHDID is responsible for making contact with an individual within seven days of receipt of referral for initial evaluation; LOC re-evaluations will be conducted at least thirty days prior to the end of an enrolled individual's waiver year. DBHDID will administer the LOC tool and collect supporting documentation from members of the individuals support system (to include but not be limited to: physician's, current care team providers, schools, etc.). For both initial and re-evaluations, DBHDID will determine the LOC.

Once DMS renders a final LOC determination (either initial or upon re-evaluation), the individual is notified of the outcome. Due process is issued and hearing rights are provided in the event of an adverse decision for initial or re-evaluated LOC.

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):*

As specified above, re-evaluations for LOC are conducted at least annually or upon change of condition. Case managers are responsible for tracking upcoming renewal dates and/or noting in a participant's record when a change of condition has occurred requiring a new LOC assessment be administered.

When a participant is found to meet LOC eligibility, the participant's record is updated in the Medicaid Management Information System (MMIS) and the MWMA to indicate a new one year waiver span. Case managers are responsible for making all recertification material available to DMS and DBHDID.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR § 441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR § 92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Copies of evaluations are retained in MWMA until after the participant's termination and then maintained electronically for seven (7) 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:

B1. Number and percent of new KY CHILD waiver participants who had a level of care (LOC) indicating a need for institutional LOC prior to receipt of waiver services. N = Number of LOC determinations made for new KY CHILD participants indicating a need for institutional LOC, prior to receipt of waiver services. D = Total number of new enrollees.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

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 =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. *Sub-assurance: The 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.

Performance Measure:

B2. The number and percent of KY CHILD waiver participants whose reassessment of level of care (LOC) were completed with DMS approved processes and instruments. Numerator: Number of LOC reassessment determinations reviewed that were completed with DMS approved processes and instruments. Denominator: Total number of LOC reassessment determinations reviewed.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

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 =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Add another Data Source for this performance measure

Data Aggregation and Analysis:

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

Performance Measure:

B3. The number and percent of KY CHILD waiver participants whose initial level of care (LOC) determinations were completed with DMS processes and instruments. Numerator: Number of initial LOC determinations that were completed with DMS processes and instruments. Denominator: Number of initial LOC determinations.

Data Source (Select one):

Reports to DMS on delegated administrative functions

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 =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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:

B4. The number and percent of KY CHILD waiver participants whose initial or subsequent LOC was appropriately determined using the CANS and supporting documentation based on criteria outlined in regulation and waiver requirements. N= Number of waiver participants who initial or subsequent LOC was appropriately determined using the CANS and supporting documentation, based on requirements. D= Total number of LOC determinations reviewed.

Data Source (Select one):

Reports to DMS on delegated administrative functions

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 =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Assessment services include a comprehensive initial functional assessment within the appropriate calendar days of receipt of the request for the assessment. DMS and DBHDID will also receive a monthly report of reassessments that were not completed within the appropriate period to allow for identification of issues.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction 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.

DMS and DBHDID address problems as discovered through the generated reports noted above. DMS reviews the reports and provides remediation activities to DBHDID 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:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

⊗ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

All waiver participants are informed of their choice of institutional care or waiver programs and available services by their case manager. This information is provided at the initial person-centered planning meeting and at least annually thereafter. It is electronically captured and retained in MWMA.

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

Freedom of choice information is retained in MWMA until after the participant's termination and then maintained electronically for seven (7) 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 DMS. When DBHDID learns of a participant who needs assistance, staff consult with the participant, case manager and the service provider to determine the type of language translation assistance needed; it may be the provider's responsibility to arrange the services.

All entities serving individuals enrolled on the CHILD waiver are required to comply with Federal standards regarding the provision of language services to improve access to their programs and activities for participants who are limited in their English proficiency. DMS, DBHDID, and all provider serving participants of the CHILD waiver must provide a method of identifying LEP participants and language assistance measures including interpretation and translation, staff training, providing notice to LEP participants, monitoring compliance, and updating procedures. CHFS has established a Language Access Section to assist all CHFS organizational units, including DMS and DBHDID, 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 CHFS units and contractors throughout the State, contracts with a telephone interpretation service for use by CHFS units and contractors when appropriate, provides translation services for essential program forms and documents, establishes policies and procedures applicable to CHFS, and provides technical assistance to CHFS units as needed. Procedures employed by individual departments and units (i.e. DMS and DBHDID) 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; staff training; and monitoring of staff offices and contractors.

Appendix C: Participant Services

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

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

Service Type	Service
Statutory Service	Case Management
Statutory Service	Respite
Other Service	Community Living Supports
Other Service	Environmental and Minor Home Modifications
Statutory Service	Clinical Therapeutic Services
Statutory Service	Supervised Residential Care

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

01 Case Management

Sub-Category 1:

01010 case management

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

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):*

Case management activities include assisting participants in gaining access to waiver services and other needed services through the Medicaid State Plan and other non-Medicaid funded community-based programs to support the participant's home and community-based needs. Case management involves working with the participant, the participant's legal guardian, and/or their authorized representative and others who the participant identifies, such as immediate family member(s), in developing a person-centered service plan (PCSP). Using a person-centered planning process, case managers assist in identifying and implementing support strategies to enable the PCSP to advance the participant's identified goals while meeting assessed community-based needs using waiver and non-waiver funded services. Support strategies incorporate: the principles of empowerment, community inclusion, health and safety assurances, and the use of formal, informal, and community supports. Additionally, it is the expectation that the resultant PCSP identifies applicable unpaid natural supports and provides for transition plans when a child or youth is expected to age out or otherwise transition from the CHILD waiver program.

In accordance with federal requirements, case managers adhere to person-centered principles during all planning, coordination, and monitoring activities. Activities are documented, and plans for support and services are reviewed by the case manager at least annually and more often as needed using the person-centered planning processes described in Appendix D.

Case management activities may include in-person, virtual, telephonic, and other methods of communication (as approved in a participant's PCSP) to provide coordination and oversight to assure the following:

- Conflict-free options counseling to select appropriate services to meet identified needs and HCBS goals, along with education about available HCBS service providers;
- The desires and needs of the participant are determined through a person-centered planning process;
- The development and/or review of the PCSP, including monitoring of the effectiveness of the PCSP to advance person-centered goals and objectives and respond to changes in participant goals and objectives;
- The coordination of multiple services and/or among multiple providers;
- Linking waiver participants to services that support their home and community-based needs, regardless of funding source;
- Monitoring the implementation of the PCSP, participant health and welfare, and corrective action plans (CAPs);
- Addressing problems in service provision;
- Implementing participant crisis mitigation plans and making appropriate referrals to address active or potential crisis, when appropriate;
- Detecting, reporting, and mitigating suspected abuse, neglect, and exploitation of participants, including adherence to mandatory reporter laws, and monitoring the quality of the supports and services;
- Assisting participants in developing and coordinating access to social networks to promote community inclusion as requested by the participant.
- Assess the quality of services, safety of services, and cost-effectiveness of services being provided to a participant to ensure that implementation of the participant's PCSP is successful and done so in a way that is efficient regarding the participant's financial assets and benefits.
- Collaborate with involved MCO care teams on: identifying necessary non-waiver (Medicaid and non-Medicaid funded services) to include in PCSPs, coordinate state plan non-emergency medical transportation, and other activities as required to wholly support the child or youth in the community.

This service may be provided in-person or virtually via telehealth. Telehealth services may be provided under specific circumstances as described in regulation. In-person case management services must be provided whenever possible and in accordance with specifications noted in C-1-d. Participation in services via telehealth should be documented in the PCSP. Participants who are offered telehealth by the provider have the right to request and receive in-person services instead.

DMS will support individuals who need assistance with technology required for telehealth services through the case manager. Case managers will document the use of the identified telehealth technology in the PCSP and when appropriate, will connect participants with trainings.

Case management under the CHILD 1915(c) will not duplicate or supplant targeted case management or care coordination offered under the Medicaid State plan or a child's MCO, respectively. The assigned CHILD case manager holds responsibility for coordinating the provision of care with other involved case management entities who may also be involved in the participant's care.

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

Case management is limited to one billing unit per participant per calendar month but may be authorized in excess of that unit through the exceptional support process as enumerated in Kentucky Administrative Regulations (KAR) [INSERT PLACEHOLDER CHILD KAR NUMBER].

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	Certified Waiver Provider

Provider Category:

Agency

Provider Type:

Certified Waiver Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certifications are granted by DMS or their designee

Other Standard *(specify):*

The agency must meet certified waiver provider qualifications as defined in KAR 7:005 and [INSERT PLACEHOLDER CHILD KAR NUMBER].

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

- Bachelor's degree in Social Work/Human Services or relevant field; OR
- Bachelor's degree in any field not closely related AND one year of human services related experience; OR
- An associate degree in a behavioral science, social science, or a closely relevant field* AND two years human services relevant experience**; OR
- Three years of human services related experience.
- *Relevant fields of study may include:
  - Social Work
  - Psychology
  - Rehabilitation
  - Nursing
  - Counseling
  - Education
  - Gerontology
  - Human Services
  - Sociology
- **Relevant experience may include:
  - Experience as a case manager or in a related human services field
  - Certified Nursing Assistant experience
  - Certified Medical Assistant experience
  - Certified Home Health Aide experience
  - Personal Care Assistant experience
  - Paid professional experience with aging and/or disabled populations or programs as a Case Manager, a Rehabilitation Specialist or Health Specialist, and/or Social Services Coordinator
  - Assessment and care planning experience with clients
  - Experience in working directly with persons with intellectual, developmental, or other types of disabilities or mental illness. Work providing assistance to individuals and groups with issue such as economically disadvantaged, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, inadequate house; OR
  - Be a registered nurse; or
  - Be a licensed practical nurse; or
  - Be a licensed clinical social worker;
  - Be a licensed marriage and family therapist;
  - Be a licensed professional clinical counselor;
  - Be a licensed psychologist; or
  - Be a licensed psychological practitioner.
- Completes DMS-approved, waiver-specific training and is monitored for competency on topics including, but not limited to:
  - Abuse, neglect, exploitation and incident recognition and reporting, root cause analysis, and prevention.
  - Medication administration.
  - Professional boundaries.

- Trauma-informed care.
- Person-centered thinking.
- HCBS settings final rule requirements.
- HCBS access final rule requirements.
- Person-centered planning.
- Telehealth.

- Completes DMS-approved case management training.

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

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

- Is certified in CPR and First Aid.

Verification of Provider Qualifications
Entity Responsible for Verification:

DMS or its designee

Frequency of Verification:

Initially and every two years or more frequently if necessary

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
09 Caregiver Support	09012 respite
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)*:

Respite services are provided to CHILD waiver participants who are unable to independently care for themselves. Respite services are provided on a short-term basis due to the absence of or need for relief of the primary caregiver. Respite may be provided in a variety of settings including the participant's own home, a private residence or other CHILD certified residential setting.

Receipt of respite care does not preclude a participant from receiving other services on the same day. For example, a child or youth may receive Supported Community Living on the same day as he/she receives respite care as long as the services are not provided at the same time.

A provider may not use another person's bedroom or another person's belongings to provide respite for a different

person. Respite care may not be furnished for the purpose of compensating relief or substitute staff for a Supervised Residential Care agency staff member. The costs of such staff are met from payments for Supervised Residential Care service.

Respite provided under the CHILD waiver may not supplant educational services available under the IDEA (20 U.S.C. 1401 et seq.). Respite services made available through the CHILD waiver may not supplant or duplicate like services available under the Kentucky Medicaid state plan.

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

The following limitations apply to the Respite service as provided under the CHILD waiver:

- Unit of service: 15 minutes
- Limited to 830 hours per waiver eligibility span, unless otherwise approved through the established exceptional review process as enumerated in KAR [INSERT PLACEHOLDER CHILD KAR NUMBER].
- Children and youth currently authorized and receiving Supervised Residential Care may not receive respite services.
- Respite will not be authorized for children and youth during school hours.

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	Certified Waiver Provider

Provider Category:

Agency

Provider Type:

Certified Waiver Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

DMS or its designee

Other Standard *(specify):*

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

- Be at least eighteen (18) years of age.
- Complete DMS-approved, waiver-specific training and is monitored for competency on topics including, but not limited to:
    - Abuse, neglect, exploitation and incident recognition and reporting, root cause analysis, and prevention.
    - Medication administration.
    - Professional boundaries.
    - Trauma-informed care.
    - Person-centered thinking.
    - HCBS settings final rule requirements.
    - HCBS access final rule requirements.
    - Person-centered planning.
    - Telehealth.
- Has the ability to:
    - Communicate effectively with a participant and the participant's family.
    - Read, understand, and implement written and oral instructions.
    - Perform required documentation.
    - Participate as a member of the participant's person-centered team if requested by the participant.
    - Demonstrate competence and knowledge of topics required to safely support the participant as described in the PCSP.
- Undergoes pre-employment screenings
- Is certified in CPR and First Aid.
- If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable State laws while operating the vehicle.

Verification of Provider Qualifications

Entity Responsible for Verification:

DMS or its designee

Frequency of Verification:

Initially and every two 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

Service:

Community Living Supports

Alternate Service Title (if any):

Personal Care

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
08 Home-Based Services	08030 personal care
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):*

Community Living Support (also referred to as Personal Care) assists enrolled children and youth with age appropriate-tasks that would otherwise be accomplished but for the participant's disability. Community Living Supports are intended to provide direct one-on-one assistance (including hands-on assistance, reminders, cueing, observation, and training) while facilitating independence and promoting integration into the community. Community Living Supports are based upon therapeutic goals, are not diversional in nature, and are not to replace other work or day activities.

Community Living Supports includes assistance, support (including reminding, observing, and/or guiding), and/or training in activities such as:

- Activities of daily living (ADLs) such as bathing, eating, dressing, toileting, transferring.
- Instrumental activities of daily living (IADLs) such as shopping; money management, meal preparation or light housework.

- Medication monitoring.
- Non-medical care not requiring nurse or physician intervention.

Community Living Supports also include socialization, relationship building, leisure choice and participation in generic community activities. This service may take place in an individual's home or the community, based on the child or youth's assessed needs and in accordance with the approved PCSP.

Community Living Supports may only be authorized for children/youth who are not currently authorized and receiving Supervised Residential Care, unless the conditions noted in the limitations section of this service are otherwise met. Community Living Supports will also not be authorized during school hours.

Providers of Community Living Supports are limited to DMS-approved agency or independent providers. Legally responsible individuals, relatives (as defined in 922 KAR 2:160), and guardians are prohibited from becoming providers of community living supports for their child, relative, or ward.

Community Living Supports is not available when medically necessary personal care is covered by EPSDT. Community Living Supports are limited to additional services intended to avoid institutionalization that are not otherwise covered under the Kentucky Medicaid State plan, including EPSDT. Community Living Supports may not supplant education services available under the IDEA (20 U.S.C. 1401 et seq.).

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

Community Living Supports is limited to 448 15-minute units (112 hours) per week, with no more than 16 hours per day delivered, unless otherwise approved through the established exceptional review process as enumerated in Kentucky KAR [INSERT PLACEHOLDER CHILD KAR NUMBER].

- Community Living Supports will not be authorized for children or youth who are currently authorized and receiving Supervised Residential Care, unless the child or youth's person-centered service plan includes documented evidence that the individual and their support system are reintegrating the individual back to their family (including foster parent's) residential home. In this scenario:
  - Community Living Supports authorizations are limited to no more than a total of 80, 15-minute units (20 hours) per week when the participant is temporarily residing with their family (including foster parents).
  - Authorization of Community Living Supports will expire if the child or youth is no longer actively working towards reintegration into the family or foster parent's residential home.
  - Additional hours of Community Living Supports may be authorized if the child or youth successfully reintegrates with their family (including foster family) and the authorization of supervised residential supports expires.
- Community Living Supports will not be authorized for any child or youth during school hours.

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	Certified Waiver Provider

Provider Category:

Agency

Provider Type:

Certified Waiver Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified by DMS or its designee

Other Standard *(specify):*

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

- Be at least eighteen (18) years of age.
- Complete DMS-approved, waiver-specific training and is monitored for competency on topics including, but not limited to:
  - Abuse, neglect, exploitation and incident recognition and reporting, root cause analysis, and prevention.
  - Medication administration.
  - Professional boundaries.
  - Trauma-informed care.
  - Person-centered thinking.
  - HCBS settings final rule requirements.
  - HCBS access final rule requirements.
  - Person-centered planning.
  - Telehealth.
- Has the ability to:
  - Communicate effectively with a participant and the participant's family.
  - Read, understand, and implement written and oral instructions.
  - Perform required documentation.
  - Participate as a member of the participant's person-centered team if requested by the participant.
  - Demonstrate competence and knowledge of topics required to safely support the participant as

described in the PCSP.

- Undergoes pre-employment screenings
- Is certified in CPR and First Aid.
- If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable State laws while operating the vehicle.

Verification of Provider Qualifications

Entity Responsible for Verification:

DMS or its designee

Frequency of Verification:

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

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

Service:

Environmental and Minor Home Modifications

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
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):*

Environmental and Minor Home Modifications are any necessary adaptations to a private or family residence required to ensure the child or youth's health, welfare, and safety. Environmental and Minor Home Modifications must be delineated in the PCSP and may include adaptations to the home such as:

- Installation of ramps and grab-bars.
- Wheelchair accessibility modifications including widening of doorways, lowering of counters/cabinets, and modification of bathroom facilities.
- Installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual.

Certain adaptations or improvements to the home shall exclude those that are not of direct medical or remedial benefit to the waiver individual, which may include carpeting, painting, roof repairs, etc. Approval from DMS is required for requested items not delineated above when a clinician overseeing the child or youth's care provides documentation of the medical need.

Environmental and Minor Home Modifications may be authorized up to 180 consecutive days of admissions in advance of a child or youth transitioning from a PRTF or an ICF/IID to a family, guardian, or foster care home. Environmental and Minor Home Modifications may not be reimbursed by DMS until the date a child or youth is enrolled in the waiver following discharge from the institution.

Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g. to improve ingress/egress to a residence or to configure a bathroom to accommodate a wheelchair.

Environmental and Minor Home Modifications may be approved for children and youth living in a family, guardian, or foster care home. Children and youth who are residing in a Supervised Residential Care setting may not be authorized Environmental and Minor Home Modifications.

Environmental and Minor Home Modifications are limited to additional services intended to avoid institutionalization that are not otherwise covered under the Kentucky Medicaid state plan, including EPSDT.

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

Environmental and Minor Home Modifications have a CHILD waiver lifetime cost limit of $9,680, unless otherwise approved through the established exceptional review process as enumerated in KAR [INSERT PLACEHOLDER CHILD KAR NUMBER].

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	Certified Waiver Provider

Provider Category:

Agency

Provider Type:

Certified Waiver Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified by DMS or its designee

Other Standard *(specify):*

Home Modification providers must have an applicable business license, insurance, and meet applicable building codes; DBHDID Contract

Verification of Provider Qualifications

Entity Responsible for Verification:

DBHDID

Frequency of Verification:

Prior to contract approval or renewal; as needed based on service monitoring concerns

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Clinical Therapeutic Services

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
10 Other Mental Health and Behavioral Services	10040 behavior support
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09020 caregiver counseling and/or training
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):*

Clinical Therapeutic Services is approved, based on assessed needs, to support children, youth, and their families in understanding, mitigating, and providing long term solutions for behavior challenges. This service is designed to provide family crisis prevention and stabilization supports to the waiver enrolled child or youth, primary caregiver, family (including foster care families). Additionally, Clinical Therapeutic Services may be used to support other waiver providers, with the exception of those providing Environmental and Minor Home Modifications, working with a child or youth on the types of prevention and stabilization techniques best suited to the child's needs. Activities provided through Clinical Therapeutic Services to achieve the service's intended outcomes include:

- Identification of behavioral triggers through review of the CANS assessment and other clinical/therapeutic

documentation to identify behavioral triggers that may lead to crisis situations and/or escalated negative behaviors.

- Training for primary caregivers in trauma-informed methods for preventing crisis; mitigation and support techniques for when crises occur, and implementation of positive coping strategies to directly address crisis and/or negative behavior escalation.
- Development and incorporation of individualized wraparound support plans within a PCSP, as informed by the CANS and other clinical/therapeutic documentation to prevent crisis and/or escalated negative behaviors.
- Parental and family support (e.g. family-to-family networking).
- Assistance to the child or youth in the acquisition, retainment, or improvement of age-appropriate behavior and social skills necessary to help avoid institutionalization. Assistance may take the form of training the youth, family, and/or provider in stabilization techniques, working with the individual, family, and/or provider to identify triggers and developing person-centered approaches for preventing behavioral crisis prior to occurrence, and assistance to the waiver enrolled individual in acquiring, retaining, and improving areas of self-help and socialization.

Additional activities that may occur in situations in which a child or youth is "stepping" down from institutional care or is otherwise transitioning between residential settings may include:

- Support for establishing or re-establishing the child or youth in a family home, foster home, or other community-based residential setting, such as development of schedules, practices, and expectations within the new setting.
- Implementation of specialized behavior management techniques focused on mitigating disruptions resulting from the transition.
- Other activities as deemed appropriate by the child or youth's family, foster, family and broader care team to effectively mitigate the impacts of transitions out of and between institutional or residential settings.

This service will be provided in the home of a relative (as defined in 922 KAR 2:160), guardian, or foster care family and/or in the community.

The appropriate staffing ratio is determined based on assessed needs and unique circumstances of the individual and family with input from the individual's case manager.

Clinical Therapeutic Services is limited to additional services intended to avoid institutionalization that are not otherwise covered under the Kentucky Medicaid state plan, including EPSDT.

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

Clinical Therapeutic Services is initially limited to 160 units per year, unless otherwise approved through the established exceptional review process as enumerated in KAR [INSERT PLACEHOLDER CHILD KAR NUMBER].

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	Certified Waiver Provider

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Clinical Therapeutic Services

Provider Category:

Agency

Provider Type:

Certified Waiver Provider

Provider Qualifications

License *(specify):*

Certificate *(specify)*

Certified by DMS or its designee.

Other Standard *(specify) :*

The agency must meet certified waiver provider qualifications as defined in 907 KAR 7:005 and [INSERT PLACEHOLDER CHILD KAR NUMBER].

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

- Individuals providing Clinical Therapeutic Services must be one of the following:
  - Certified psychologist as defined in 201 KAR Chapter 26;
  - Certified psychologist with autonomous functioning as defined in KRS 319.056;
  - Certified school psychologist as defined in 16 KAR 2:090;
  - Licensed behavior analyst as defined in KRS 319C.010
  - Licensed psychological practitioner as defined in KRS 319.053;
  - Licensed clinical social worker as defined in KRS 335.100;
  - Licensed marriage and family therapist as defined in KRS 335.300(2);
  - Licensed professional clinical counselor as defined in KRS 335.500(3);
  - Licensed psychological associate in accordance with KRS 319.010(6), and 201 KAR Chapter 26; or
  - Licensed psychologist as defined in KRA 319.010(6) and 201 KAR Chapter 206
- Completes DMS-approved, waiver-specific training and is monitored for competency on topics including, but not limited to:

- Abuse, neglect, exploitation and incident recognition and reporting, root cause analysis and prevention.
- Medication administration.
- Professional boundaries.
- Trauma-informed care.
- Person-centered thinking.
- HCBS settings final rule requirements.
- HCBS access final rule requirements.
- Person-centered planning.
- Professional boundaries.
- Telehealth.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DMS or designee

Frequency of Verification:

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

C-1/C-3: Service Specification

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

Service Type: Statutory

Service: Supervised Residential Care

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1: 02 Round-the-Clock Services	**Sub-Category 1:** 02011 group living, residential habilitation
Category 2:	**Sub-Category 2:**
02 Round-the-Clock Services	02012 group living, mental health services
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)*:

Supervised Residential Care is targeted to children and youth who require 24-hour intense residential services and the supports provided in a Supervised Residential Care setting are individually tailored to assist with the acquisition, retention, or improvement in skills related to living in the community. Supervised Residential Care is intended to support children or youth who:

- Are discharged from a PRTF or ICF/IID but are not yet able to return back to their family, guardian, or foster care residence. OR
- Is unable to be cared for within their family, guardian, or foster care residence due to high-risk behaviors and/or complex medical conditions, but do not wish to receive services in an appropriate institutional setting. OR
- Currently are unhoused as a result of their disability and care needs and are unable to access appropriate community-based supports through another funding source.

These supports include adaptive skill development, assistance with activities of daily living, community inclusion, and social and leisure skill development to assist the child or youth to reside in the most integrated setting appropriate to his/her needs. The supports required for each participant will be outlined in their PCSP, which includes a Crisis

Prevention Plan. Supervised Residential Care services also include protective oversight and supervision, transportation, personal assistance and the provision of medical and health care services that are integral to meeting the daily needs of residents.

Supervised Residential Care settings are limited to serving no more than three participants at any given time. To the extent feasible, Supervised Residential Care settings will not serve children or youth who are not enrolled on the CHILD waiver or for whom there is an age difference of plus or minus (+/-) five years in age between the oldest and youngest resident (unless the children are siblings); all efforts will be given to provide children and youth with alternative setting choices in which there is not a +/- five year age difference between residents. Additionally, case managers are required to place children and youth in Supervised Residential Care settings that will limit the presentation or risk of problematic behaviors in individuals placed at the setting. This will be accomplished through case manager review of individual PCSPs and health risk screening results, prior to placement.

The agency providing Supervised Residential Care is responsible to arrange for or provide transportation to:

- A family, guardian, or foster care home.
- School (when applicable).
- A place of employment (when applicable).
- Other community locations when the provision of managed care-covered transportation is unavailable.

Supervised Residential Care may include the provision of up to five (5) unsupervised hours per day per child or youth who are at least fourteen (14) years of age as identified in the PCSP. Unsupervised hours are intended to promote increased independence are based on the individual needs of a child or youth as determined with the person-centered team and reflected in the PCSP. Those who cannot safely be unsupervised would not be unsupervised. For each child or youth approved for any unsupervised time, a safety plan will be created based upon their assessed needs. The case manager, as well as other team members, will ensure the child or youth is able to implement the safety plan. On-going monitoring of the safety plan, procedures or assistive devices required would be conducted by the case manager to ensure relevance, ability to implement and functionality of devices if required.

If a child or youth experiences a change in support needs or status, adjustments in Supervised Residential Services shall be made to meet the support needs. If changes are anticipated to be chronic (lasting more than 3 months), the Supervised Residential Care provider may request reassessment to determine if needs have changed. Any increase in funding based on assessed needs shall be used for provision of additional supports as outlined in a revised PCSP.

Cameras are prohibited in bedrooms and bathrooms. Provider-owned or leased residences where Supervised Residential Care services are furnished must be compliant with the Americans with Disabilities Act based on the needs of the persons supported.

Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. The method by which the costs of room and board are excluded from payment for Supervised Residential Services is specified in Appendix J. Supervised Residential Services are furnished in a provider-owned residence with variable rates based on three or fewer persons in the residence; versus four or more persons in the residence.

Children and youth authorized and receiving Supervised Residential Care may not be authorized to receive Respite, Community Living Supports, or Environmental and Minor Home Modifications, unless otherwise noted in the service definitions and limitations of these other CHILD waiver services.

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

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Supervised Residential Care is limited to one (1) unit per participant per calendar day.

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	Certified Waiver Provider

Provider Category: Agency

Provider Type: Certified Waiver Provider

Provider Qualifications

License *(specify):*

By OIG 902 KAR 20:078

Certificate *(specify):*

Certified by DMS or its designee

Other Standard *(specify):*

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

- Be at least eighteen (18) years of age; and
- Complete Department-approved, waiver-specific training and is monitored for competency on topics including, but not limited to:
  - Abuse, neglect, exploitation and incident recognition and reporting, root cause analysis, and prevention.
  - Medication administration.
  - Professional boundaries.
  - Trauma-informed care.
  - Person-centered thinking.
  - HCBS settings final rule requirements.
  - HCBS access final rule requirements.
  - Person-centered planning.
  - Professional boundaries.
  - Telehealth.
- Has the ability to:

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

Verification of Provider Qualifications Entity Responsible for Verification: DMS or its designee

Frequency of Verification: Initially and every two (2) years or more frequently if necessary

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

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

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

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

Check each that applies:

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

☐ **As a Medicaid state plan service under 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 functions are carried out by providers certified for provision of the CHILD waiver services.

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.

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:

   Case management and Clinical Therapeutic Services are the only CHILD waiver service approved to be delivered through an approved telehealth method. Certified waiver providers who employ remote service delivery will ensure that conversations with the child and youth and their support team take place in an area that is separate from other case management operations to afford privacy and that the telehealth methods used will comport with all HIPAA requirements.

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

   Remote Case management and Clinical Therapeutic Services delivery will be allowed in an effort to improve adapting to individual lifestyle choices within the community. Remote delivery allows for flexibility and opportunities to better engage children and youth in their care planning.

   Case management and Clinical Therapeutic Services delivered through telehealth is limited to only those CHILD waiver participants for whom remote case management is authorized in their PCSP. In-person Case management and Clinical Therapeutic Services must be provided whenever possible.

☒ 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:

Case management and Clinical Therapeutic Services delivered through telehealth are limited to only those CHILD waiver participants for whom remote service delivery is authorized in their PCSP.

In-person case management must be provided whenever possible.

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

It is the responsibility of a child or youth's assigned case manager to ensure appropriate education and supports are in place for an individual prior to authorization of remote services. Education and any specialized adaptive equipment needed for an individual to participate in remote service delivery must be noted in the PCSP.

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

Allowing Case management and Clinical Therapeutic Services to be delivered remotely helps to improve the safety and health of children and youth who otherwise have difficulty participating in group conversations due to their disability. By engaging children and youth in case management and Clinical Therapeutic Services through remote technologies, DBHDID and DMS are allowing additional opportunities for children and youth to participate in care planning and engage meaningfully in community-based services.

Should a child or youth be found to need additional supports as a result of their disability, DBHDID and the assigned case manager will determine if remote service delivery is best meeting the needs of the individual. A discussion will occur with the child, youth, and their support team to review the appropriateness of remote services in these instances.

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):

All providers who have contact with participants are required to undergo a background investigation at hiring and then repeated as appropriate. Kentucky offers employers two options for conducting pre-employment background investigations.

1. The Kentucky Applicant Registry and Employment Screening (KARES) system, 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).

2. If KARES is not used, pre-employment background investigations must be conducted using all five (5) of the following:
    a. 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.
    b. Kentucky Child Abuse and Neglect (CAN) Registry operated by CHFS and an equivalent out-of-state agency if the individual resided or worked outside of Kentucky during the twelve (12) months prior to employment.
    c. Caregiver Misconduct Registry operated by CHFS.
    d. Nurse Aide Abuse Registry operated by the Kentucky Board of Nursing.
    e. Sex Offender Registry maintained by the Kentucky State Police.

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.

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

1. A prior conviction for an offense as described in KRS 17.165(1) through (3).
2. A prior felony conviction.
3. A conviction of trafficking, manufacturing, or possessing an illegal drug during the past five years.
4. A conviction for abuse, neglect, or exploitation (ANE) as defined in Appendix G.
5. Has substantiated finding of abuse, neglect or exploitation through adult protective services (APS) or child protective services (CPS).
6. Has a prior substantiated case of Medicaid fraud by the Office of Medicaid Fraud and Abuse Control, OIG, or Office of Attorney General (OAG) or Medicare fraud.
7. A registered sex offender.
8. Employees who have a driving under the influence conviction, amended plea bargain, or diversion in the past year shall not transport participants.

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

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

○ **No. The state does not conduct abuse registry screening.**

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

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; (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 agency employees who have 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 KSP and 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) (CAN)

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 confirming within the KARES system that 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. 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 CAN Registry operated by the CHFS 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 CHFS.
4. Nurse Aide Abuse Registry operated by the Kentucky Board of Nursing.
5. Sex Offender Registry maintained by the Kentucky State Police.

For traditional service providers who conduct screenings using the AOC, CAN, Caregiver Misconduct Registry, and Sex Offender Registry, the agency must randomly check 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. DMS reviews the findings of this check upon recertification of the provider and at provider billing reviews.

Appendix C: Participant Services

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

Note: Required information from this page (Appendix C-2-c) 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 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 qualified individual or entity who meets the requirements and agrees to the provider terms and conditions. A potential provider may contact a CHFS provider enrollment staff through a toll-free phone number, complete the application process, and obtain an agency license or certification as required. Provider enrollment forms are also accessible through Internet web access.

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:

C1: Number and percent of new providers that meet initial certification, licensure requirements and adhere to other standards prior to the furnishing of waiver services. N=Number of new providers who meet initial certification, licensure requirements and adhere to other standards prior to furnishing services. D=Number of new providers

Data Source (Select one):

Other

If 'Other' is selected, specify:

Combination of on-site interviews, observations, monitoring, desk review of 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 =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:

C2: Number and percent of enrolled providers who continue to meet certification and licensure requirements and adhere to other standards following initial enrollment as required to continue to render waiver services. N=Number of enrolled providers who continue to meet certification and licensure requirements and adhere to other standards following initial enrollment as required to continue to render waiver services D=Number of enrolled providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

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

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

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

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

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

Performance Measure:

C3: Number and percent of non-licensed/non-certified waiver providers who meet other provider standards as specified in the CHILD waiver application. N= Number of non-licensed/non-certified waiver providers who meet other provider standards as specified in the CHILD waiver application. D= Total number of non-licensed/non-certified CHILD waiver providers.

Data Source (Select one):
Onsite desk reviews

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 =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

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):*
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

c. ***Sub-Assurance: The state implements is 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:

C4: Number and percent of providers in which at least 90% of staff have successfully completed mandatory training in accordance with state requirements and the approved waiver N=Number of providers in which at least 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:

Combination of desk review of records compared to required trainings, onsite interviews, observations, and monitoring.

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:	

Add another data source for this performance measure

Data Aggregation and Analysis:

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

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.

CHFS verifies that 100% of all CHILD waiver providers are qualified and certified (as specified herein) prior to rendering services. Providers who have completed the CHILD new provider training/certification process are eligible to become Medicaid providers. Through the DBHDID, CHILD providers are recertified at least every two years. All State policy and procedure updates, additions, and/or changes are communicated through provider notifications, MWMA, the DMS website and/or DBHDID website.

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.

DBHDID performs trainings upon request of providers and provides technical assistance whenever requested. Should an enrolled provider no longer meet requirements to provide services, DBHDID as the certifying agency will recommend DMS terminate the 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):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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.'

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.

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.*)

Children and youth enrolled on the CHILD waiver may reside in any of the following setting types:

- A setting licensed and certified as Supervised Residential Care location.
- Privately-owned or leased family, guardian, or foster care homes.
- Residences owned or leased by a youth (e.g. a youth who is aged 20 may live alone or with a roommate in a privately-owned or leased residence).

Private residences include licensed foster homes that are family-based settings.

2. Description of the means by which the state Medicaid agency ascertains that all settings in which HCBS are received meet federal HCB settings 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.*)

CHFS has determined that the residential settings in which CHILD waiver services may be provisioned are compliant with requirements in 42 CFR 441.301(c)(4)-(5). Privately-owned or leased residences inherently meet HCBS settings requirements; all licensed and certified Supervised Residential Care providers are either found to already meet HCBS settings requirements because they provision HCBS other approved Kentucky 1915(c) waivers, or CHFS determines compliance prior to the provisioning of services.

All settings are confirmed to:

- Be integrated into and provide access to the greater community.
- selected by the individual among options.
- ensures individual rights of privacy/dignity/respect/freedom from coercion and restraint.
- Optimize autonomy and independence; and facilitate service and provider choice.

DMS confirms that all allowable settings meet federal settings requirements through provider certification, which includes site visits and occurs at least every two years.

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*).

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:***

Case management shall be conflict-free. Conflict-free case management requires that a provider who renders case management to the participant must not also provide another waiver service to that same participant unless the case manager is the only willing and qualified provider in the geographical area thirty (30) miles from the participant's residence. Participants may request an exception to this based on a lack of qualified

case managers in remote areas of the state. DMS will ensure that each participant who chooses a case manager who could be conflicted will be free from undue influence when selecting a service provider.

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

1. Documentation, including denials from the referred agencies indicating they are not accepting the participant, showing that there are no willing case managers within thirty (30) miles of the participant's home.
2. Documentation of conflict-of-interest protections.
3. An explanation of how case management and service advisor functions are separated within the same entity.
4. Demonstration of the availability of a clear and accessible dispute resolution process that advocates for participants within a service or case management entity.

DMS or its designee will review the request for a conflict-free exemption. Exemptions for conflict free case management shall be requested initially and upon reassessment or at least annually.

Reviewers will use the DMS-approved process to verify there are no willing case managers within thirty (30) miles of the participant's residence.

The following safeguards are instituted to assure participant choice:

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

If the exemption requested via the Department-approved form is denied, the PCSP will be returned to the case manager via MWMA and the participant will be notified by letter. Participants are provided with a clear and accessible informal reconsideration process in cases when adverse decisions result from missing or inadequate documentation related to the initial request for exemption. The participant may also dispute the state's determination that there is not another entity or individual that is not that participant's provider to develop the PCSP through a clear and accessible alternative dispute resolution process.

(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.

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

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

1. Is collaboratively developed by:
2. A waiver participant and a waiver participant's legal guardian or authorized representative, if applicable.
3. The case manager.
4. The participant's person-centered team, which is comprised of representatives from each waiver, state plan or other provider entity who provides services and/or supports for the participant.
5. Any other person identified by the waiver participant, legal guardian, or their authorized representative.

B. Uses a process that:

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

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

D. All individuals participating in the development and execution of the PCSP, including participants, any legal guardian/authorized representatives, the CM, and all providers responsible for implementing services, must sign the PCSP to indicate their involvement and understanding of the plan's contents. The signatures will be recorded on the Department-approved form, uploaded to, and housed in the MWMA. The signatures should not be obtained until the person-centered planning process and the PCSP are complete.

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 child/youth advises the CHILD participant and the participant's legal guardian and/or authorized representative, if applicable, that they must select a case manager to initiate service planning prior to receipt of services. The enrollment notice contains instructions on how to access information on case management agencies so that the participant may initiate contact and selection of a case manager. Once a case manager is selected, they must associate themselves in MWMA. The participant's PCSP is developed utilizing completed assessments and screenings, including the CANS and other medical and behavioral assessments as applicable.

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

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

   Once the person-centered planning team is confirmed, the case manager completes the primary activities:

   a. The team collectively reviews the findings of the child/youth's 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 for all services on the PCSP must be:

i. Stated Clearly: The goal or objective should be understandable to the participant and in his/her own words. Additionally, if a participant is receiving a service to improve upon current skills or acquire new skills, the goal and objectives must also be: Measurable: There should be markers of progress toward achieving a goal or objective that can be identified and quantified.

ii. 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.

iii. 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 case manager will provide detailed information to participants about available non-waiver services that may assist in reaching their goals and objectives. Goals and objectives must be documented, along with an inventory of a participant's personal preferences, individualized considerations for service delivery (i.e., how to bathe, what preferred activities the participant might wish to partake, desired schedule for services, etc.), as well as information about the participant's needs, wants, and future aspirations. The results of this conversation are to be included in the PCSP, which is housed in MWMA. It must be signed by the participant and the participant's legal guardian or authorized representative, if applicable.

The case manager, and all other individuals responsible for the implementation of services 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 case manager is required to provide 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 child/youth and the participant's legal guardian or authorized representative, if applicable, selects providers to deliver services pursuant to the frequency and amount, the case manager 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 case manager is responsible to ensure that the scope, frequency, amount and duration of services falls within the allowable utilization criteria and limitations set by DMS, including those documented in Appendix C and clearly document any planned changes in utilization anticipated over the course of the year (i.e. anticipated change in utilization while a participant under the age of 18 is out of school for the summer, anticipated increases due to anticipated changes in caregiver availability, etc.).

c. The case manager 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 case manager, and all 1915(c) waiver funded service providers delivering PCSP included services, services may be initiated. The signatures should not be obtained until the person-centered planning process and the PCSP are complete.

a. Services rendered prior to signed attestation of understanding of the contents of the PCSP by

these parties will not be reimbursed.

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

B. **Initial Development of the Person-Centered Service Plan (for a new participant's first PCSP):** Once the assessment is complete and the participant chooses a case manager, the participant and the participant's legal guardian and/or authorized representative, if applicable, begins the process of developing the PCSP with the case manager's assistance. Upon acceptance of a new participant, the case manager must conduct an initial in-person visit to begin the person-centered planning process. Person-centered service planning and development of the PCSP should follow the steps described under "**A. Process for Developing a Person-Centered Service Plan**" in this section.

C. **Annual PCSP Redetermination.** A participant's PCSP is recertified on an annual basis. Prior to review and modification of the PCSP, the following activities must occur:

a. The case manager is encouraged to co-attend and review the annual assessment, which is housed in MWMA.

b. Should a case manager choose to attend the functional assessment, they are expected to support the participant in answering questions and not answer questions on his/her behalf or influence the participant's response or lack of response. The assessor is not to use information provided by a case manager 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, pending the completed LOC evaluation.

The PCSP must be completed and uploaded to MWMA seven (7) calendar days prior to the end of the current LOC period. The LOC period is defined as the period spanning 364 calendar days from the date a participant is allocated a waiver slot in MWMA. Person-centered service planning and development of the PCSP should follow the steps described under "**A. PCSP Development Process for a New Participant**" in this section.

D. **Event-Based Modification of the PCSP**. 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. Additionally, throughout the course of plan monitoring, the case manager is responsible for addressing instances when a modification to the PCSP may be appropriate. The case manager may not initiate any modification to the PCSP without the consent of the participant and the participant's legal guardian or authorized representative, if applicable. The service providers affected by an event-based modification to the PCSP must be involved in the process as well.

Certain modifications or event-based circumstances may require the team to make necessary adjustments to the participant's PCSP. These include:

a. Inpatient admission to an institutional care setting with changes at discharge in functional ability from previous assessment including decreased functional ability in one or more activities of daily living or decreased functional ability in three (3) or more instrumental activities of daily living.

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

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

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

The updated PCSP must be signed by the participant and the participant's legal guardian or authorized representative, if applicable, the case manager and any new service providers or providers for whom the scope, amount, or duration of service has been adjusted from what was previously consented to or for whom services have been impacted. The signatures should not be obtained until the person-centered planning process and the PCSP are complete. The modified PCSP will remain in effect until the end of the

participant's original LOC year. The modified PCSP does not eliminate the need for a participant's annual PCSP redetermination. All providers delivering services will be notified via MWMA when a participant's PCSP has changed and will be responsible to review changes and work with the participant's case manager 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.

Potential risks to the participant are identified during the completion of the CANS and other screenings/assessments as applicable. All health, safety and welfare risks are required to be identified and addressed in the person-centered planning meeting and on the PCSP. Providers are required to have agency emergency plans and person specific crisis and safety issues incorporated into their person-centered service plan.

The case manager will assess the participant's individual risks by reviewing the participant's assessment, any critical incident reports, the participant's behavior support plan (if applicable), and through discussion with the person-centered planning team.

When applicable, the following should be documented in MWMA:

1. Medical diagnoses that may require emergency intervention.

2. Behaviors that could harm the participant's health, safety, and welfare or harm the health, safety, and welfare of others.
3. Emergency backups for paid caregivers who do not show up.
4. Any other identified or observable risks that could adversely affect the environment, health, safety, and welfare of the participant or pose a risk of harm to service providers.

Children and youth with legal decision-making authority have the right to accept risks. The participant's case manager 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 child or youth, individuals with whom the participant resides, and those who interact with the participant in order to deliver the PCSP.

A participant's case manager 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 child or youth refuses to engage in risk mitigation strategies and accepts risks, the case manager is responsible to assess the child or youth's understanding of risks and potential consequences. The case manager is responsible for educating the participant when risks impede the ability of providers to deliver services safely and effectively, which is a violation of a participant's signed rights and responsibilities form and must make participants aware of disruption or loss of services due to ongoing risks that are not mitigated. The case manager must proceed in this manner with any participants with an appointed legal guardian or authorized representative with decision-making authority. If concern exists that a child or youth may not demonstrate understanding of risk and consequence, the case manager 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 case manager 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 case manager 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. 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.

A child or youth's case manager is required to provide information about available services including, but not limited to:

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

The participant's case manager is responsible for notification of available waiver service providers. The case manager is responsible for assisting the child or youth 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 of web-based provider profiles.

Case managers are trained by DBHDID to respond to child, youth, or family/guardian/foster care parent inquiries regarding choice of provider in a manner that avoids conflict of interest and/or conveys personal, subjective

opinion. The case manager will ensure, on an individual basis, that participants who have a conflicted case manager due to their geographic location, and have been approved to do so, will be free from undue influence regarding choice of providers and will document those efforts in case records housed in MWMA.

All CHILD waiver participants are ensured freedom of choice as defined by:

- The experience of independence, individual initiative, or autonomy in making life choices, both in small everyday matters (what to eat or what to wear), and in large, life-defining matters (where and with whom to live and work).
- The service, provider and setting are selected by the child or youth from among setting options including non-disability specific settings.
- The individual must be provided with the choice of where to live with as much independence as possible, and in the most community-integrated environment.
- The setting options are identified and documented in the person-centered service plan and are based on the individual's needs and preferences, and, for residential settings, resources available for room and board.

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, the case manager is responsible for submitting the PCSP through MWMA for review and service authorization. Service authorization shall not be issued without appropriate review and approval.

Once the complete PCSP is submitted, it will undergo system checks and, if indicated, it will be reviewed by DMS. DMS reviews a sample of all PCSPs for each agency are reviewed during the certification review.

If the PCSP is approved, the participant will receive a letter in the mail. A copy of the notification is also available in MWMA. If the determination results in an adverse decision, the participant will receive an adverse decision notice, which explains what was denied, the reason for denial, and their right to an informal reconsideration and a fair hearing, via certified mail. The case manager is responsible for notifying providers of approval or denial of the completed PCSP via MWMA.

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 MWMA until after the participant's termination and then maintained electronically for seven (7) 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 case manager is responsible for the coordination and monitoring of all CHILD enrolled participant's waiver services included in the PCSP and will assist in identifying and connecting the participant with non-waiver services, including monitoring back-up plan effectiveness.

The case manager shall conduct one visit with the participant each calendar month – at least one (1) in-person visit every other month must be conducted; remote service delivery may be approved in a child/youth's PCSP as described in Appendix C of this waiver application. Additionally, at least quarterly, there will be one in-person visit at the participant's residence. In-person visits must include input from the enrolled child/youth and may include input from others such as the participant's providers, legal guardian, or authorized representative, if applicable, or other natural supports.

For participants with communication barriers, the case manager must take steps to ensure the conversation is conducted in a way that is accessible to the participant. This may include arranging for an interpreter or a communication device.

All case management contact must include discussions about:

- Progress in meeting 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 services.
- Any concerns with health, safety, and welfare, and/or risk mitigation needs.
- 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 case manager is also responsible for using professional judgment in screening for evidence of possible abuse, neglect, or exploitation, and/or the possibility of an unreported critical incident. The participant's case manager must report all suspected critical incidents, including abuse, neglect, and exploitation concerns as defined in Appendix G.

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

b. Monitoring Safeguards. 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 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*).**

The state has established the following safeguards to ensure that monitoring by the waiver service provider (who is also the only willing and qualified entity within the geographic area) is conducted in the best interests of the participant:

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

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

(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 and community integration 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:

D1. Number and 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 service plans reviewed.

Data Source (Select one):

Record reviews, off-site

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 = 95% confidence interval with a +/- 5% margin of error

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):*
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:

D2. Number and percent of service plans with goals and objectives that address the assessed individual's goals N = Number of service plans with goals and objectives that address the assessed individual's goals. D = Number of reviewed service plans.

Data Source (Select one):

Record reviews, off-site

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 = 95% confidence interval with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance:*** 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.

Performance Measure:

D3. Number and percent of participants whose service plans were updated and submitted within one year of their initial or last assessment. N= Number of participants whose service plans were updated and submitted within one year of their initial or last assessment D= Number of participants with approved plans.

Data Source (Select one):

Record reviews, off-site

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**
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:

D4. Number and percent of participants with a modification to the person-centered service plan due to an identified change in service needs. N=Number of participants with a modification to the person-centered service plan due to an identified change in service needs D= number of participants with an identified change in service needs that were reviewed.

Data Source (Select one):

Record reviews, off-site

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 = 95% confidence interval with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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:

D5. Number and percent of records that demonstrate correct type, amount, scope, and frequency of services were provided for the duration specified in the person-centered service plan N=# of records that demonstrate correct type, amount, scope, and frequency of services were provided for the duration specified in the person-centered service plan D=# of records reviewed.

Data Source (Select one):

Record reviews, off-site

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 = 95% confidence interval with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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:

D6. Number and percent of participant records indicating individual has been given choice of waiver services and choice between eligible waiver providers. N=number of participant records indicating individual has been given choice of waiver services and choice between eligible waiver providers. D=number of participant records

Data Source (Select one):

Other

If 'Other' is selected, specify:

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

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

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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:

D7. Number and percent of service plans reviewed that were developed in accordance with State policies and procedures. N = Number of service plans reviewed that were developed in accordance with State policies and procedures. D = Total number of service plans reviewed.

Data Source (Select one):

Record reviews, off-site

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 = 95% confidence interval with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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.

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction 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.

DMS or its designee determines an identified need noted on the assessment has not been addressed on the PCSP, DMS 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 DMS or its designee. If issues are noted, DMS will follow the policies and procedures as noted in regulation.

ii. Remediation Data Aggregation

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

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

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)

a. **Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. **Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the waiver. *Select one*:

◯ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.

◯ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

◯ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. **Availability of Participant Direction by Type of Living Arrangement.** *Check each that applies*:

☐ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**

☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**

☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

○ **Waiver is designed to support only individuals who want to direct their services.**

○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

☐ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one)*:

○ **The state does not provide for the direction of waiver services by a representative.**

○ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☐ **Waiver services may be directed by a legal representative of the participant.**

☐ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
	☐	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◯ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☐ **Private entities**

◯ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

◯ **FMS are covered as the waiver service specified in Appendix C-1/C-**

The waiver service entitled:

◯ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

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

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

☐ **Assist participant in verifying support worker citizenship status**

☐ **Collect and process timesheets of support workers**

☐ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**

☐ **Other**

Specify:

Supports furnished when the participant exercises budget authority:

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

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

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

☐ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other services and supports**

Specify:

Additional functions/activities:

☐ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**

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

☐ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

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

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

☐ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
	☒

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one)*.

☐ **No. Arrangements have not been made for independent advocacy.**

○ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only			Budget Authority Only or Budget Authority in Combination with Employer Authority		
Waiver Year	**Number of Participants**			**Number of Participants**		
Year 1						
Year 2						
Year 3						
Year 4						
Year 5						

Appendix E: Participant Direction of Services

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

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☐ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law

employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☐ **Recruit staff**

☐ **Refer staff to agency for hiring (co-employer)**

☐ **Select staff from worker registry**

☐ **Hire staff common law employer**

☐ **Verify staff qualifications**

☐ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

☐ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

☐ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☐ **Determine staff wages and benefits subject to state limits**

☐ **Schedule staff**

☐ **Orient and instruct staff in duties**

☐ **Supervise staff**

☐ **Evaluate staff performance**

☐ **Verify time worked by staff and approve time sheets**

☐ **Discharge staff (common law employer)**

☐ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- ☐ **Reallocate funds among services included in the budget**
- ☐ **Determine the amount paid for services within the state's established limits**
- ☐ **Substitute service providers**
- ☐ **Schedule the provision of services**
- ☐ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- ☐ **Specify how services are provided, consistent with the service specifications contained in Appendix C- 1/C-3**
- ☐ **Identify service providers and refer for provider enrollment**
- ☐ **Authorize payment for waiver goods and services**
- ☐ **Review and approve provider invoices for services rendered**
- ☐ **Other**

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

☐ **Modifications to the participant directed budget must be preceded by a change in the service plan.**

○ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

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.

CHILD waiver enrollees are first informed of their appeal rights for an administrative hearing, informal reconsideration, and the grievance processes during the initial in-person visit through distribution of the waiver welcome packet. Verification that the participant has been informed of their right to request an administrative hearing is obtained by signature of the participant on the DMS-approved form. An enrolled child or youth may request assistance from their case manager to submit a request for an administrative hearing. If the participant would prefer assistance from another party, the following entities are authorized to assist participants with filing an administrative hearing request:

5. Office of the Ombudsman.
6. Kentucky Protection and Advocacy.
7. Office of Legal Support.
8. DCBS.
9. By calling the Medicaid Waiver Help Desk.

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

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

All administrative hearings are handled by the CHFS Hearing and Appeals Branch. Participants who are denied due to failure to meet level of care criteria, suspension, reduction, or termination of services are issued written notification of adverse action, along with their appeal rights.

When this function is conducted by a designee, DMS or its designee will develop all templates and perform oversight activities to ensure process timeliness and that the adverse action notice includes the following:

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

All administrative hearing rights are outlined in 907 KAR 1:563. Written notification of appeal rights sent to the participant stipulates that participants must request, in writing, an administrative hearing within thirty (30) calendar days of the date of the notification. Services will continue as previously indicated in the PCSP prior to the adverse action if the request for an administrative hearing is made within ten (10) calendar days. The notices are generated electronically at the time of an adverse action, delivered, via certified mail, to the participant and the participant's legal guardian or

authorized representative, if applicable, delivered electronically to the case manager, and recorded electronically in MWMA.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

○ **No. This Appendix does not apply**

⊗ **Yes. The state operates an additional dispute resolution process**

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

The reconsideration process is an optional process in which the CHILD waiver participant has 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 the quickest and most efficient way to resolve an adverse action. The participant may request an administrative hearing immediately after receiving an adverse action notice or after they have pursued the reconsideration process. The reconsideration process is not a pre-requisite for an administrative hearing. Participants are first informed of the reconsideration process during the initial eligibility assessment, at the same time as they are informed of the administrative hearing, and complaint and grievance process. Participants are again informed of those processes during the annual LOC re-assessment process and as part of any adverse action notice.

The reconsideration process is operated by DMS or its designee. The reconsideration process is summarized in the following steps:

1. The participant, the participant's legal guardian/authorized representative acting on the participant's behalf, or a provider can request a reconsideration. The request must be made in writing and can be submitted to DMS via U.S. Mail or by email. Participants with a disability which prevents them from submitting a written request can call DMS for assistance.
    a. Reconsideration requests must be postmarked, or dated and timestamped, within fourteen (14) calendar days from the date of the written notice of adverse action. Reconsideration requests postmarked or dated and timestamped more than fourteen (14) calendar days from the date of the written notice of adverse action are considered invalid.
    b. The individual making the request will receive an out-of-timeframe letter notifying them that the request was not made within the established 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.
    c. The out-of-timeframe letter will explain the right to an administrative hearing and the process for requesting one as described in Appendix F-1. A request for an administrative hearing must be made in writing, sent via U.S mail, and postmarked within thirty (30) calendar days of the date of the initial written notice of adverse action. Requests made via email are not accepted.
2. DMS or its designee will conduct the reconsideration, render a determination, and send a letter of decision to the participant, participant's legal guardian or authorized representative, if applicable, or the provider

within the timeframe set forth in 907 KAR 1:563.

a. If the adverse action is upheld, the letter will be sent via certified mail.

b. If the adverse action is overturned, the letter will be postmarked within the timeframe referenced in 907 KAR 1:563.

3. If the reconsideration determination upholds or modifies the original decision resulting in an adverse action, the participant, the participant's legal guardian or authorized representative, or provider may request an administrative hearing. Information on how to request an administrative hearing is included in the reconsideration determination letter.

a. The participant has thirty (30) calendar days from the reconsideration determination to submit a written request an administrative hearing.

b. The request must be received or postmarked within thirty (30) calendar days of the reconsideration determination letter.

c. 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 CHFS as described in section F-1.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

○ **No. This Appendix does not apply**

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

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

Children and youth enrolled in the CHILD waiver 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 DMS.

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

Waiver participants may register any grievance or complaint regarding waiver service provision or service providers by contacting DBHDID, or via mail. 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 DMS, or a provider to adhere to established operating procedures, regulations, and waiver requirements. Grievances may require the DMS follow up and resolution as determined by the categorization process described below.

A complaint or grievance can be submitted at any time. The participant is informed that filing a complaint or grievance is not a prerequisite of a fair hearing. These complaints and grievances are documented in a central database administered by DMS. All complaints and grievances are tracked and trended by DMS to identify if

additional provider trainings and participant education opportunities should be developed and conducted.

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

1. An immediate response is necessary if a participant's health, safety, or welfare are jeopardized. Grievances will be addressed, and the appropriate parties notified immediately of learning of the event. DMS will contact the participant via his/her preferred method of communication once the grievance is resolved and throughout the investigation as necessary.
2. DMS 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.
    a. Some action, including opening an investigation and notifying the appropriate parties, must be taken within seven (7) calendar days of receiving the grievance.
    b. Resolution of the grievance is dependent on the nature of the grievance and resolution is not required to occur within seven (7) calendar days.
    c. DMS or its designee will contact the participant via his/her preferred method of communication once the grievance is resolved.
3. If no action is necessary, DMS or its designee will document the complaint within the DMS- approved system. During this complaint/grievance assessment, DMS will determine if other agencies are responsible for licensure, certification, or monitoring of the provider and will notify or involve these agencies as appropriate.
    a. DMS 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, DMS will alert the appropriate parties and follow the process described in Appendix G of this waiver application.
4. Lastly, DMS will require all waiver service providers to implement policies and procedures to address participant complaints, grievances, and appeals independently from the state complaint/grievance/appeal process.
    a. Providers are required to educate all participants regarding the procedure and provide adequate resolution in a timely manner.
    b. The provider grievances and appeals are monitored by DMS or its designee 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).

Reportable Incident Types:

A. Kentucky is responsible for establishing a reporting process and for carrying out investigations of abuse, neglect, and exploitation (ANE) involving CHILD waiver participants as outlined 907 KAR 3:090 and the following Kentucky statutes and administrative regulations:

1. "Abuse" as defined in KRS 209.020(8) and 922 KAR 5:070,
2. "Sexual Abuse" as defined in KRS 600.020(58),
3. "Exploitation" as defined in KRS 209.020(9) and 922 KAR 5:070, and
4. "Neglect" as defined in KRS 209.020(16) and 922 KAR 5:070.

B. DMS or its designee requires the following additional incident types to be reported:

1. Serious injury requiring treatment beyond basic first aid,
2. Unexpected Death, and
3. Events that serve as indicators of risk to participant health and welfare (e.g., unplanned in-patient hospitalizations, medication errors, use of restraints or behavioral interventions).

A full list of instances required to be reported is found at the following URL: https://www.chfs.ky.gov/agencies/dms/dca/Documents/irinstructionalguide.pdf.

For organizational and prioritization purposes, DMS 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:

A. Any individual who witnesses or discovers a critical or non-critical incident is responsible for reporting it. This includes but is not limited to all persons as defined in KRS 209.030(2) and KRS 620.030.

1. All individuals should report abuse, neglect, and exploitation to Adult Protective Services (APS) or Child Protective Services (CPS) as required in KAR.

2. Only providers with access to MWMA are required to report a CHILD defined critical and/or non-critical incident.

Incident Reporting Timeframes and Methods for Reporting:

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 DCBS. DCBS operates children protective services for the Commonwealth of Kentucky.

A. For critical incidents, the participant's legal guardian and/or authorized representative shall be notified immediately following notifications to law enforcement and/or CPS, unless he/she has suspected involvement.
    1. DMS defines "immediately" as making the notification as soon as possible but no later than eight (8) hours after the incident.
    2. The CHILD waiver participant's case manager shall also be notified immediately.
    3. A critical incident report shall be submitted via MWMA within eight (8) hours of the time the incident is witnessed or discovered, and no later than the next businesses day if it is witnessed or discovered outside of regular business hours.
    4. CHILD waiver providers must begin their investigation into the critical incident immediately upon witnessing or discovering the incident and submit a full, written investigative report using MWMA within seven (7) calendar days.

B. For non-critical incidents, the participant's legal guardian and/or authorized representative and CM shall be notified within twenty-four (24) hours upon witness or discovery of the incident.
    1. Case managers or providers shall enter the non-critical incident report in MWMA within twenty-four (24) hours of witnessing or discovering the incident.
    2. Non-critical incidents witnessed or discovered on a weekend or state holiday should be reported the next business day.

C. DCBS operates both a telephone hotline and an online system for reporting suspected ANE.
    1. Reporters can reach the Child Protection Hotline, toll-free, at 1-877-597-2331 to report suspected ANE of either an adult or child. The phone line is staffed twenty-four (24) hours a day, seven (7) days a week including weekends and holidays.
    2. Reporters can also contact their local DCBS office to report suspected ANE.
    3. There is also an online system for reporting suspected ANE.
        i. 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.
        ii. Reports are not reviewed on evenings, weekends, or State holidays.
    4. If a child 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.
    5. Any person making such a report shall provide the following information, if known:
    6. The name, age, and address or location where the child or adult can be found and/or any other person responsible for their care;
        i. The nature and extent of the ANE, including any evidence of previous ANE; The identity of the suspected perpetrator; The name and address of the reporter, if they choose to be identified; and Any other information that the person believes might be helpful in establishing the cause of the abuse, neglect, or exploitation. Those who witness or discover a non-critical or critical incident shall

report it using MWMA. It is the provider's responsibility to contact all pertinent entities including but not limited to case manager, law enforcement, and protective services.**Ongoing DMS Incident Reviews**:

A. DMS or its designee will continually monitor incident trends and patterns and may require additional incident types be reported beyond those listed above, as needed.

B. DMS or its designee reviews critical and non-critical incident summary data generated by MWMA to identify systemic issues and conduct follow-up activities as warranted.

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.As required by regulation, children and youth enrolled on the CHILD waiver are educated on mental, verbal, sexual, and physical abuse, neglect, exploitation, isolation, corporal or unusual punishment, including interference with daily functions of living.

A. DBHDID provides on-line training for providers regarding the statutory and regulatory reporting requirements and identification and prevention of abuse, neglect and exploitation.

1. This training is available online through the Adobe Learning Manager (ALM).
2. CHILD waiver providers are required to educate all waiver participants and their families/guardians regarding recognition of abuse, neglect, and exploitation and the process to report the same. The training is to be done when they begin services, when a need is determined, and on at least an annual basis.
3. Training is tailored to each CHILD waiver participant's learning style and can be provided in a variety of formats either online or in-person.
4. Each provider is required to assist and support the participant's ability to communicate freely with family members, guardians, friends, and case managers.

B. The child or youth's case manager is responsible for ongoing education that the participant and their caregiver (including parents and foster parents) are educated about ANE and the reporting methods.

1. Case managers schedule an initial visit with the child or youth, the participant's legal guardian and/or authorized representative, if applicable, and anyone else designated by the participant and provides information and resources regarding strategies to identify, prevent, report, and intervene in any instances or potential instances of ANE.
2. Upon completion of this discussion, the case manager reviews with and requests that the child or youth (and/or the legally responsible individual in the case of a minor), sign a document that attests their understanding of ANE and how these critical incidents can be prevented, reported, and addressed.
3. The case manager retains the original document, provides the child or youth and caregiver with a copy for their records, and uploads a copy to MWMA for DMS availability.
4. Participants and their caregivers are asked to attest to their knowledge and training on ANE and critical incidents annually.

C. Depending upon the individual needs of each waiver participant, additional training or information shall be made available and related needs addressed in the participant's PCSP.

D. DMS requires all providers to complete training on ANE identification and reporting on hiring and repeat or refresher training is provided as needed.

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 timeframes for responding to critical events or incidents, including conducting investigations.

The response below describes the DMS' role in reviewing and responding to critical and non-critical incidents, DMS cooperates with other investigative agencies, including DCBS, DBHDID, and law enforcement, to complete investigative activities in a timely manner with minimal stress to the CHILD waiver participant.

A. The entity that receives reports of each type of critical event or incident:

1. Shall submit an incident report using MWMA.
2. Shall report any suspected ANE to DCBS.

B. The entity that is responsible for evaluating reports and how reports are evaluated:

1. Upon receiving the report, DMS or its designee becomes responsible for evaluating reports.
2. DMS may upgrade or downgrade an incident based on the report submitted.

C. A non-critical incident shall:

1. Be submitted via MWMA. DMS or its designee reserves the right to escalate any categorical non-critical incident to a critical incident as circumstances require.
2. Be minor in nature and not create a serious consequence or risk for participants.
3. Not require an on-site investigation conducted by DMS or their designee.
4. Be monitored for future follow-up and intervention as appropriate.

D. A critical incident shall:

1. Be reviewed by DMS or its designee and appropriately classified as a critical or non-critical incident and the investigative process will be initiated as appropriate.
2. Be serious in nature.
3. Pose immediate risk to health, safety, or welfare of the participant, co-residing participants, or others.
4. Have an investigation report completed within seven (7) calendar days of the incident.
5. Warrant an on-site DMS investigation as needed

E. The timeframes for conducting and completing an investigation:

1. 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.
2. For both critical and non-critical incidents, the participant's legal guardian/authorized representative and case manager shall be notified as soon as the above steps have been taken.
3. Once these steps have been taken, the provider agency initiates an investigation into the incident based on its classification as follows:
    a. Non-Critical Incidents: DMS reviews non-critical incident reporting. Based on the findings, DMS may require more information or escalate the incidents to a critical incident. If the non-critical incident is escalated to a critical incident, the critical incident processes below will apply.

b. Critical Incidents: Provider agencies must initiate investigations of critical incidents immediately upon witnessing or discovering the incident.

i. DMS shall be notified, via an incident report entered into MWMA, the same day if the incident is witnessed or is discovered during business hours and the next business day if it is witnessed or is discovered outside of business hours.

ii. DMS or its designee conducts a review of the critical incident. DMS 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.

iii. All DBHDID investigations must be completed within thirty (30) days of investigator assignment.

iv. APS/CPS and/or law enforcement investigations may take longer.

v. DMS will maintain a MOU with APS/CPS regarding the results of investigations and will take appropriate action based on the outcome.

vi. The provider must upload a complete, investigative report on the critical incident within seven (7) calendar days of witness or discovery MWMA. This report only includes provider findings.

F. All CHILD waiver providers are expected to meet the standards set forth in their provider agreement with DMS, with DMS ANE training, DBHDID waiver certification, and/or OIG licensure regarding ANE/critical incident investigations and reporting.

G. The entity that is responsible for conducting investigations and how investigations are conducted:

1. Providers conduct and upload investigations on critical incidents to MWMA within seven (7) calendar days.

2. In opening and initiating an investigation, DMS or its designee contacts and coordinates with APS/CPS, law enforcement, and other responsible agencies immediately if needed.

3. DMS 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.

4. DMS 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.

5. DMS 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.

a. As part of the investigation, DMS or its designee may interview parties involved in the incident including provider staff, participants, witnesses, or other parties.

b. In addition, DMS or its designee may request and review medical reports, claims data, police reports, and other pertinent documentation to support DMS' investigation.

c. If necessary, DMS 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.

6. 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.

DMS or its designee is responsible for overseeing the reporting of and response to critical incidents affecting CHILD waiver participants. DMS or its designee will conduct an investigation and will intervene to address imminent health, safety, or welfare concerns of a participant as deemed necessary. DMS tracks and trends all incident reports. DMS or its designee may conduct follow-up monitoring visits, technical assistance, or provider training as needed, based on trend analysis. Trend analysis monitors the following data elements:

- Nature of the incident.
- Frequency of incidents.
- Adherence to time standards.
- CAP status.
- Providers who have a high frequency of incident reports.
- Recurring participants.
- Rate of unreported incidents identified via MMIS claims data. All incident reports are submitted through MWMA.

DMS or its designee samples a select number of providers and verifies through certification surveys, monitoring visits, or investigations that critical incidents were timely and 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 therefore the responsibility of all CHILD waiver service providers to utilize a person-centered approach as a means of crisis prevention.

Kentucky is dedicated to fostering a restraint-free environment in all waiver programs. DMS prohibits the use of mechanical or chemical restraints, seclusion, manual restraints, including any manner of prone (breastbone down) or supine (spine down) restraint. DMS also prohibits the use of chemical restraints, which are defined 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 which is not a standard treatment for the participant's medical or psychiatric diagnosis. A psychotropic medication 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; PRN psychotropic medication is not considered a chemical restraint.

All medication administration must adhere to a physician's order that shall include drug, dosage, directions, and reason for use. The PCSP, risk mitigation form, and behavior support plan, if applicable, shall incorporate the protocol for use of a psychotropic PRN and is applicable to participants in approved CHILD waiver Supervised Residential Care settings. These are reviewed annually as part of the person-centered planning process or more often if needed.

DMS and DBHDID are responsible for oversight of the person-centered planning process which includes monitoring of case management reports, incident reports, and complaints. The continuous quality improvement process reveals trends, patterns, and remediation necessary to ensure proper implementation of the PCSP and participant safety.

A participant has the right to be free of any physical or chemical restraints. Any interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior must be evaluated on at least an annual basis. If a participant's unanticipated violent or aggressive behavior places him/her or others in imminent danger, a restrictive intervention may be used as a last resort to maintain health, safety, and welfare. State laws, regulations, and policies will be made available to CMS upon request through the Medicaid agency or the operating agency.

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

⊗ **The 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.

Interventions that restrict participant movement, participant access to other individuals, locations or activities, restriction of rights, or employ aversive methods to modify behavior must be reviewed and approved on an annual basis by a Human Rights Committee (HRC) that is organized by provider agencies. When a participant's support team believes that a rights restriction is necessary to maintain health, safety and welfare, the rights restriction must be reviewed and approved by an HRC. The HRC is charged with reviewing sound documentation that less restrictive attempts to teach and support the participant to make an informed choice have not been effective. The rights restriction shall include a plan to restore the participant's rights and should be reviewed on at least an annual basis.

Prohibited restrictive measures include withholding of food or hydration as a means to control; access to a legal advocate or ombudsman; access to toilet, bath or shower; deprivation of medical attention or prescribed medications; deprivation of sleep; removal of access to personal belongings; and removal of access to natural supports. The use of restrictive interventions comport with the HCBS requirements at Section 42 CFR 441.301(c)(4)(iii) and (vi)(F), and person-centered service planning and plan requirements at 42 CFR 44.301(c)(1) and (c)(2).

Utilization of restrictive interventions is monitored as part of individual critical incident reviews conducted by DBHDID, in addition to monitoring of incident data trends on each of the following levels: participant, provider, regionally and statewide. PCSP implementation and supports are monitored routinely by DBHDID Quality Administrators. Through this process, DBHDID identifies areas in which technical assistance is needed. Assistance may be provided in a variety of ways, but always in the manner best suited to the identified issue, and may include sharing of information, formal training, or consultation with DBHDID.

State laws, regulations, and policies related to use of restrictive interventions will be made 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:

Restrictions of rights are reviewed by DBHDID during the provider's monitoring process. In addition, human rights restrictions are reviewed through the incident process as needed. Critical incident data is reviewed and trended to identify patterns. Concerns regarding trends are addressed with providers.

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:

DMS or its designee is responsible for detecting the unauthorized use of seclusion, as described in section G-2-a. DMS or its designee incorporates oversight into on-site monitoring and review of critical incidents.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

○ **No. This Appendix is not applicable** *(do not complete the remaining items)*

⊗ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Every case manager and any staff person who will be administering medications must successfully complete DBHDID, Division of Developmental and Intellectual Disabilities (DDID) Medication Administration curriculum for non-licensed personnel that was approved by the Kentucky Board of Nursing. DDID registered nurses provide the “train the trainer” course to registered nurses who are employed by or contracted with providers. Those nurses then teach the DDID medication curriculum to provider staff.

Each CHILD waiver provider is required by regulation to have policies in place specific to medication

administration to ensure the health, safety, and welfare of the participants they support. The ongoing monitoring of the participant's medication regimen is the responsibility of the CHILD waiver providers. Focus areas include reviewing for:

- Polypharmacy usage;
- Follow up with doctor appointments and prescriptions;
- Review of laboratory results;
- Overall health, appearance, affect;
- A participant's compliance with their medications;
- Staff competency of medication administration;
- Documentation of medical diagnosis regarding the need for the medication;
- Medication reduction plans;
- Reaction and interaction with other medications;
- Documentation of need and effectiveness of PRN medications;
- Timely reordering of medications;
- Staff training;
- Reporting medication errors correctly;
- Compliance with state and federal laws; and
- Agency quality improvement measures.

Monitoring can be conducted by:

- Direct observation, assessment, and interview of the individuals;
- Reviewing medication administration record (MAR) and PRN reports;
- Incident reports;
- Laboratory reports;
- Doctor orders;
- Medication error reports;
- Pill counts;
- Behavior support plan implementation;
- Participant's health status;
- Review of health logs; and
- Interviews with direct support staff.

Regulatory requirements specify monitoring of medication administration is to be done at least monthly. However, more frequent monitoring may occur as part of the agency's quality improvement process or based on the participant's support needs. CHILD provider specific policies describe the frequency of monitoring. Provider agencies receive technical assistance from DBHDID to utilize best practice when providing supports. DBHDID monitors providers through incident review and regular monitory by DBHDID Quality Administrators.

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.

DBHDID monitors medication management administration during recertification reviews of provider agencies, which occurs at least once every twenty-four months as well as during technical assistance visits. Providers are required to report medication errors through the incident reporting process and DBHDID reviews critical incidents as they are reported as well as reviewing the providers' risk mitigation/investigation reports.

Technical assistance is provided by DBHDID when a health, safety, welfare concern is identified. If the concern puts the CHILD waiver participant at immediate risk, the CHILD waiver provider is required to act to ensure health, safety, and welfare. The provider must provide DBHDID their plan to address the situation and the measures they will implement to prevent it from happening again.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

○ **Not applicable.** *(do not complete the remaining items)*

⊗ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DBHDID, DDID, in collaboration with the Department for Public Health, and the Kentucky Board of Nursing (KBN) has developed a standardized curriculum for training medication administration to non-licensed personnel. This course is intended for non-licensed personnel who administer medications to CHILD waiver participants.

Upon successful completion of this course, the non-licensed personnel prove competency in administration of a child or youth's medication for those who are unable to self-administer, and when appropriate, observation of a CHILD waiver participant's self-administration of medications. The CHILD waiver provider must utilize a DDID trained RN to provide medication administration training for anyone who will administer medications, as well as case managers. Providers are required to have policies in place to address competency in medication administration.

Provider registered nurses provide additional training as a result of medication monitoring (medication audits of medications counts, prescriptions/ physician's orders and MARs and medication errors). The CHILD providers determine how to ensure a participant can self-administer medications safely and document such on a medication administration record, according to their policy and procedures.

DDID maintains a listing of qualified RN trainers. A roster of staff who have completed the medication administration training is maintained by the College of Direct Supports. DDID RNs may periodically observe the curriculum being taught. Technical assistance is provided to CHILD waiver providers, as

needed.

iii. Medication Error Reporting. *Select one of the following:*

⊗ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

Medication errors are reported in MWMA and tracked by agency providers on a medication error log. Both DMS and DBHDID have access to the information, but it is DBHDID's direct responsibility to review and respond accordingly.

(b) Specify the types of medication errors that providers are required to *record:*

A medication error occurs when a CHILD waiver participant receives an incorrect drug, dose, form, quantity, route, concentration, or rate of administration from a direct service provider. Incorrect documentation is also considered to be a type of medication error. Furthermore, 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.

CHILD waiver providers must record two (2) levels of medication errors while a participant is in their care as follows:

A. Non-Critical: Refusal by the participant is considered non-critical. If the participant refuses three or more doses or if they refuse doses three or more times in 90 days it is upgraded to a critical incident. For provider assisted medications (e.g., administering or cueing), medication errors only relate to medications included on the MAR.

B. Critical: Errors in prescribed medication or medication management by CHILD waiver providers including a missed dose, a wrong dose or wrong medication, or that result in an adverse reaction are considered critical. For provider assisted medications (e.g., administering or cueing), medication errors only relate to medications included on the 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. CHILD waiver providers must report non-critical and errors following the timeframes set forth in section G-1-B.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

DMS or its designee is responsible for monitoring CHILD waiver providers' performance in administration of medication. This oversight begins with review and approval of provider policy and procedures for ongoing monitoring of medication administration. DMS 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 DMS or its designee. In addition, all medication errors must be reported through MWMA and will be followed up as warranted.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.

i. Sub-Assurances:

a. *Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.*

Performance Measures

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:

G1. Number and percent participants (or families/legal guardians as appropriate) who received information regarding how to identify and report ANE. N = Number of participants (or families/legal guardians) who received information regarding how to identify and report ANE. D = Number of participants reviewed.

Data Source (Select one):

Record reviews, off-site

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 =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

	☐ **Other** Specify:

Performance Measure:

G2. Number and percent of incident reports of potential ANE & unexpected death submitted in required timeframe. N= Number of incident reports of potential ANE & unexpected death submitted in required timeframe. D= Number of incident reports of potential ANE & unexpected deaths.

Data Source (Select one):

Record reviews, off-site

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 =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:

G3. Number and percent of potential ANE & unexpected death incidents reviewed/investigated in required timeframe. N= Number of potential ANE & unexpected death incidents reviewed/investigated in required timeframe. D= Number of potential ANE & unexpected death incidents reviewed.

Data Source (Select one):

Record reviews, off-site

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 =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:

G4. Number & percent of ANE & unexpected death incidents for which follow-up action was completed as required. N = Number of ANE & unexpected death incidents in which follow-up action was completed as required. D = Number of ANE & unexpected death incidents for which follow-up actions were required.

Data Source (Select one):

Record reviews, off-site

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 =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:

G5. Number and percent of ANE incidents referred to DCBS for follow-up. N = Number of ANE incidents referred to DCBS for follow-up. D = Number of ANE incidents reviewed.

Data Source (Select one):

Record reviews, off-site

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 =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

G6. Number and percent of employees records indicating successful completion of training on ANE. N = Number of employees records indicating successful completion of training on ANE. D = Number of employee employees records.

Data Source (Select one):

Record reviews, on-site

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 =95% confidence level with a +/- 5% margin of error

☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state 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:

G7. Number and percent CHFS fact finding reports indicating no corrective action plan needed. N = Number of CHFS fact finding reports indicating no corrective action plan needed. D = Number of critical incidents reviewed.

Data Source (Select one):

Record reviews, off-site

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 = 95% confidence level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** 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):*
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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:

G8: Number and percent of critical incident reports submitted without inappropriate use of seclusion or restraint. N = Number of critical incident reports submitted without inappropriate use of seclusion or restraint. D = Number of critical incident reports indicating seclusion or restraint.

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

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 = 95% confidence level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:

G9. Number and percent of rights restrictions that followed state procedures. N = Number of rights restrictions that followed state procedures. D = Rights restrictions reviewed.

Data Source (Select one):

Record reviews, off-site

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**

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):*
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

	☐ **Other** Specify:

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:

G10. Number and percent of critical incident reports which indicated the inappropriate use of seclusion or restraints. N=Number of reports with inappropriate use of seclusion or restraints D=Number of critical incident reports regarding use of seclusion or restraint

Data Source (Select one):

Record reviews, off-site

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**

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):*
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:

G11. Number and percent of participants whose PCSP reflects determination of appropriate state plan services. N = Number of participants whose PCSP reflects determination of appropriate state plan services. D = Number of PCSPs reviewed.

Data Source (Select one):

Record reviews, off-site

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 = 95% confidence level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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 two (2) years by the OIG which includes the monitoring of the employees records for criminal checks and abuse registry checks.

Licensed and certified agencies are reviewed by DMS or its designee annually or more frequently as required. DMS or its designee performs first line monitoring and identifies deficiencies of the CHILD 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 process DMS or its designee will review the procedures of the provider that train employees and ensure the health, safety, and welfare of the participants and that incidents are reported appropriately.

CHILD waiver providers must ensure that children, youth, and legal guardians have access to agency staff and know their case manager's name and contact information. DMS 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, legal guardians or authorized representatives, and other interested parties. The purpose of this telephone Hotline is to enable complaints or other concerns to be reported to the OIG. DMS or its designee monitors the complaint process by examining complaint logs and the results of client satisfaction surveys.

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 two (2) years by the OIG; include the monitoring of employee records for criminal checks and abuse registry checks. Licensed and certified agencies are reviewed by DMS or its designee. Should an enrolled provider not meet requirements to provide services, OIG would notify Program Integrity. DMS or its designee performed first line monitoring and audit reviews. All documentation concerning the monitoring process for providers is kept for a period of five (5) years after the last claim is processed or the expiration/termination of the contract, whichever is sooner.

ii. Remediation Data Aggregation

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

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

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 data collected provides meaningful insights and informs decisions related to process and systems improvement. DMS has defined its quality-related operational elements including data aggregation, measurement, and reporting activities which promote consistent, rigorous quality management approaches that are institutionalized within CHFS operations and culture. DMS determined what data should be collected based on several factors including;

- Relevance to participant health and welfare;
- Reliability of data;
- Importance to DMS operational goals; and
- Ease and feasibility of data collection.

The information collected includes data from:

- LOC determinations;
- Service authorizations;
- Service and expenditure reports;
- PCSPs and outcomes;
- Incident reports;
- Consumer surveys;
- Visit monitoring;
- Progress toward achieving CAP goals; and
- Recertification reviews.

DMS analyzes the aggregate data based on established performance targets related to each data point. DMS evaluates data collected against these performance targets to identify performance gaps. As gaps are identified, DMS evaluates program-wide data in a manner that enables DMS staff to observe overarching trends and to “drill down” to observe differences among various geographies, waivers, subpopulations, etc. so that DMS can begin to understand potential root causes of performance patterns and variation. Subsequently, DMS identifies opportunities to improve operational processes based on performance gaps and trends.

DMS prioritizes the process improvement to address performance gaps and trends based on the measure. DMS strategically identifies opportunities to enhance operational processes based on how the process can improve participant health and welfare, strengthen compliance with federal regulations and guidance, improve efficiencies of staff resource use, among other factors. Implementation of system improvements is dependent on the performance gap. DMS will assess the performance gap and identify the root cause to be addressed. DMS or its designee, will develop a tailored implementation plan, identify needed staff, and determine the steps, sequence, and timeline for system improvement so performance gaps can be addressed in a timely manner.

ii. System Improvement Activities

Responsible Party *(check each that applies):*	**Frequency of Monitoring and Analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

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.

DMS 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. DMS 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. The Department can modify its design changes based on outcomes indicated by its performance data. As new performance gaps arise, the DMS prioritizes additional systems changes to address these gaps. DMS, or its designee, creates reports to track progress of these systems improvements and discusses progress with the appropriate parties. This process continues as DMS improves its operations to meet its program-wide goals

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

CHFS' quality management activities are focused on recognizing the importance of both regulatory compliance and quality improvement to promote improved participant outcomes and other performance improvements. As such, DMS has selected performance measures that allows for 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.

DMS 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 DMS performs a formal annual review of its quality strategy and revises, as needed.H-2. Use of a Patient Experience of Care/Quality of Live Survey

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):*

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 entity responsible for conducting the periodic independent audit of the waiver program is the Kentucky Auditor Public Accounts (APA). DMS or DBHDID shall conduct annual utilization audits of all waiver providers. Providers are not required to secure an independent audit. These audits shall include a post-payment review of Medicaid reimbursement to the provider agency for services rendered to a waiver member. DMS or its designee shall utilize reports generated from MMIS reflecting each service billed by the waiver provider. Comparison of payments to member records, documentation and approved PCSP shall be conducted. If any payments were issued without the appropriate documentation or not in accordance with approved PCSP, DMS will initiate recoupment of the monies. Additional billing reviews are conducted based on issues identified during certification surveys or investigations.

DMS conducts annual utilization audits of 100% of enrolled waiver providers utilizing a statistically valid sample with a confidence level of 95% +/- 5% margin of error. Billing/Utilization audits are conducted as desk reviews regardless of the service type or provider. If there are extenuating circumstances where the provider is unable to submit the documentation electronically, an onsite visit may be conducted. Incidents, anomalies in billing or entries in EVV may trigger additional audits. The reviews do not differ based on service type or provider.

Community Living Supports and Respite provided under the CHILD waiver are subject to EVV. EVV offered the state improved monitoring and quality assurance to ensure health, safety, and welfare and reduction in fraud, waste, and abuse and eliminated the need for paper documentation creating flexibilities around agencies and caregiver scheduling and delivering services. Staff include EVV records (service checklist, notes, visit information) as part of the utilization review. Review of all services follows the same process.

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:

I1. Number and percent of claims coded and paid for in accordance with the established reimbursement methodology specified in the approved waiver. N = Number of claims coded and paid in accordance with the established reimbursement methodology specified in the approved waiver. D = Number of claims coded and paid.

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:

I2. Number and percent of paid waiver service claims for which verification of service delivery has been determined. N= Number of paid waiver service claims for which verification of service delivery has been determined. D= Number of claims reviewed. .

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**
☒ **Other** Specify: *MMIS*	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:

I3. 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 throughout the five-year waiver cycle.

Data Source (Select one):

Program logs

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 =
☒ **Other** Specify: *MMIS*	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: *MMIS*	☒ **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.*

DMS reviews and adds edits/audits to MMIS periodically for program compliance and as policy is revised to ensure claims are not paid erroneously.

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*

DMS 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). DMS performs trainings upon request of providers and provides technical assistance whenever requested or as needed. 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):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☒ ***Quarterly***
☒ ***Other*** *Specify:* MMIS	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

c. Timelines

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

⊗ ***No***

○ ***Yes***

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

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. Proposed CHILD waiver rates and rate methodologies are reflective of those established under the Acquired Brain Injury (ABI) and Supports for Community Living (SCL) waivers. The following information pertains to the rate methodologies developed for ABI and SCL services and adopted for use in the CHILD waiver.

DMS established rates for most ABI and SCL services through an independent cost study conducted by Guidehouse Consulting to determine costs associated with each service component. In addition to other ABI and SCL service rates as noted within the approved ABI and SCL applications, respectively, the following ABI and SCL services adapted for the CHILD waiver were included in the rate study: Supervised Residential Care – Level 1 (ABI-only) Case Management, Clinical Consultative and Therapeutic (CCT) - Psychological Services, Personal Assistance and Respite (SCL). 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.

Cost-based services (e.g. Environmental Accessibility) were not included in the rate study. Cost-based services will continue to be paid at cost with the limits for each service described in Appendix C.

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 are derived from the provider cost and wage surveys, as well as benchmarks from the federal Bureau of Labor Statistics, the Medical Expenditure Panel Survey 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 used to solicit information on the rate development conducted by Guidehouse included 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. 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.

DMS will review rates every five years, or more frequently as necessary, to ensure rates are adequate to maintain the provider pool.

b. *Flow of Billings.* *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from*

providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Billings for waiver services shall flow directly from the waiver providers to the Commonwealth's Medicaid Management Information System (MMIS). Providers may also choose to bill Community Living Services from the EVV software.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. *Certifying Public Expenditures* *(select one):*

⊗ ***No. state or local government agencies do not certify expenditures for waiver services.***

○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. *Billing Validation Process.* *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

All waiver providers shall be enrolled with DMS's Division of Program Integrity (DPI), provider enrollment, and have a signed contract on file. MMIS has edits and audits established to ensure that:

1. The participant was eligible on the date of service
2. Services billed were included on the approved service plan.
3. Services were rendered.

DMS or its designee shall conduct audits of all waiver providers. These audits shall include a post-payment review of Medicaid reimbursement to the provider agency for services rendered to a waiver participant. DMS or its contractors shall utilize reports generated from the MMIS reflecting each service billed by the waiver provider. Comparison of payments to participant records, documentation and approved PCSPs shall be conducted.

If any payments were issued without the appropriate documentation or not in accordance with approved PCSP, DMS shall initiate recoupment of the monies utilizing an accounts receivable process through MMIS. DMS subtracts the amount noted for recoupment from the federal funds that are drawn down.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

⊗ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***

○ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☒ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☐ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

⊗ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS.

Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

⊗ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*

○ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

○ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***

○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***

○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

⊗ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***

○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

⊗ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***

○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR § 447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

⊗ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR § 447.10.***

○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

⊗ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***

○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of section 1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

○ ***This waiver is a part of a concurrent section 1915(b)/ section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***This waiver is a part of a concurrent section 1115/ section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☒ ***Appropriation of State Tax Revenues to the State Medicaid Agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the

Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ ***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:*

Supervised Residential Care rates do not include any margin for room and board related expenses. The Medicaid provider contract specifies that room and board expenses must be covered from sources other than Medicaid. Providers of waiver services are contractually prohibited from billing for room and board expenses through Medicaid. DBHDID staff review individual records during both certification and utilization reviews to verify that the costs for room and board are excluded. DMS staff also verify during second level reviews.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

⊗ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***

○ ***Yes. Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs***

attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

⊗ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***

○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

☐ ***Nominal deductible***

☐ ***Coinsurance***

☐ ***Co-Payment***

☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded.

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.

The following table lists the waiver services defined in C-1/C-3 for which a charge is made, the amount of the charge, and the basis for determining the charge.

Waiver Service	Charge
	Amount: **Basis:**

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.

Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant (select one):

○ **There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.**

○ **There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.**

Specify the cumulative maximum and the time period to which the maximum applies:

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: Hospital, ICF/IID

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	$140,358.04	$22,542.49	$162,900.53	$234,265.89	$34,966.70	$269,232.59	$106,332.06
2	$144,560.68	$23,217.31	$167,777.99	$241,278.70	$36,013.44	$277,292.14	$109,514.15
3	$148,884.61	$23,910.36	$172,794.97	$248,481.05	$37,088.47	$285,569.52	$112,774.55
4	$153,208.55	$24,603.41	$177,811.96	$255,683.40	$38,163.49	$293,846.89	$116,034.93
5	$157,754.57	$25,332.94	$183,087.51	$263,264.82	$39,295.10	$302,559.92	$119,472.41

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: Hospital	*Level of Care: Nursing Facility*	*Level of Care: ICF/IID*
Year 1	100	50		50
Year 2	100	50		50
Year 3	100	50		50
Year 4	100	50		50
Year 5	100	50		50

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates *(2 of 9)*

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The average length of stay (ALOS) for the CHILD waiver is estimated to be 350 days, based on experience from Kentucky's other 1915(c) waivers serving children with an ICF/IID LOC. Kentucky assumes that once claims and historical trends are established for the CHILD waiver, fluctuations in ALOS may be realized. Ongoing monitoring of ALOS will commence upon approval of this waiver from CMS; ALOS estimates will be updated once the program is established for a period of several years.

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:*

Factor D estimates were derived from analyzing historical utilization experience and claims data from the ABI-Acute and SCL waivers. DMS applied SCL utilization experience to similar services as proposed under the CHILD waiver to determine an approximate proportion of average service units per CHILD waiver enrollee. The average cost per unit was estimated using the same fee schedule as that approved for SCL. Waiver years 2-5 were adjusted using forecasted inflation factors from the Q4 2024 CMS Market Basket for Inpatient Psychiatric Facilities by trending from midpoint to midpoint.

As DMS collects claims experience for the CHILD waiver, the Department will review the Factor D estimates to determine any required adjustments in projects for future years.

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 utilized SFY24 claims data for SCL waiver enrollees to develop Factor D' estimated for Waiver Year 1. Only Medicaid payments made for non-SCL waiver services were included to derive an estimate for D' for the CHILD waiver. DMS trended data to Waiver Years 1-5 using forecasted inflation factors from the Q4 2024 CMS Market Basket for Inpatient Psychiatric Facilities by trending from midpoint of the date (or previous Waiver Year) to midpoint of each Waiver Year.

As DMS collects claims experience for the CHILD waiver, the Department will review the Factor D' estimates to determine any required adjustments in projects for future years.

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:*

To develop the factor G estimates for the CHILD waiver, DMS used the following methodology:

ICF/IID costs:

The most recently established (SFY25) rates were used as a baseline for developing the ICF/IID portion of the Factor G estimate by determining the statewide average of the provider specific rates. These rates are based on each provider's fiscal year 2023 costs report. Cost report data is inflated using the most recent IHS Market Basket Data at the time of rates being established. DMS then multiplied this rate by Medicaid days from the same time period to determine a total of routine payments made. Medicaid ancillary costs are not included in the rate but are determined on the cost report so those amounts were also added in to get to a total ICF Factor G Medicaid costs Ancillary services included in ICF/IID reimbursement include physical therapy, X-ray, laboratory, respiratory therapy, speech therapy, occupational therapy, and psychology services. Total institutional costs were then divided by members who had at least one unique routine ICF/IID stay during fiscal year 2024 (432 members) to develop an estimate for ICF/IID Factor G.

PRTF Costs

To be included in the PRTF portion of the Factor G estimates, a member had to have an inpatient stay in a psychiatric residential treatment facility. DMS found 365 individuals in SFY24 who qualified. DMS multiplied the total paid days for stays at a PRTF by the established KAR rate as of 11/01/2024. Reserve days were multiplied by the max percentages established in KAR for PRTF services. Estimated payments to be made was calculated to be approximately $18.1 million.

Both ICF/IID and PRTF estimated Medicaid costs were trended forward using Q4 2024 CMS Market Basket for Inpatient Psychiatric Facilities by trending from midpoint of the rate period, cost report period, or previous Waiver Year to the midpoint of each Waiver Year. ICF/IID and PRTF costs were then combined by prorating the amounts calculated from above descriptions by the percentages estimated in J-2(a) above.

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:*

To calculate Factor G', DMS pulled all claims for SFY24 for the 432 & 365 individuals identified above for ICF/IID and PRTF LOCs, respectively. DMS then excluded the facility costs from the total universe of paid claims in fiscal year 2024 for the members who qualified to be included in the Factor G derivations. Most of the remaining Medicaid paid claims included pharmacy services and hospital stays. The separate G' estimates for ICF/IID and PRTF LOCs were then added together after having the estimated proportion of each LOC to be served in the CHILD waiver (50% - ICF/IID, 50% - PRTF) applied to the respective Factor G' estimates. The result was a combined G' estimate; this estimate also had an inflation factor applied, as described above. Both ICF/IID and PRTF estimated Medicaid costs were trended forward using Q4 2024 CMS Market Basket for Inpatient Psychiatric Facilities by trending from midpoint of the rate period, cost report period, or previous Waiver Year to the midpoint of each Waiver Year.

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	
Case Management	
Respite	
Community Living Supports	
Environmental and Minor Home Modifications	
Clinical Therapeutic Services	
Supervised Residential Care	

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/ section 1915(c) waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), section 1937). *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. If applicable, check the capitation box next to that service. 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*
Case Management	Monthly	100	12	$425.92	$511,104.00	$511,104.00
Respite	15-minute	50	1,660	$5.92	$491,360.00	$491,360.00
Community Living Supports	15-minute	50	6,240	$7.37	$2,299,440.00	$2,299,440.00
Environmental and Minor Home Modifications	Per adaptation	15	1	$3,226.67	$48,400.05	$48,400.05
Clinical Therapeutic Supports	15-minute	50	800	$29.95	$1,198,000.00	$1,198,000.00
Supervised Residential Care	Daily	50	345	$550.00	$9,487,500.00	$9,487,500.00
Grand Total:						***$14,035,804.05***
Total Estimated Unduplicated Participants:						***100***
Factor D (Divide total by number of participants):						***$140,358.04***
Average Length of Stay on the Waiver:						***350***

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/ section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. 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*
Case Management	monthly	100	12	$438.67	$526,404.00	$526,404.00
Respite	15-minute	50	1,660	$6.10	$506,300.00	$506,300.00
Community Living Supports	15-minute	50	6,240	$7.59	$2,368,080.00	$2,368,080.00
Environmental and Minor Home Modifications	Per adaptation	15	1	$3,323.26	$49,848.90	$49,848.90
Clinical Therapeutic Supports	15-minute	50	800	$30.85	$1,234,000.00	$1,234,000.00
Supervised Residential Care	daily	50	345	$566.46	$9,771,435.00	$9,771,435.00
Grand Total:						***$14,456,067.90***
Total Estimated Unduplicated Participants:						***100***
Factor D (Divide total by number of participants):						***$144,560.68***
Average Length of Stay on the Waiver:						***350***

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/ section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. 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*
Case Management	monthly	100	12	$451.76	$542,112.00	$542,112.00
Respite	15-minute	50	1,660	$6.28	$521,240.00	$521,240.00
Community Living Supports	15-minute	50	6,240	$7.82	$2,439,840.00	$2,439,840.00
Environmental and Minor Home Modifications	Per adaptation	15	1	$3,422.46	$51,336.90	$51,336.90
Clinical Therapeutic Supports	15-minute	50	800	$31.77	$1,270,800.00	$1,270,800.00
Supervised Residential Care	daily	50	345	$583.37	$10,063,132.50	$10,063,132.50
Grand Total:						***$14,888,461.40***
Total Estimated Unduplicated Participants:						***100***
Factor D (Divide total by number of participants):						***$148,884.61***
Average Length of Stay on the Waiver:						***350***

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/ section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. 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*
Case Management	monthly	100	12	$464.85	$557,820.00	$557,820.00
Respite	15-minute	50	1,660	$6.46	$536,180.00	$536,180.00
Community Living Supports	15-minute	50	6,240	$8.05	$2,511,600.00	$2,511,600.00
Environmental and Minor Home Modifications	Per adaptation	15	1	$3,521.66	$52,824.90	$52,824.90
Clinical Therapeutic Supports	15-minute	50	800	$32.69	$1,307,600.00	$1,307,600.00
Supervised Residential Care	daily	50	345	$600.28	$10,354,830.00	$10,354,830.00
Grand Total:						***$15,320,854.90***
Total Estimated Unduplicated Participants:						***100***
Factor D (Divide total by number of participants):						***$153,208.55***
Average Length of Stay on the Waiver:						***350***

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/ section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. 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*
Case Management	monthly	100	12	$478.63	$574,356.00	$574,356.00
Respite	15-minute	50	1,660	$6.65	$551,950.00	$551,950.00
Community Living Supports	15-minute	50	6,240	$8.29	$2,586,480.00	$2,586,480.00
Environmental and Minor Home Modifications	Per adaptation	15	1	$3,626.08	$54,391.20	$54,391.20
Clinical Therapeutic Supports	15-minute	50	800	$33.66	$1,346,400.00	$1,346,400.00
Supervised Residential Care	daily	50	345	$618.08	$10,661,880.00	$10,661,880.00
Grand Total:						***$15,775,457.20***
Total Estimated Unduplicated Participants:						***100***
Factor D (Divide total by number of participants):						***$157,754.57***
Average Length of Stay on the Waiver:						***350***