KENTUCKY COMMISSION ON SERVICES AND SUPPORTS FOR INDIVIDUALS WITH INTELLECTUAL AND OTHER DEVELOPMENTAL DISABILITIES

A G E N D A

Capitol Annex - Room 131
December 3, 2015
1:00 – 3:00 p.m.

OPENING REMARKS	Eric Friedlander, Deputy Secretary Mary Begley, Commissioner
REVIEW of MINUTES	Eric Friedlander, Deputy Secretary Mary Begley, Commissioner
COMMITTEE REPORTS	• Community Integration—MaryLee Underwood • Health & Wellness—Dr. Kathy Sheppard-Jones • Participant Directed Services--Patty Dempsey & Cathy Edwards
REVISE HB 144 GOALS AND RESTRUCTURE COMMITTEES	Missy McKiernan
HB 144 MEMBERSHIP STATUS	Mary Begley, Commissioner
DMS UPDATES	Leslie Hoffmann, DMS
HCB STATEWIDE TRANSITION PLAN PUBLIC COMMENTS	Leslie Hoffmann, DMS Lynne Flynn, DMS
UPCOMING MEETING DATES	March 3, 2016 June 2, 2016 September 8, 2016 December 8, 2016

KENTUCKY COMMISSION
ON
SERVICES AND SUPPORTS
FOR INDIVIDUALS WITH INTELLECTUAL
AND OTHER DEVELOPMENTAL DISABILITIES

September 3, 2015
Legislative Research Commission
Capitol Annex
Frankfort, Kentucky

MEMBERS PRESENT:

Commissioner Mary Begley
Tabitha Burkhart-Wilson
Leslie Hoffmann for Commissioner Lee
Senator Julie R. Adams
Mary Lee Underwood
Peter A. Perry
Kathy Sheppard-Jones
Donald Putnam
Lynn Braker
Christopher George
Brandon Griffith
James Chesser
Brenda Hosford
Patty Dempsey
Andrew Venetianer
Representative Joni Jenkins
Julie Sweets

MEMBERS ABSENT:

Deputy Secretary Eric Friedlander
Representative David Watkins
Missy McKiernan
Gayle DiCesare
Buddy Hoskinson
Senator Tom Buford
Cathy Edwards
Melissa David

WELCOME

Commissioner Begley opened the meeting and welcomed new and returning members and guests.

REVIEW OF THE MINUTES

Minutes from the June 4, 2015 meeting were approved as presented.

COMMITTEE REPORTS

Community Integration **Mary Lee Underwood**

- Have met twice since the last Commission meeting
- Have partnered with the committee on Participant Directed Services (PDS)
- Presented recommendations for the Michelle P Waiver that had been prepared for the March Commission meeting, which was cancelled due to inclement weather
    1. Strategies for how operations can be improved
    2. Requested that these recommendations be reviewed, formal action taken, and a written response be received from the Cabinet before the next Commission meeting

- Response by Leslie Hoffman re: changes that have already taken effect within the Michelle P waiver
    1. Denial letter has been revised to include the reason for the denial
    2. A sister-agency resource letter is accompanying the denial letter
    3. An interagency committee is working on an assessment tool for children
    4. Timeline for this tool may be the next waiver period: July – September 2016
- The committee is down to 3 members, need more participants
- CHFS will send an email to Commission members to inquire about their interest in serving on committees

Health and Wellness **Kathy Sheppard-Jones**

- Committee has not met, are putting dates together and will be appointing a new chair due to the retirement of Dr. Kleinert

Participant Directed Services **Patty Dempsey & Mary Lee Underwood**

- Most information was presented with the Integration Committee report as they have met together the last two times
- Need new members
- Looking at potential solutions to defer pre-employment costs
- Ongoing issue with payroll being processed timely; are losing staff because of lateness of pay
- Recommendations were presented and include:
    1. Change the language regulating waivers to allow for flexibility in paying for pre-employment and ongoing employment costs
    2. Reallocate existing funds to fund employment-related costs
    3. Reduce employment-related costs
    4. KY Medicaid request technical assistance and implement suggestions from CMS re: how to develop new infrastructure where participants are not responsible for employment-related costs
    5. Use funding set aside for Natural Supports training to use for employment-related expenses
- In a separate report, Committee members request that the legislature appropriate a 20% increase in funding for FY's 2017 and 2018 to address the SCL and MPW waiver waiting lists
- Requested that recommendations be reviewed by the Cabinet with a written response by the next Commission meeting
- Commissioner Anderson commented on the efficacy of recommendations and shared how they will be considered
- Her group is working with various community partners in an attempt to lower some of the PDS employment-related costs and reported that the Department for Aging and Independent Living (DAIL) is hiring nurses to conduct TB screenings. If the screening indicates the need for a TB test, Medicare, Medicaid and most private insurances will cover the test.

PRESENTATIONS

CUSTOMIZED EMPLOYMENT

- This is the 25th anniversary of the Americans with Disabilities Act (ADA). To get involved go to http://adaanniversary.org/
- Kathy Sheppard-Jones introduced a video on Customized Employment produced by the Human Development Institute (HDI) at the University of Kentucky
- Katie Wolf-Whaley presented SCL and other data re: Supported Employment and what consumers want
- Though 42% of those consumers asked stated that they would like a job, only 13% have employment on their Plan of Care (POC). Since the start of SCL-2, the number of participants who state they want a job has increased to 50% which may be related to the increased emphasis on educating participants on employment opportunities.
- Tim Moore, an employee of the Commonwealth's Council on Developmental Disabilities, spoke about the positive impact employment has had on his life
- Melanie Tyner Wilson, parent, spoke about the importance of Customized Employment and the difference it has made in her son's life.

Oakwood Specialty Clinic **Don Putnam**

- Provides core services for medical and psychiatric care on an outpatient basis
- The physical clinic is being expanded
- One phone call to one number can schedule any and all appointments
- The other outpatient clinic in the state is the Lee Specialty Clinic which is housed at Hazelwood ICF/IID

Final Rule Update **Leslie Hoffmann and Lynne Flynn**

- Power Point presentation included information on:
    1. The statewide transition plan
    2. Compliance plan templates
    3. Waiver renewal updates and timelines
    4. OT, PT, and Speech therapies availability, coverage and reimbursement rate
- Commission members requested to receive the language from CMS requiring the changes to therapy services that were discussed.

ANNUAL REPORT

- This will be emailed to Commission members in late September

PUBLIC COMMENTS

- Commissioner Begley opened the meeting to receive public comments
- Testimony received from:
    1. Vickie Roark – family member/caregiver re: the 16-hour cap on receiving home-based services with the waiver and how this is not enough for some consumers
    2. Kelly Upchurch – President of KY Association of Adult Day Centers re: consumers having to wait 6+ months to receive services and requesting that the amended regulation be

filed as an emergency so that people will not have continued delay in accessing needed services.

- Comments from Commission members Chris George and Brandon Griffith supported the statements from Ms. Roark and addressed how the Shared Living service is not a viable option for $600 a month.

Meeting was adjourned at 3:15 pm.

OUR COALITION FOCUSES ON 874,000+ KENTUCKIANS WITH DISABILITIES

We Count! We Matter! We Vote!

More than 874,000 Kentuckians have disabilities.

And this US Census data does not include Kentuckians under the age of 5 or those individuals residing in institutions such as long term care facilities and prisons.

We make up nearly 21% of Kentucky's population!

874K DISABILITIES COALITION ADVOCACY EVENT

TUESDAY, FEBRUARY 2, 2016

Capitol Annex and Rotunda

Gather in the Annex: 10 am EST. Rally in the Rotunda: 1 –2 pm EST.

Educate Policymakers about the "874,000+ Returns on Investments"

Advocate, Attend Committee Meetings, Share Stories (Lunch Provided)

Individuals with disabilities and their families, advocates and providers – more than 800 strong from all regions of Kentucky – will meet with their local legislators, Cabinet and Administration officials during the 874K Advocacy Event on February 2, 2016. The purpose of the event is to give policy-makers an opportunity to meet with their constituents to discuss services and supports that have been invested in Kentuckians with disabilities, the returns on those investments, and unmet needs which have not yet been addressed.

Those attending the event will be encouraged to make appointments to visit with their legislators, to attend legislative committee meetings and to speak with policy-makers and the media about their desire for self-determination and choice. The Governor and all legislators will be invited to participate in the Rotunda Rally.

Topics include barriers to employment, person-centered and consumer-directed services, the ABLE Act, inclusive education, changes in the Medicaid program, assistive technology, accessible transportation, housing, and the funding shortfalls which threaten needed services and supports. The United 874K Coalition is comprised of nearly 80 organizations representing individuals with disabilities and their families, advocates, providers and concerned citizens focusing on the needs of more than 874,000 Kentuckians.

For more information, please call 502-836-4222 or email kyadvocacy@gmail.com

A Report on Supports for Community Living Waiver Program: Paying the Costs of Background Checks and Other Requirements for Direct Service Workers

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Prepared for the

Commonwealth Council on Developmental Disabilities

June 9, 2014

University of Kentucky

Executive Summary

The Supports for Community Living (SCL) waiver program is designed as an alternative to institutional care and a home- and community-based program funded by the Kentucky Department for Medicaid Services and administered by the Department for Behavioral Health, Developmental and Intellectual Disabilities.

The SCL waiver program includes many requirements for direct support professionals including CPR training, TB Skin screening, and multiple background checks that cost $ 372 per employee. This cost becomes a significant issue for individuals who get self-directed services because they cannot require a direct support professional to pay the cost in Kentucky.

This report focuses on showing how this issue is handled in other states. It is based on information collected by reviewing each state's statutes and contacting 15 states by email inquiries (May 22nd – June 4th, 2014).

- Requirements for direct services and financial responsibility for the requirements vary from state to state (see Table).
  - In brief, the costs for requirements are paid through three ways: by an employer, an agency (as administrative costs), or an employee.
    a) Employer's responsibility: Kentucky, Minnesota, and Wisconsin (training);
    b) Administrative costs: Indiana, Missouri (background checks), Michigan, Alabama, Colorado, Louisiana, and Wisconsin (background checks);
    c) Employee's responsibility: Missouri (training), Ohio, West Virginia, Arkansas, Nevada, Florida, Hawaii, and Idaho.
  - Many states financially assist individuals who self-direct supports in terms of background checks using their agency or administrative funds, and it appears that most states consider that employees are responsible for the costs of training requirements for them.

- The costs of a Medicaid provider agency ensuring that its employees meet qualifications identified in rules are built into the reimbursement rate in all responding states.

State	Requirement	Responsibility for Cost for Requirements
Kentucky	CPR, TB Test, background checks	- Employer/Not defrayed by Medicaid
Minnesota	CPR and background checks (optional)	- Training: employer with his/her annual self-directed service budget

State	Requirement	Responsibility for Cost for Requirements
		- Checks: employer/Not defrayed by Medicaid
Indiana	CPR, TB Test, background checks	- Provider agency
Michigan	CPR, background checks	- Training: administrative cost - Checks: agency
Missouri	CPR, background checks	- Training: employee - Checks: administrative cost
Ohio	CPR, background checks	- Employee
West Virginia	CPR, background checks	- Employee
Arkansas	CPR, background checks	- Employee
Nevada	CPR, background checks	- Employee
Alabama	Background checks	- Financial management service agency
Colorado	Background checks	- PPL CO agency - Additional requirement: employer
Louisiana	Background checks	- Fiscal/employer agency
Wisconsin	Background checks	- Training: employer - Checks: Fiscal/Employment agent
Florida	Background checks	- Employee
Hawaii	Background checks	- Employee or employer
Idaho	Background checks	- Employee

Introduction

1. Supports for Community Living (SCL) Waiver Program
   - The SCL Waiver Medicaid program is developed as an alternative to institutional care for individuals with mental retardation or developmental disabilities to allow them to remain in or return to the community in the least restrictive setting (Kentucky Voices, 2012).

2. Federal and Kentucky Statutory Basis
   - §1915(c) of the Social Security Act: The 1915(c) waivers are one of many options available to states to allow the provision of long term care services in home and community based settings under the Medicaid Program. States can offer a variety of services under a Home and Community-Based Settings (HCBS) Waiver program. Programs can provide a combination of standard medical services and non-medical services. Standard services include but are not limited to: case management (i.e. supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care. States can also propose "other" types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community (Center for Medicaid and CHIP Services).

   - 907 KAR 12:010. New Supports of Community Living Waiver Services and Coverage Policies: The SCL waiver program is federally authorized via a 1915(c) Home and Community based waiver.

3. Direct Support Professional (907 KAR 12:020)
   - The direct support professional means an individual who provides services to a participant of SCL waiver programs and has direct contract with a participant when providing services to the participant.

4. The Requirement for Direct Support Professional
   - The Kentucky Labor Cabinet has consistently interpreted KRS 336.220[1] to prohibit an employer/potential employer from passing to the employee/applicant the cost of furnishing any records required by the employer as a condition of employment. This includes background checks, drug screening, etc.

[1] 336.220 Cost of medical examination required by employer.
(1) It shall be unlawful for any employer to require any employee or applicant for employment to pay the cost of a medical examination or the cost of furnishing any records required by the employer as a condition of employment.

- An employer is responsible for payment for processing drug screen, TB screen, CPR/First Aid, College of Direct Support (CDS), any additional training, possible educational requirements, and background check requirements; the funding for these requirements is the responsibility of the employer; having these requirements paid for the first five employees by Medicaid is not an option (Q & A of Kentucky Cabinet for Health and Family Services).

5. Self-Directed Services
   - Self-directed Medicaid services means that participants have decision-making authority over certain services and take direct responsibility to manage their services with the assistance of a system of available supports. Self-direction of services allows participants to have the responsibility for managing all aspects of service delivery in a person-centered planning process (Centers for Medicare & Medicaid Services).

State by State Information

I. Neighboring States

1. Indiana

- Requirement (460 IAC 1.2-6-3 and 460 IAC 1.2-14-1)
  - Indiana does not enroll individual rendering providers; this state ONLY holds the entities (or agencies) responsible for meeting overall staffing qualifications and other requirements.
  - Staff providing direct care for HCBS providers must:
    a) Submit a copy of a current negative TB test or negative chest x-ray that is completed annually.
    b) Maintain current CPR certification, verification of each training session attended by the employee, and limited criminal history information that meets the requirements of 460 IAC 1.2-6-2(3).

- Costs for Requirement
  - <u>The costs of meeting the employee/staffing requirements are incurred by the prospective or approved provider agency</u>. Indiana has not outlined requirements from whom specifically those costs must be paid.

2. Missouri

- Requirement (Self Directed Supports (SDS) Handbook, 2014)
  - Anyone over age 18 with a High School diploma or GED, who the individual or their designated representative chooses to hire, can be a SDS employee.
  - When participants self-direct supports, they have the freedom as well as the responsibilities that come with being an employer. The Fiscal Management Service (FMS) acts as an agent for them. The FMS assists employers with processing prospective employees' background checks and verifying that their employees have received required training.
  - Employees must meet pre-employee training requirements and must submit documentation for the training. Personal Assistants (employees) may have CPR, First Aid, Med Aide, and Behavioral training unless the training has been exempted by the individual/designated representative. It is the responsibility of the employee to keep all training current during the duration of employment.
  - Background Checks are required for all potential employees prior to beginning employment. The screening is processed by the FMS organization.

- Costs for Requirement (Self Directed Supports (SDS) Handbook, 2014)
  - The services from the FMS are provided as an administrative service and not as a waiver service and do not come out of your individual budget.
  - Employees are responsible for the cost of training requirement.

3. Ohio

- Requirement
  - Individuals who wish to be certified are treated as independent contractors and must be qualified in order to be approved to deliver waiver services.
  - Each employee shall meet the following requirements (Ohio Revised Code 5123:2-2-01):
    a) Hold valid "American Red Cross" or equivalent certification in first aid.
    b) Hold valid "American Red Cross" or equivalent certification in cardiopulmonary resuscitation ("CPR").
    c) Have completed, prior to application for initial certification in the case of an independent provider and prior to providing services in the case of an employee, contractor, or employee of a contractor of an agency provider, eight hours of training in accordance with guidelines established by the department.
  - Background checks are required for each employee (Ohio Revised Code 5123:2-2-01)

- Costs for Requirement
  - An individual who is a participant using the self-directed waiver may hire individuals directly, who must be certified as independent contractors (employees) and so must be responsible for their own training.
  - The individual with a waiver does not have any financial obligation for the costs of DSP training.
  - Meanwhile, independent contractors or individuals not associated with agencies can find training opportunities through their local county agencies that assist families with finding available and qualified providers.
  - Often the trainings are free and paid for by counties and in some cases, as in for CPR, the counties make available a list to providers of available trainers so that the rule requirements can be maintained.
  - Each independent provider has financial responsibility for a criminal record check (ORC 5164.341).

4. **West Virginia**
   - Requirement
     - All Qualified Support Workers (QSW) must have documentation of initial and renewal of training requirements (WV Section 513.9.2.2.1) :
       a) Documented training on Emergency Procedures, Emergency Care, and Infectious Disease Control;
       b) Documented training on First Aid and in Cardiopulmonary resuscitation (CPR) by a certified trainer;
       c) Documented training on Member-specific needs (including special needs, health and behavioral health needs);
       d) Documented training in Recognition of, Documentation of and Reporting of suspected Abuse/Neglect and Exploitation
   - Costs for Requirement
     - The QSW may be responsible for the certain costs, i.e. CPR and First Aid certifications, CIB/NCIC background checks (WV Section 513.9.2.2.1).
     - The employer of record may pay these trainings, but does not have to. If the employer of record does not wish to pay for requirements, then it is the responsibility of the employee to do so.

II. Other States

1. **Alabama**
   - Requirement
     - The self-directed employees need to meet the requirements of the waiver. This includes:
       a) A 10th grade education at minimum;
       b) Minimum 1 year experience;
       c) Background check and drug testing.
     - Meanwhile, the certification requirements for a contract provider include the CPR training, TB Skin Test, background check, and drug screening.
   - Costs for Requirement
     - Financial Management Services Agency reviews all requirements and runs the background screenings on behalf of the self-directed participant.

- The family could require more than the minimum, but they would have to bear the costs of this.

2. **Arkansas**
   - Requirement
     - A criminal background check has been initiated. The Division of Developmental Disabilities Services (DDS) requires criminal background checks for all direct care staff (DHS Policy 1082).
     - Caregivers must submit to a drug screen upon employment and to subsequent random drug screens (DHS Policy 1082).
     - Training Requirements for direct care staff (DDS Certification Standards 301.5):
       a) CPR (Initial Certification, renewed as required by American Heart Association, Medic First Aid, or Red Cross);
       b) Medication—Implications, Side Effects, Legality of Administering medication;
       c) Twelve (12) hours minimum completed within (30) days of employment (does not include First Aid and CPR training).
   - Costs for Requirement
     - Caregivers must pay all costs and fees for the required criminal background checks.

3. **Colorado**
   - Requirement
     - The Consumer Directed Attendant Support Services program has only a few requirements for employees (Managing Employer Training Handbook):
       a) Must complete a criminal background check and board of nursing background check on all workers and the person must pass both checks to be employable by PPL CO (Public Partnership LLC – Colorado);
       b) Must be 18 years old.
     - An attendant[2] (employee) is hired through the contracted FMS[3] organization.
   - Costs for Requirement

[2] Attendant means the individual who meets qualifications in § 8.510.8 who provides CDASS as determined by § 8.510.3 and is hired through the contracted FMS organization (CCR 2505-10 Section 8.510).

[3] Fiscal Management Services organization (FMS) means the entity contracted with the Department as the employer of record for Attendants, to provide personnel management services, fiscal management services, and skills training to a client/AR receiving CDASS (CCR 2505-10 Section 8.510).

- The prospective employee will need to fill out the Criminal Background and Board of Nursing form in order for PPL CO to run the background check. The check identifies the person's criminal history in Colorado.
- If the attendant has worked in other states, an individual who self-direct services would need to run this additional background check at individual's expense.

4. **Florida**
   - Requirement
     - The Consumer-Directed Care Plus (CDC+)[4] Program has a requirement for employees: Background Screening that is a criminal history check and must include, but not be limited to, fingerprinting for statewide criminal history records checks through the Florida Department of Law Enforcement, and national criminal records checks through the Federal Bureau of Investigation, and may include local criminal records checks through local law enforcement agencies (CDC+ Handbook, 2012).
   - Costs for Requirement
     - The prospective employee or the CDC+ employer is responsible for the cost of background screening. The CDC+ employer cannot use the CDC+ monthly budget to pay for background screenings (Background Screening, 2010).

5. **Hawaii**
   - Requirement
     - The Hawaii's Medicaid waiver program includes a requirement for a personal assistant (employee): Background Checks including criminal conviction record check and reference checks (Consumer Directed Personal Assistance Handbook, 2013).
   - Costs for Requirement
     - Employers will need to pay for the criminal conviction record check or require their applicant to pay for this (Consumer Directed Personal Assistance Handbook, 2013).

6. **Idaho**
   - Requirement

[4] CDC+ is a Florida Medicaid program that permits certain Consumers to self-direct their own Personal Assistance Services (Developmental Disabilities Medicaid Waivers Consumer-Directed Care Plus Program Coverage, Limitations, and Reimbursement Handbook, 2012).

- Individuals who provide direct care or services (employees) must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06.
- Otherwise, the Consumer Directed Services rules do not specifically identify provider qualifications that must be met to deliver the supports.
- It is the responsibility of the participants (employers) to ensure their employees have the skills necessary to deliver supports in a safe and appropriate manner; however, the Consumer Directed Services rules do state if the identified supports require specific licensing or certification within the state of Idaho, the identified community support workers must obtain the applicable license or certification.

- Costs for Requirement
  - Employees are responsible for those costs.
  - Additional funds are not available to defray the costs associated with ensuring that an employee meets those qualifications required by rule or necessary to ensure safe and appropriate care provision to a participant.
  - A participant's individualized budget may not specifically be used to pay the cost of criminal history checks for employees, assist the employee to meet licensure or certification requirements, obtaining testing and/or attend training courses to develop the needed skill sets to provide safe and appropriate care.

7. Louisiana

- Requirement (Self-Direction Option Employer Handbook, 2014)
  - The potential employee/applicant must pass criminal history background and direct services worker registry checks.
  - It is the responsibility of the employer to complete follow up background checks every 6 months after hire; The employer is required to:
    a) Complete a search of the Direct Service Worker (DSW) Registry;
    b) Complete a search on the Office of Inspector General's List of Excluded Individuals/Entities.

- Costs for Requirement (Self-Direction Option Employer Handbook, 2014)
  - The initial background check and a criminal conviction history check will be completed by the fiscal/employer agent[5]. The follow up background checks are available at the websites.

[5] The Fiscal/Employer Agent is a required component of the Self-Direction option. The fiscal/employer agent will assist participants in managing some of the financial responsibilities of being an employer. The fiscal/employer

- Fiscal/Employer agent is responsible for monitoring employment related costs.

8. **Michigan**
   - Requirement
     - The MI Choice waiver program requires CPR training and background checks for individuals hired directly by the program participant through the self-determination option.
     - There are no specific requirements for TBI Skin Testing through the waiver program itself.

   - Costs for Requirement
     - The requirement of CPR training is met in various ways. Some waiver agencies have purchased CPR training tapes or DVDs, and Michigan has the potential employee sign a statement indicating that they have watched and understand the content of the video.
     - Some waiver agencies have staff who are trained CPR instructors and will periodically offer CPR instruction. Other potential employees will take courses offered through the Red Cross or other organization.
     - In addition, Michigan has training as one of the waiver services and, in the definition of this service, Michigan includes training self-determined workers, so can assist with paying for this requirement through that service.
     - Background checks can be done for free by a non-profit agency. If there is a cost, this would be part of the administration for the program.

9. **Minnesota**
   - Requirement (Consumer Handbook and Agency Manual)
     - The Consumer Directed Community Support (CDCS) waiver program requires participants to have a case manager/care coordinator through the lead agency and a Fiscal Support Entity (FSE) who is responsible to approve all expenditures requested on an individual's community support plan.
     - The person providing assistance does not need a license, certificate or credentialing unless required by the consumer. Background checks are also optional[6].

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agent will also notify participants once their potential employees are clear for hire including the criminal history background and direct services worker registry checks.

[6] Consumers (employers) must include information in their plan on which support workers they choose to do background checks on and which ones they will not do background checks on (Consumer Handbook, p.13).

- The person can also define additional provider qualifications such as knowledge of sign language or completion of CPR training.

- Costs for Requirement (Consumer Handbook and Agency Manual)
  - If the participant is the employer of the support worker, the cost of paid or unpaid support staff training and education comes out of the participant's annual CDCS budget; when a consumer defines additional provider qualifications, the consumer could hire a person and pay for this training for the individual.
  - Background checks are optional, and FSE can help an employer get the background check done and will bill for the cost of the background check. The cost of the background check does not come out of the employers' budget when they choose to have a background check done.
    a) On the other hand, if employers choose to use an agency as their agency with choice that requires background checks, the cost of the background check is included in the administrative rate for that agency, which comes out of their budget.
    b) If employers select a waiver or Alternative Care service that requires a formal provider to have a background check, then the cost of the background check is included in the rate for that waiver or Alternative Care service, which comes out of their budget.

10. Nevada

- Requirement
  - Nevada requires TB tests, CPR training, and fingerprint based criminal background checks for all potential employees.

- Costs for Requirement
  - It is the individual caregivers who are fiscally responsible for obtaining these requirements. There are no Medicaid or other funds available to offset these costs.

11. Wisconsin

- Requirement (IRIS Participant Handbook)

- Everyone in IRIS[7] has an IRIS Consultant. Consultants will help participants design a plan that fits into their allocation, make sure all the paperwork is done, and find workers, service providers and items.
- Background checks are required for all potential employees. The Fiscal/ Employment Agent (F/EA)[8] completes all background checks on the workers for employers.

- Costs for Requirement
  - The services delivered by the IRIS Consultant or the F/EA are provided as an administrative service through the approved HCBS waiver.
  - The participants are responsible for providing all training to their workforce.

[7] IRIS is a Medicaid funded, long-term care program offered by the Wisconsin Department of Health Services. IRIS is grounded in the Principles of Self-Determination.

[8] The Fiscal/Employment Agent is contracted by the Department of Health Services to provide payroll services to participants who choose to serve as the employer of record.

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HB 144 PARTICIPANT DIRECTED SERVICES COMMITTEE

Recommendations

December 3, 2015

The Participant Directed Services Committee makes the following recommendations to the HB 144 Committee. These recommendations are in line with the goals and objectives of the Committee to promote community education, outreach and access to services and supports that meets the needs and expectations of participants.

1. Include participants and/or their families in the construction of new waivers and regulations.

   The Committee encourages the appropriate CHFS agency to include participants and/or families in discussions that pertain to new waivers or waiver changes being considered, particularly when pertaining to self-directed services.

2. Notify participants whenever regulation changes are proposed that will impact their services and supports. (Currently participants do not receive regulation change information until after the proposed change(s) have taken place).

3. Allow participants to change line items as needed within their Plan of Care (budgets) across all waivers.

   Medicaid waivers through the Center on Medicaid Services are intended to give people with disabilities more opportunities to better community living and control of their lives. However, prohibiting changes in line items in the individual Plan of Care (budget) creates barriers and the flexibility intended in self-directing services.

   Also, when preparing a Plan of Care, it would be helpful if the participant could be provided a copy of the regulations by the Case Manager as they may not have online service.

HB 144 COMMISSION GOALS

In 2012 HB 144 Commission members, in collaboration with the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) established the following five (5) long-term initiatives for the next 5-10 years.

GOAL 1:

Community education and outreach must be a combined effort to create an awareness of need and available services for people with intellectual and developmental disabilities (I/DD).

GOAL 2:

Promote inclusion of citizens with disabilities to increase natural supports in the community and in the workplace.

GOAL 3:

Advocate for adequate funding for a system of services and supports throughout the individual's lifespan.

GOAL 4:

People with disabilities and their families will have continued access to services and supports that meet their needs and expectations.

GOAL 5:

The primary focus for public intermediate care facilities will shift to expand networks providing a continuum of health care within the individual's community.

Responses to HB144 Recommendations for the Michelle P. Waiver

First, we recommend that letters of denial should provide substantive reasons for denial and be written in easily understood language. Also, the appeal process and timeline should be outlined in the denial letter. The denial letter should be sent to the individual applicant, family members as appropriate and any provider or organization which assisted the individual with the application process.

Response: Denial letters for Michelle P. Waiver have been revised to include the reason for denial. When an individual receives a denial letter, instructions for reconsideration are included. Once reconsideration is denied, another letter on how to appeal the denial and timelines for the appeal is mailed to the individual. ***Please see enclosed examples.***

Second, we recommend that a statement of the criteria for certification with an outline of the process be developed. In addition, this document should be written in clear language and should be made available to clients, their parents, and caseworkers involved in the certification process. Furthermore, a tool appropriate for assessing children should be developed to reflect these criteria.

Response: An individual may be eligible for the MPW waiver if s/he has a developmental or intellectual disability, who requires a protected environment while learning living skills, educational experiences, awareness of their environment, and meet Medicaid financial eligibility requirements. Furthermore, the participant will need to undergo an assessment, which is currently done by the MAP-351. Eligibility is determined by the results of this assessment, and since each individual is unique, the process varies.

The Cabinet for Health and Family Services (CHFS) is in the process of contracting with a local university to conduct a pilot for a new assessment tool that is appropriate for both children and adults. No one will lose eligibility because of this pilot; rather, the purpose of the pilot is to assess the impact that a new tool would have on the MPW population. The Cabinet is hopeful that the pilot will begin in the next couple of months.

Third, we recommend that the Cabinet for Health and Family Services (CHFS) provide on its website a "dashboard" of current waiver allocations similar to what has been distributed to the HB 144 commission so that everyone – individuals with disabilities, parents and providers – understands the availability of waiver services.

Response: At the present time we are not able to provide via the website an up to date current waiver allocation "dashboard" due to the lack of capabilities in the system. Information will continue to be distributed to the HB 144 Commission on a quarterly basis. ***Please see enclosed quarterly report.***

Fourth, we recommend that the website should provide clear recommendations for alternative supports, given that most or all of the waiver slots are currently allocated. In addition, the electronic case management system being developed by CHFS should incorporate all available supports appropriate for individual applicants.

Response: Every individual who is screened for waiver services receives this letter, which includes an extensive listing of alternative supports. ***Please see enclosed resource letter.***

Fifth, and most importantly – we recommend that CHFS in collaboration with individuals with disabilities, family members, advocates, and providers should initiate a process with a well-defined timeline to address the future of the Michelle P. Waiver and the development of possible alternatives for children and young adults with Autism Spectrum disorders. This initiative could be incorporated into KY's effort in addressing the HCBS Federal Final Rules.

Response: Kentucky intends to renew the Michelle P. Waiver when it is up for renewal in September, 2016. This means that Kentucky will continue offering the waiver for the five year renewal period. There are also many services available in the Medicaid State Plan for individuals with autism, including services provided by Licensed Behavior Analysts and Licensed Assistant Behavior Analysts.

While we agree that resources for children and young adults with Autism Spectrum disorders is an important issue, we believe that it is most appropriately addressed separately from the HCBS Federal Final Rules. Those rules apply to all existing Home and Community Based Services (HCBS) in all States, and Kentucky's current efforts are focused on assessing HCBS providers and settings to determine which of them will require heightened scrutiny by the Center for Medicaid Services.

Funding requests for SCL and Michelle P. Waivers (MPW)

SFY 2017: DMS Requested 200 slots for SCL and 200 slots for Michelle P.

SFY 2018: DMS requested that the 200 slots/waiver include in the SFY 2017 budget request continue and also requested an additional 200 slots for SCL and 200 slots for Michelle P.

****Total 400 for SCL and 400 for MPW 2017-18 budget years

July 10, 2015

[redacted]

HP Enterprise Services has contracted with Carewise Health, a utilization review agency, to perform the review of services provided to Medicaid recipients.

This is to notify you, [redacted] that the following services and requested dates of service have been denied in accordance with 907 KAR 1:022, 907 KAR 1:835, 907 KAR 3:130:

Service Description	Date Range
MICHELLE P - LOC	05/28/2015 - 05/26/2016

The specific reason for the denial is current documentation is lacking that this recipient has impairment of general intellectual functioning or adaptive behavior similar to that of an individual with intellectual disability, or substantial functional limitations in major life activity, consistent with review criteria required by regulation. Therefore, the request for Michelle P LOC certification is not authorized.

If you, the recipient, your authorized representative, your legal guardian, or provider acting on behalf of the recipient, are dissatisfied with this decision, you may exercise your right to dispute these findings by following the procedure listed on the last page of this letter.

[redacted]

CC: BLUEGRASS.ORG

Kentucky UNBRIDLED SPIRIT

Notice of Right to Reconsideration

Should you, as a Medicaid recipient, applicant, guardian or provider acting on the behalf of the recipient, disagree with this decision, you have the right to request a reconsideration. The request for reconsideration must be in writing and postmarked within 10 calendar days of the date of this letter. The written request must state clearly that you dispute this finding. It must be submitted to: Carewise Health, Attn: Reconsideration Coordinator, 9200 Shelbyville Rd., Suite 800, Louisville, KY 40222. If you are already receiving services, you will continue to receive them through the date of the final decision. Within three (3) business days of your request we will make a decision on your request.

The reconsideration will consist of a review of medical records and any additional relevant information submitted by you, your legal guardian, your authorized representative, or your provider for consideration by one or more physicians not involved in the initial review.

At the conclusion of the reconsideration, a decision will be made and the review agency will notify you or your authorized representative, your legal guardian, and the provider of the results within two (2) business days. Included with this notification will be a description of your further hearing rights to the Department for Medicaid Services along with the procedures for requesting a hearing. To request a hearing, please send a request in writing to the Division of Program Quality & Outcomes, 275 East Main Street, 6 C-C, Frankfort, KY 40621 within 10 calendar days of the date of the denial letter.

If you have any questions about the reconsideration process they should be addressed to: Carewise Health, Attn: Reconsideration Coordinator, 9200 Shelbyville Rd., Suite 800, Louisville, KY 40222 or (800) 292-2392.

Kentucky UNBRIDLED SPIRIT

July 24, 2015

[redacted]

HP Enterprise Services has contracted with Carewise Health, a utilization review agency, to perform the review of services provided to Medicaid recipients.

This is to notify you, [redacted] that the following services and requested dates of service have been denied in accordance with 907 KAR 1:022, 907 KAR 1:835, 907 KAR 3:130:

Service Description	Date Range
Respite Care Services, Up To 15 Minutes	07/14/2015 - 07/12/2016

The specific reason for the denial is the recipient lives independently in her own apartment; the medical necessity for respite (T1005) is not supported by a review of the current clinical information provided, and therefore, is not authorized.

If you, the recipient, your authorized representative, your legal guardian, or provider acting on behalf of the recipient, are dissatisfied with this decision, you may exercise your right to dispute these findings by following the procedure listed on the last page of this letter.

[redacted]

CC: [redacted]

Kentucky UNBRIDLED SPIRIT

Notice of Right to Reconsideration

Should you, as a Medicaid recipient, applicant, guardian or provider acting on the behalf of the recipient, disagree with this decision, you have the right to request a reconsideration. The request for reconsideration must be in writing and postmarked within 10 calendar days of the date of this letter. The written request must state clearly that you dispute this finding. It must be submitted to: Carewise Health, Attn: Reconsideration Coordinator, 9200 Shelbyville Rd., Suite 800, Louisville, KY 40222. If you are already receiving services, you will continue to receive them through the date of the final decision. Within three (3) business days of your request we will make a decision on your request.

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At the conclusion of the reconsideration, a decision will be made and the review agency will notify you or your authorized representative, your legal guardian, and the provider of the results within two (2) business days. Included with this notification will be a description of your further hearing rights to the Department for Medicaid Services along with the procedures for requesting a hearing. To request a hearing, please send a request in writing to the Division of Program Quality & Outcomes, 275 East Main Street, 6 C-C, Frankfort, KY 40621 within 10 calendar days of the date of the denial letter.

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Kentucky UNBRIDLED SPIRIT

1915 C Waiver	Approved Allocations	Allocated/Active/Discharged	Waiting List
ABI Acute	383	383	110
ABI LTC	320	320	179
Model Waiver II	100	46	0
MPW	10,500	10,500	4515
HCBS	17,050	9291	0

As of 10.31.15

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Steven L. Beshear
Governor

Leslie Hoffmann
Director
Commissioner

Division of Community Alternatives
275 E Main St, 6 W-B
Frankfort, KY 40621
Phone: (502) 564-7540
Fax: (502) 564-0249
www.chfs.ky.gov

Audrey Tayse Haynes
Secretary

Lisa D. Lee

DATE

John Doe
123 Anywhere St
Nowhere, KY 40666

Information was recently submitted on your behalf to the Medicaid Waiver Management Application (MWMA) Portal because you were interested in a Medicaid Waiver Program. Submitting information through the MWMA starts a prescreening process to review if an individual may be eligible for a Waiver Program. Only those individuals who meet the prescreening criteria will go on to a formal application. Currently, you do not meet the requirements to advance to a full review.

Below you will find other programs, resources, or organizations that may be of assistance:

Advocacy/Resource Centers:

Advocacy Action Network:	http://www.advocacyaction.net/
	502-894-0777 or 877-894-0222
Aging and Disability Resource Center (ADRC)	877-925-0037
Commonwealth Council on Developmental Disabilities:	www.kyccdd.com/
	877-367-5332
Community Action Kentucky	502-564-7841
Kentucky Family Resource and Youth Service Centers	http://chfs.ky.gov/dfrcvs/frysc/
	502-564-4986
Kentucky Long-Term Care Ombudsman	http://www.ombuddy.org/
Kentucky Partnership for Families and Children	502-875-1320 or 800-369-0533
Kentucky Self Advocates for Freedom	http://www.kyselfadvocates.org/
	859-245-0717
Kentucky Special Parent Involvement Network (SPIN)	http://www.kyspin.com/
	502-937-6894 or 800-525-7746
Kentucky State Coordinator for Americans with Disabilities Act	http://ada.ky.gov/
	502-564-3850 or 877-423-2933
Learning Disabilities Association of Kentucky	http://www.ldaofky.org/
	877-587-1256 or 877-587-1256
Kentucky Protection and Advocacy:	http://kypa.net/
	502-564-2967 or 800-372-2988
Kentucky Youth Advocates	502-895-8167 or 888-825-5592
The Arc of Kentucky	502-875-5225

Aging Care:

Aging and Disability Resource Center (ADRC)	877-925-0037
Personal Care Attendant Program	502-564-6930
Kentucky Caregiver	502-564-6930
Kentucky Homecare Program	502-564-6930

Behavioral Health:

National Alliance on Mental Illness, Kentucky Affiliate	http://namikyadvocacy.com/ 606-451-6935 or 800-257-5081

Blind:

Office for the Blind	http://blind.ky.gov/Pages/contactus.aspx 502-564-4754 or 800-321-6668

Brain Injury:

Brain Injury Alliance of Kentucky	http://www.biak.us 502-493-0609 or 800-592-1117
Traumatic Brain Injury Trust Fund	502-564-6930 or 855-816-9577

Children/Physical Disabilities:

First Steps:	http://chfs.ky.gov/dph/firststeps/ 877-417-8377
Commission for Children with Special Health Care Needs	http://chfs.ky.gov/ccshcn/ 502-429-4430 or 800-429-4489

Developmental, Physical and/or Intellectual Disability:

Community Action Kentucky	502-875-5863 or 800-456-3452
HART Supported Living	502-564-6930
Epilepsy Foundation of Kentuckiana	http://www.efky.org/ 502-637-4440 or 866-275-1078
Kentucky Autism Training Center	http://louisville.edu/education/kyautismtraining/ 502-852-4631 or 800-334-8635
Kentucky Commission on Deaf and Hard of Hearing	http://www.kcdhh.ky.gov 502-573-2604 or 502-416-0607 Video Phone
Kentucky Fetal Alcohol Spectrum Disorders Center	http://www.kyfasd.org/ 859-225-3296
Spina Bifida Association of Kentucky	http://spinabifidakentucky.org/ 502-637-7363

Financial Assistance:

Community Action Kentucky	502-875-5863 or 800-456-3452

Health Care/Insurance:

Health Kentucky (Health Care Access Line)	800-633-8100
Kentucky Children's Health Insurance Program (KCHIP)	http://kidshealth.ky.gov/en/kchip/ 877-524-4718 or 877-524-4719 TTY/TDD
Kentucky State Health Insurance Assistance Program (SHIP)	877-293-7447

Technology:

Kentucky Assistive Technology Loan Program	http://katlc.ky.gov/Pages/default.aspx 877-675-0195
Kentucky Assistive Technology Services (KATS)	http://www.katsnet.org/ 800-327-5287

DEPARTMENT FOR MEDICAID SERVICES

RESPONSES TO HB 144 PARTICIPANT-DIRECTED SERVICES AND COMMUNITY INTEGRATION

Recommendations

The Participant-Directed Services (PDS) and Community Integration Committees make the following recommendations to HB 144 Committee. Employing one recommendation would have some impact, but implementing two or more would have a much more significant impact.

(1) Change the language regulating waivers to allow for flexibility in paying for the pre-employment and ongoing employment costs. KRS 205.6317 includes language prohibiting paying for "non-direct services" … Removing this language or amending it to, "Direct services shall include costs associated with pre-employment and on-going employment requirements as dictated by regulations" in the Supports for Community Living waiver and then replicating it through the other waiver programs may allow for more flexibility in paying the pre-employment costs.

This would require a statute change. This recommendation will be taken under advisement to discuss amongst CHFS administration following the transition.

(2) Reallocate existing funds to fund employment-related costs. Since January 2014, there have been no SCL II prior authorizations for "Natural Supports" and "Family Training" and only approximately $1,200 has been paid through the ABI long term care waiver. Funds in these categories could potentially be reallocated for a new code to be used for "Employment Costs", or another new or modified code. There are no existing funds, like a bank holding funds. This would still be an increase in cost to DMS.

There are no existing excess funds, like a bank holding funds. This would still be an increase in cost to DMS. The entire Medicaid benefits budget is used to pay for covered services for Medicaid recipients. Funds are not reserved or held back.

(3) Reduce employment-related costs. Costs are being substantially increased as waivers are being updated. New requirements in SCL II are expected to be incorporated into other waivers (as each is revised). Costs that could be eliminated include:

- First Aid & CPR Training provided through American Red Cross or American Heart Association (cost $70 – $125)
- TB Screening (cost varies dramatically, up to $75)
- Drug Testing – regulation is unclear on what is required and many individuals believe it is ineffective and overly invasive (cost varies dramatically, up to $75)

We recognize these requirements may cause hardships to those recipients choosing PDS; however the new requirements were established to ensure the health, safety and welfare of all SCL recipients. These requirements comply with the current traditional provider requirements; therefore, all direct service providers have met the same requirements prior to providing hands on services to recipients. Furthermore, the requirements prevent recipients from having direct service

providers who could otherwise endanger the recipient with unhealthy circumstances. The requirements allow the direct service to be prepared to assist the recipient, if necessary, in their own medical emergency.

(4) Kentucky Medicaid should request technical assistance and implement suggestions from Centers for Medicare & Medicaid Services (via Molly Murphy) regarding how to adapt the infrastructure for the self-directed model to ensure that participants are not responsible for employment-related costs. ***Thank you for this recommendation; we are aware of options related to self-direction; however based upon the statute language, we are unable to pursue moving costs to other aspects within the waiver(s).***

Supports for Community Living Allocations
FY16 Progress & Totals FY08-FY15

FY16 Progress			
Date	ER	URGENT	Total
Jul-15	51	1	52
Aug-15	58	1	59
Sept 15	49	1	50
Oct 15	58	0	58
Nov 15	34	1	35
YTD	**250**	**4**	**254**

Region													
1	2	3	4	5	6	7	8	10	11	12	13	14	15
3	1	3	3	7	5	3	1	1	2	4	3	3	13
1	4	2	1	4	11	1	0	3	1	5	3	7	16
1	2	5	3	9	7	5	0	3	0	2	3	4	6
2	3	0	4	9	10	4	0	6	1	3	2	5	9
2	1	4	4	5	6	1	0	1	0	1	1	1	8
9	**11**	**14**	**15**	**34**	**39**	**14**	**1**	**14**	**4**	**15**	**12**	**20**	**52**

FY08 - FY15						
Fiscal Year	ER	PASRR	DCBS	MFP	Urgent	Total
FY15	495	14	4	32	8	**553**
FY14	342	NA	NA	24	14	**380**
FY13	397	NA	NA	38	216	**651**
FY12	226	2	30	81		**339**
FY11	133	5	33	0		**171**
FY10	136	9	30	0		**175**
FY 09	159	15	22	0		**196**
FY08	197	33	33	0		**263**

Region													
1	2	3	4	5	6	7	8	10	11	12	13	14	15
29	27	28	58	31	143	17	2	14	18	21	15	47	103
7	26	13	33	20	92	32	7	10	12	24	19	18	67
17	42	36	54	39	172	65	3	21	13	20	21	33	115
14	17	11	26	10	62	32	0	11	14	30	16	37	59
7	8	6	11	16	39	8	1	6	4	12	12	16	25
10	14	4	5	16	31	11	0	8	8	16	15	16	21
4	6	8	22	13	41	15	1	14	12	7	7	21	25
3	17	9	20	24	62	17	5	12	10	18	16	11	39

SCL Waiting List Report

As of 11/29/2015

Future Planning	Urgent	Emergency	Total
1985	39	2	2026

Of those on the waiting list, 96.7% (1921) report receiving services.

Funding Source or Services Reported by those on the waiting list:

Funding Source or Service Reported	#	%
Case Management	1952	96.3%
Michelle P Waiver	1348	66.5%
Respite	1169	57.7%
Day Program	883	43.6%
Speech Therapy	713	35.2%
School	679	33.5%
Mental Health	673	33.2%
Transportation	560	27.6%
Occupational Therapy	536	26.5%
Behavior Support	529	26.1%
other	520	25.7%
Physical Therapy	401	19.8%
Supported Employment	346	17.1%
HCB Waiver	275	13.6%
EPSDT	255	12.6%
Residential	227	11.2%
In home support	182	9.0%
Home Health	178	8.8%
Supported Living	137	6.8%
ABI (Acquired Brain Injury-Waiver)	124	6.1%
ABI (Acquired Brain Injury Long Term Care-Waiver)	12	0.6%

KENTUCKY

Cabinet for Health and Family Services

DEPARTMENT FOR MEDICAID SERVICES

HOME AND COMMUNITY BASED SERVICES WAIVERS UPDATE

HB144 COMMISSION

PRESENTED BY:

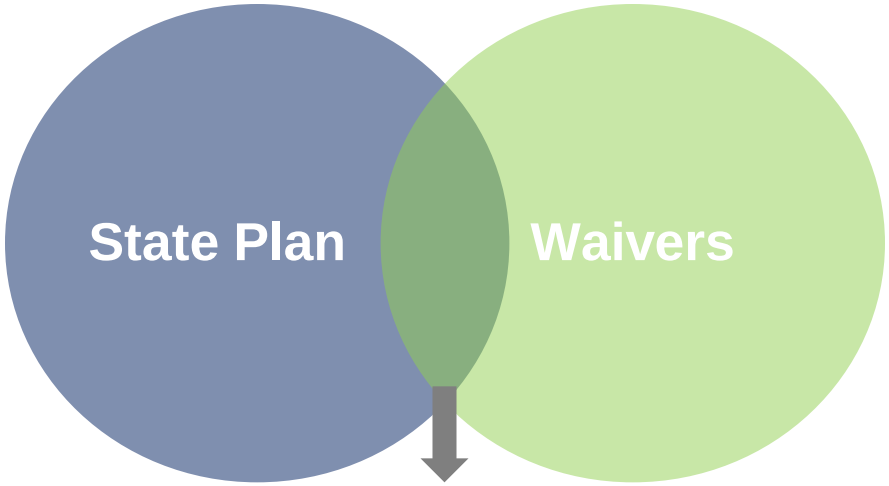
LESLIE HOFFMANN, DIRECTOR, DIVISION OF COMMUNITY ALTERNATIVES, DEPARTMENT FOR MEDICAID SERVICES
LYNNE FLYNN, POLICY ADVISOR, COMMISSIONER'S OFFICE, DEPARTMENT FOR MEDICAID SERVICES

DECEMBER 3, 2015

Update on Ancillary Services

PT/OT/ST Waiver Transition to State Plan

PT/OT/ST have been historically provided to children through EPSDT and to HCBS waiver participants. However, on 1/1/14, DMS added PT/OT/ST as covered benefits its state plan for all Medicaid members.



- Overlap between a service provided in a state plan and a service provided in the waiver is **not** allowed by the Centers for Medicare and Medicaid Services (CMS).
- There are some options for states to provide ***similar*** services in its state plan and its waiver, but the services cannot be the same in both.
  - **Extended state plan services** are only allowable in the waiver if the service in the state plan has a hard limit that cannot be exceeded by medical necessity
  - **"Other" services** are only allowable if the waiver service is distinct or materially different from the state plan service
  - **For children**, any service which CMS allows as a state plan service must be provided through the state plan. If not covered by the state, the service must be provided through Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

PT/OT/ST Waiver Transition to State Plan

Since DMS cannot cover PT/OT/ST in both the waivers and the state plan, DMS is transitioning these services from the HCBS waivers into the state plan at the time of renewal for each of the HCBS waivers.

	Transition in Progress
SCL	• Submitted renewal application to CMS without PT/OT/ST in June • Filed SCL regulations without PT/OT/ST as covered services in August • Transition anticipated: **March, 2016**
HCB	• Submitted renewal application to CMS without PT/OT/ST in April • Filed HCB regulations without PT/OT/ST as covered services in September • Transition anticipated: **March, 2016**
	Upcoming Transition
ABI-LTC	• Submit renewal application to CMS on April 1, 2016 (effective date of July 1, 2016) • File ABI-LTC regulations without PT/OT/ST as covered services in January • Transition anticipated: **July, 2016**
MPW	• Submit renewal application to CMS on June 1, 2016 (effective date of September 1, 2016) • File MPW regulations without PT/OT/ST as covered services in March • Transition anticipated**: September, 2016**
ABI	• Submit renewal application to CMS on October 1, 2016 (effective date of January 1, 2017) • File MPW regulations without PT/OT/ST as covered services in July • Transition anticipated**: January, 2017**

Update on MWMA

Medicaid Waiver Management Application

The use and continued deployment of the Medicaid Waiver Management Application (MWMA) continues to progress positively. Currently, use of MWMA is not mandated by regulations.

MWMA Utilization

- Over **1,330 external users** from 160 case management organizations have log in IDs and passwords
- **950 Case Managers** with active case loads
- More than **95% of all individuals in HCBS** waiver programs have been transitioned into MWMA based on data existing in other systems (**21,350 individuals**)
- Case Managers are utilizing MWMA to perform their daily tasks:
  - Over **980 new applications** received with 170 in progress
  - Nearly **2,580 individuals** completed or are in progress of their **reassessments**
  - Over **114,000 Case Notes** have been entered
  - **62 individuals** have been newly **enrolled** through use of MWMA
- Web based training, job aids and other reference materials have been developed for Release 5, but there will be no instructor led training and interactions with the external agencies

Additional MWMA Functionality (will be implemented as part of Release 5 of KHBE):

- Capacity/Wait List Management
- Incident Reporting (introduces Direct Service Providers to MWMA)

Update on HCBS Federal Final Rules

HCBS Federal Final Rules State Response

While some parts of the rule require immediate implementation, CMS allows states to implement the setting requirements over five years. Specific requirements around this transition include:

State Transition Requirements		
• Submit a waiver-specific transition plan at the time of the first waiver renewal or amendment to CMS	• Submit a statewide transition plan for all waivers to CMS within 120 days of submitting the first waiver renewal or amendment	• Be in full compliance with the HCBS final rules by the timeframe approved in the transition plan, and no later than Mar. 17, 2019

Kentucky Timeline

Aug. 28, 2014
Submitted Michelle P. (MPW) Transition Plan

Dec. 19, 2014
Submitted the Initial Statewide Transition Plan

Mar. 17, 2019
Must be compliant with all setting rules

Kentucky Implementation Activities

Waiver staff representing various departments across the Cabinet for Health and Family Services (CHFS) comprise the HCBS rules workgroup that will be implementing the key activities outlined in the transition plan.

Key Workgroup Activities
Completed
• Created surveys for providers to self-assess their level of compliance with the HCBS federal final rules • Submitted statewide transition plan to CMS; submitted minor revisions to plan after receiving CMS comments • Developed stakeholder engagement strategy to seek input from participants and providers and held 7 public forums for participants and families • Filed revised regulations to implement the rules in Kentucky • Created and distributed compliance plan templates to providers to complete • Posted revised statewide transition plan for public comment • Distributed updated compliance categories to providers
Upcoming
• Receive public comments on statewide transition plan and update based on stakeholder feedback, as needed • Submit revised statewide transition plan to CMS

Opportunities for Public Input

Participants, families, and other advocates have had, and will continue to have, several opportunities to provide input into the Kentucky waiver programs.

Previous Opportunities	Upcoming Opportunities
• **November, 2014**: Statewide transition plan public comment period • **February-April, 2015**: HCBS Federal Final Rules public forums • **March, 2015**: HCB waiver renewal public comment period • **May, 2015**: SCL waiver renewal public comment period	• **November, 2015**: Updated statewide transition plan public comment period • **November, 2015**: HCB waiver regulation public comment period • **April, 2016**: ABI waiver renewal public comment period • **June, 2016**: MPW renewal public comment period

All public notices will be posted on DMS' webpage: http://chfs.ky.gov/dms/

Statewide Transition Plan

The Statewide Transition Plan (STP) describes how DMS will shift its policies, waiver applications, processes, and providers to compliance with the HCBS final rules. Below are the key components of the STP:

- **Timeline:** Outlines key dates and milestones through 2019 in Kentucky's path to compliance with the HCBS final rules
- **Assessment Process:** Describes how the workgroup compared state policies, procedures, and waiver applications against the HCBS final rules, including the current monitoring process
- **Provider Assessment:** Summarizes the provider surveys and compliance plan templates, describes Kentucky's assessment process of provider surveys and compliance plan templates, gives plans for future assessments, and provides counts of all providers and types of settings by level of compliance
- **Remedial Strategies:** Includes the state-level actions that must be taken to be compliant, and sample actions providers may complete to be compliant
- **Public Comment Process:** Explains how the public can comment on the transition plan and the deadline to submit comments

The revised STP is currently posted for public comment on DMS' webpage. Public comment will close on December 10, 2015.

Public Comment Period for the Statewide Transition Plan

At this time, please submit your official public comments on the Statewide Transition Plan.

Please focus your comments from this point forward ***only*** **on the Statewide Transition Plan.**

KENTUCKY COMMISSION ON SERVICES AND SUPPORTS FOR INDIVIDUALS WITH INTELLECTUAL AND OTHER DEVELOPMENTAL DISABILITIES

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8/4/2015

Kentucky 1915 (c) Waiver Statewide Transition Plan

I. Background

On March 17, 2014, updated Home and Community Based Services (HCBS) final rules became effective in the Federal Register for 1915(c) waivers, 1915(i) state plan services, and 1915(k) community first choice state plan option. As they pertain to 1915(c) waivers, these rules include requirements for several areas of HCBS: all residential and non-residential settings, provider-owned residential settings, person-centered planning process, service plan requirements, and conflict-free case management. The goal of the HCBS final rules is to improve the services rendered to HCBS participants and to maximize the opportunities to receive services in integrated settings and realize the benefits of community living. The Centers for Medicare & Medicaid Services (CMS) is allowing five years (until March 17, 2019) for states and providers to transition into compliance with the all settings and provider-owned settings requirements.

As part of the five year transition period, states must submit transition plans to CMS that document their plan for compliance. The first of these transition plans is a waiver-specific transition plan and is required when a state submits a waiver renewal or amendment. The other required transition plan is a statewide transition plan to bring all 1915(c) waivers into compliance, and is due 120 days after the submission of the first transition plan. This statewide transition plan describes the process to bring all 1915(c) waivers for a state into compliance with the HCBS all-settings and provider-owned settings requirements.

II. Introduction

The Commonwealth of Kentucky (KY) Department for Medicaid Services (DMS) operates six HCBS waivers under the 1915(c) benefit: Acquired Brain Injury (ABI), Acquired Brain Injury-Long Term Care (ABI-LTC), Home and Community-Based (HCB), Michelle P. (MPW), Model Waiver II (MIIW), and Supports for Community Living (SCL). ABI, ABI-LTC, and SCL waivers are residential, while HCB, MPW, MIIW are non-residential. Each waiver, except for MIIW, includes the option for Participant Directed Services (PDS). The following descriptions offer a high-level summary of the scope and participation for each of KY's HCBS waivers:

- ABI participants are adults aged 18 and older with acquired brain injuries working to re-enter community life who meet nursing facility level of care (907 KAR 3:090).
- ABI-LTC participants are adults aged 18 and older who meet nursing facility level or care and have a primary diagnosis of an acquired brain injury which necessitates supervision, rehabilitative services, and long term supports (907 KAR 3:210).
- HCB participants are individuals who are elderly or disabled and meet nursing facility level of care, but are able to remain in or return to their homes (907 KAR 1:160).
- MPW participants are those with a developmental or intellectual disability and who require a protected environment while learning living skills, having educational experiences, and developing awareness of their environment. MPW allows individuals to remain in their homes with services and supports (907 KAR 1:835).
- MIIW participants are individuals who reside in their homes and meet ventilator dependent status and require ventilator support for at least twelve (12) hours per day. MIIW participants receive only skilled nursing and respiratory therapy services in their home (907 KAR 1:595).
- SCL participants are individuals who have an intellectual or developmental disability and meet the requirements for residence in an intermediate care facility for people with intellectual disabilities. SCL allows individuals to remain in their homes with services or to live in residential settings (907 KAR 12:010).

A. Purpose

The purpose of this statewide transition plan is to outline the assessments that DMS has completed, and planned remedial actions to bring all HCBS waivers into compliance with the HCB setting final rules. DMS submitted the transition plan specific to MPW on August 28, 2014 to CMS, which started the 120 day clock to submit this Statewide Transition Plan. This Statewide Transition Plan serves as a guide for transitioning all HCBS waivers into compliance with the all settings and provider-owned settings rules. The goal of the implementation of these requirements is to facilitate the integration and access of waiver participants into the greater community, including providing 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 as individuals not receiving Medicaid HCBS.

Another objective of this plan is to give stakeholders an opportunity to provide input on KY's process to comply with the HCBS final rules. Stakeholders include waiver participants, legal guardians, families, parents, siblings, wives, husbands, advocacy groups, friends, and providers.

Throughout this process, one of DMS' goals is to actively engage stakeholders in the implementation of the final rules. For the purposes of this document, if a participant has a legal guardian, the legal guardian is included in all references of the participant.

B. Overview

This Statewide Transition Plan contains the process that DMS is using to evaluate and revise the Kentucky HCBS waivers. The first section describes the assessments that were conducted to determine the compliance of each waiver with HCBS final rules at the state level. The assessments focused on two components: policy (regulation and waiver application) and monitoring processes. The second section is the provider assessment, which includes residential and non-residential settings, and the results of provider surveys. After the assessment section, the remedial strategy section is outlined, with a focus on state and provider remedial actions. The state remedial strategy includes four sub-sections: 1) policy, 2) operations, 3) participants, and 4) technology. The provider-level remedial strategy includes the process for settings presumed not to be HCBS, as well as suggested sample remedial actions. The fourth and final section of this transition plan includes the process for public comment.

C. Timeline

The overarching timeline per year for KY's transition to become compliant with the HCBS final rules is located below. The timeline highlights the major activities that will occur from the time the Statewide Transition Plan is approved by CMS through March 2019 (the date in which the transition must be completed). The timeline was developed to give providers enough time to comply with the requirements and to minimize disruption for participants through the transition. The HCBS final rules will be implemented in two rounds. The first round changes include HCB setting requirements that are simpler to implement, while the second round changes include the HCBS setting requirements that are more complex, and therefore, more challenging to implement.

The transition activities are split into four activity categories: transition plan, provider compliance, heightened scrutiny, and regulations and waiver application amendments. Each activity category has subsequent sub-activities within it and a proposed start/finish time.

Table 2.1 Statewide Transition Plan Timeline

2014-2015		
	Start Date	**End Date**
Transition Plan	**12/19/14**	**Ongoing**
Submit transition plan to CMS	12/19/14	12/19/14
Receive transition plan approval	12/19/14	Ongoing
Provider Compliance	**1/1/15**	**Ongoing**
First Round Changes[1]		
Develop HCBS evaluation tool (monitoring tool for determining compliance)	1/1/15	3/31/15
Develop compliance plan template for providers to complete and notify providers of initial compliance level	1/1/15	3/31/15
Host public forums for providers and participants (families, advocates, etc.)	2/1/15	5/31/15
Conduct routine evaluations and on-site assessments with the updated HCBS evaluation tool to validate each provider's compliance plan and level of compliance	3/1/15	10/31/15
Host webinars for providers and distribute compliance plan template	4/1/15	4/30/15
Review and approve/deny providers' plans	5/1/15	11/1/15
Deadline for providers to submit compliance plans for first round changes	9/15/15	9/15/15
Regulations & Waiver Amendments	**1/1/15**	**1/1/19**
Determine regulation language with workgroup for first round of changes	1/1/15	2/28/15
Draft revised regulations	3/1/15	4/1/15
Review regulations by department/leadership	4/1/15	8/15/15
Submit revised regulations	8/15/15	8/15/15
Regulation public comment period	8/15/15	9/30/15
Submit HCB waiver renewal to CMS	4/1/15	4/1/15
Submit SCL waiver renewal to CMS	6/1/15	6/1/15
Submit MIIW waiver renewal to CMS	7/1/15	7/1/15

2016		
	Start Date	End Date
Regulations & Waiver Amendments	**1/1/15**	**1/1/19**
Revised HCBS regulations become effective	2/1/16	2/1/16
ABI-LTC waiver renewal public comment period	2/25/16	3/25/16
Submit ABI-LTC waiver renewal to CMS	4/1/16	4/1/16
MPW waiver renewal public comment period	4/21/16	5/20/16
Submit MPW waiver renewal to CMS	6/1/16	6/1/16
ABI waiver renewal public comment period	8/25/16	9/23/16
Submit ABI waiver renewal to CMS	9/30/16	9/30/16
Heightened Scrutiny	**1/1/16**	**4/15/17**
Develop tool for on-site reviews of providers	1/1/16	1/31/16
Conduct on-site reviews for providers who may require heightened scrutiny based on their submitted compliance plan template and mapping	2/1/16	7/31/16
Finalize list of providers who will require heightened scrutiny based upon documentation collected from compliance plan templates, mapping, and on-site visits	8/1/16	8/15/16
Update statewide transition plan to include final list of providers who will require heightened scrutiny	8/16/16	8/31/16
Transition plan public comment period	9/1/16	9/30/16
Submit updated transition plan to CMS	10/14/16	10/14/16
Organize documentation from compliance plan templates, mapping, on-site visits, and public comments from stakeholders for each provider who will need heightened scrutiny	10/14/16	10/31/16
Submit list of providers (and documentation) who need heightened scrutiny to CMS	11/1/16	11/1/16
2017		
Provider Compliance	**1/1/15**	**1/1/19**
Second Round Changes[1]		
CMS conduct heightened scrutiny of providers	1/1/17	12/31/17
Host public forums for providers and participants (families, advocates, etc.)	4/1/17	6/30/17
Develop HCBS evaluation tool (monitoring tool for determining compliance)	7/1/17	9/30/17
Develop compliance plan template for second round changes	7/1/17	9/30/17
Host webinars for providers and distribute compliance plan template	10/1/17	1/1/18

Heightened Scrutiny	1/1/16	4/15/17
Transition plan public comment period	3/1/17	4/1/17
Submit updated transition plan to CMS	4/15/17	4/15/17
Regulations & Waiver Amendments	**1/1/15**	**1/1/19**
Determine regulation language with workgroup for second round of changes	1/15/17	5/1/17
Draft revised regulations	5/1/17	8/1/17
Review regulations by department/leadership	8/1/17	12/31/17
2018-2019		
Provider Compliance	**1/1/15**	**Ongoing**
Second Round Changes[1]		
Review and approve/deny heightened scrutiny providers' plans for compliance	1/1/18	3/1/18
Implement relocation plans for participants who are receiving services from providers who are deemed not to be home and community-based based on heightened scrutiny	3/1/18	12/31/18
Deadline for providers to submit compliance plans for second round changes	5/15/18	5/15/18
Incorporate second round HCBS final rules in all ongoing reviews	7/1/18	Ongoing
Regulations & Waiver Amendments	**1/1/15**	**1/1/19**
Submit revised regulations	1/1/18	1/1/18
Regulation public comment period	1/1/18	2/28/18
2018-2019		
Regulations & Waiver Amendments	**1/1/15**	**1/1/19**
Regulations become effective	7/1/18	7/1/18
Regulations are implemented (state and providers must be fully compliant)	1/1/19	1/1/19

1. First round changes include HCBS setting requirements that are simpler to implement, while second round changes include the HCBS setting requirements that are more complex, and therefore, more challenging to implement.

III. Assessment Process – Systemic Review

A. Regulation and Waiver Application Assessment

To evaluate the compliance of the KY HCBS waivers with the HCBS final rules, DMS established a regimented process led by a workgroup of staff from three departments representing each waiver from across the Cabinet for Health and Family Services (CHFS). The review included a detailed

analysis of each waiver regulation, including manuals incorporated by reference, each application approved by CMS, and related state regulations, such as provider and enrollment regulations, against each requirement of the federal HCBS rule.

The workgroup categorized and color-coded state regulations and applications into three groups:

1) State policy and requirements meet the final rules (green)
2) State policy and requirements have similar language to the final rules, but need to be strengthened (yellow)
3) State policy and requirements do not specifically address all provisions of final rules, so language needs to be added (red)

For group one, no action is required. For group two, language and requirements in state policy have similar language to the final rules, but need to be strengthened. While some operational practices comply with the federal standards, state policies do not fully meet the final rules, and therefore, DMS needs to implement policy changes. For group three, current state policy does not specifically address all provisions of final rules, so language needs to be added. While some operational practices have similar intent to the federal standards, they do not fully meet the final rules and therefore, DMS needs to add additional requirements to policies.

Below is the summary analysis of each HCBS waiver operating in KY as it relates to the HCBS final rules. DMS will need to update waiver policies (regulations), operational areas, and monitoring practices to comply with the final rules. The tables below contain only the applicable HCBS final rules or applicable parts of the HCBS final rules. All HCBS final rules that were edited for the purposes of this document are indicated with an asterisk (*).

Table 3.1 ABI and ABI-LTC waiver regulation and application analysis

ABI & ABI-LTC Waivers – Residential (907 KAR 3:090 & 907 KAR 3:210; 907 KAR 7:005)
Not compliant; minor changes required. State policy and requirements have similar language to the final rules, but need to be strengthened.
• 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.
• Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
• Facilitates individual choice regarding services and supports, and who provides them.
• Each individual has privacy in their sleeping or living unit.
• Individuals are able to have visitors of their choosing at any time.

ABI & ABI-LTC Waivers – Residential (907 KAR 3:090 & 907 KAR 3:210; 907 KAR 7:005)
Not compliant with the following rules. Federal language and requirements do not currently exist in state policy and requirements and need to be added.
• 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.
• 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.
• Home and community-based settings do not include the following: (v) Any other locations that have qualities of an institutional setting, as determined by the Secretary. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution unless the Secretary determines through heightened scrutiny, based on information presented by the State or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings.*
• 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 the jurisdiction's landlord/tenant law.
• Units have entrance doors lockable by the individuals, with only appropriate staff having keys.
• Individuals sharing units have a choice of roommates in that setting.
• Individuals have freedom to furnish and decorate their sleeping and living areas within the lease or other agreement.
• Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.
• The setting is physically accessible to the individual.
• Modifications to provider-owned settings:

ABI & ABI-LTC Waivers – Residential (907 KAR 3:090 & 907 KAR 3:210; 907 KAR 7:005)
o The requirements must be documented in the person-centered service plan in order to modify any of the criteria. o The person-centered service plan be reviewed, and revised upon reassessment of function need, at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual. o Identify a specific and individualized assessed need. o Document the positive interventions and supports used prior to any modifications to the person centered service plan. o Document less intrusive methods of meeting the need that have been tried but did not work. o Include a clear description of the condition that is directly proportionate to the specific assessed need. o Include a regular collection and review of data to measure the ongoing effectiveness of the modification. o Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated. o Include informed consent of the individual. o Include an assurance that interventions and supports will cause no harm to the individual.

Table 3.2 HCB waiver regulation and application analysis

HCB Waiver - Non-residential (907 KAR 1:160; 907 KAR 7:005)
Not compliant; minor changes required. State policy and requirements have similar language to the final rules, but need to be strengthened.
• The setting is selected by the individual from among setting options including non-disability specific settings. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, and preferences.*
• Facilitates individual choice regarding services and supports, and who provides them.
Not compliant with the following rules. Federal language and requirements do not currently exist in state policy and requirements and need to be added.
• 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.
• 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.
• Home and community-based settings do not include the following: (v) Any other locations that have qualities of an institutional setting, as determined by the Secretary. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader

HCB Waiver - Non-residential (907 KAR 1:160; 907 KAR 7:005)
community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution unless the Secretary determines through heightened scrutiny, based on information presented by the State or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings.*

Table 3.3 MPW regulation and application analysis

MPW - Non-residential (907 KAR 1:835; 907 KAR 7:005)
Not compliant; minor changes required. State policy and requirements have similar language to the final rules, but need to be strengthened.
• The setting is selected by the individual from among setting options including non-disability specific settings. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, and preferences.*
• Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
• Facilitates individual choice regarding services and supports, and who provides them.
Not compliant with the following rules. Federal language and requirements do not currently exist in state policy and requirements need to be added.
• 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.
• 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.
• HCBS do not include the following: (v) Any other locations that have qualities of an institutional setting, as determined by the Secretary. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution unless the Secretary determines through heightened scrutiny, based on information presented by the State or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings.*

Table 3.4 SCL waiver regulation and application analysis

SCL Waiver – Residential (907 KAR 12:010; 907 KAR 7:005)
Not compliant; minor changes required. State policy and requirements have similar language to the final rules, but need to be strengthened.

SCL Waiver – Residential (907 KAR 12:010; 907 KAR 7:005)
• 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.
• 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.
• Each individual has privacy in their sleeping or living unit.
• Individuals are able to have visitors of their choosing at any time.
Not compliant with the following rules. Federal language and requirements do not currently exist in state policy and requirements and need to be added.
• Home and community-based settings do not include the following: (v) Any other locations that have qualities of an institutional setting, as determined by the Secretary. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution unless the Secretary determines through heightened scrutiny, based on information presented by the State or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings.*
• 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 the jurisdiction's landlord/tenant law.
• Units have entrance doors lockable by the individuals, with only appropriate staff having keys.
• Individuals sharing units have a choice of roommates in that setting.
• Individuals have freedom to furnish and decorate their sleeping and living areas within the lease or other agreement.
• Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.

SCL Waiver – Residential (907 KAR 12:010; 907 KAR 7:005)
• The setting is physically accessible to the individual.
• Modifications to provider-owned settings: o The requirements must be documented in the person-centered service plan in order to modify any of the criteria. o The person-centered service plan be reviewed, and revised upon reassessment of function need, at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual. o Identify a specific and individualized assessed need. o Document the positive interventions and supports used prior to any modifications to the person centered service plan. o Document less intrusive methods of meeting the need that have been tried but did not work. o Include a clear description of the condition that is directly proportionate to the specific assessed need. o Include a regular collection and review of data to measure the ongoing effectiveness of the modification. o Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated. o Include informed consent of the individual. o Include an assurance that interventions and supports will cause no harm to the individual.

1. MIIW Assurance (907 KAR 1:595)
   MIIW is a unique waiver in that the waiver only includes two highly technical services for individuals who are ventilator-dependent and require ventilator support for at least 12 hours per day. The individual must reside in his/her home and all services provided by the waiver must be rendered in the individual's home. DMS provides assurance that the MIIW complies with all setting rules since all services are performed in the individual's home and not provider-owned or controlled residential, or non-residential settings. DMS presumes that each MIIW participant's home comports with all HCB setting rules. The state staff validated that all services are performed in the individual's home.

B. Monitoring Process Assessment

DMS has set monitoring requirements for each of the HCBS waiver providers operating in KY and these monitoring processes will continue while providers comply with the HCBS final rules. The workgroup outlined these monitoring processes, including the oversight process and participant and provider surveying process. Each process was then analyzed to determine the impact of the HCBS final rules and areas requiring revision were identified. Some monitoring tools will need to be updated to incorporate the new federal requirements so that state staff evaluates

providers appropriately. If necessary, KY will increase the frequency and percentage of providers selected for review to confirm that state staff effectively track provider compliance. After providers have fully implemented the HCBS final rules, monitoring processes will continue with compliant tools and standards. Table 3.5 below describes the current monitoring/oversight process for each waiver, the participant and/or provider surveys that are conducted, and the areas that will need to be updated to comply with the HCBS final rules. If the department acts regarding a certified waiver provider due to the provider's behavior in one 1915(c) HCBS waiver program, the action regarding the certified waiver provider shall apply in every 1915(c) HCBS waiver program in which the provider is participating. PDS is specifically separated in Table 3.5 since PDS for all waivers is centrally monitored by state staff through separate waiver monitoring processes.

Table 3.5 Current waiver monitoring processes

Current Monitoring Process			
Waiver	*Current Oversight Process*	*Participant and Provider Surveys*	*Areas Requiring Revision*
ABI, ABI-LTC	• Every agency must be certified by state staff prior to the initiation of a service (new agencies are reviewed at regular intervals) • Every agency is re-certified annually by state staff to validate compliance • The certification process includes monitoring throughout the year and is based on compliance with state regulation • Case managers track agencies and locations as an additional line of monitoring • If there are reported issues/complaints, then the state staff might conduct a site visit, review the agency, investigate the issue, or refer the issue to the Office of Inspector General (OIG) • The citation and sanctions process is outlined in regulation	• ABI/ABI-LTC participant surveys are distributed annually by state staff	• The tools, including checklists used during on-site monitoring, do not include all of the new HCBS rules • State staff do not base their evaluations on all of the new HCBS rules • Case managers do not base their agency monitoring on all of the new HCBS rules • Participant surveys need to be developed focusing on compliance with the HCBS final rules with mechanisms in place to eliminate provider influence
HCB	• Every agency must be licensed as a home health agency or adult day health center (ADHC)	• Participant interviews are carried out during on-site monitoring	• The tools, including checklists used during on-site monitoring, do not

Current Monitoring Process			
Waiver	*Current Oversight Process*	*Participant and Provider Surveys*	*Areas Requiring Revision*
	• The DMS contracted Quality Improvement Organization (QIO) agency completes all first line evaluations of HCB providers • The evaluations are on-site and include quality questions posed to participants (are you treated with respect, are you aware of your case manager, were you given freedom of choice, etc.), agency policies and procedures, billing, and post-payment audits • Waiver providers are evaluated on a two or three year cycle • State staff complete second line monitoring for a random sample of the provider evaluations completed by DMS contracted QIO agency • The citation and sanctions process is outlined in regulation		include all of the new HCBS rules • State staff and monitoring QIO agency do not base their evaluations on all of the new HCBS rules • Monitoring process manuals do not include all of the new HCBS rules • Participant surveys need to be developed focusing on compliance with the HCBS final rules with mechanisms in place to eliminate provider influence
MPW	• Every agency must be certified by state SCL staff (including all SCL training and processes) or be licensed by OIG to provide Medicaid HCB services • Every agency is recertified/licensed by respective waiver state staff annually • The DMS-contracted QIO agency completes first line monitoring for a sample of MPW participants • The citation and sanctions process is outlined in regulation		• The tools, including checklists used during on-site monitoring, do not include all of the new HCBS rules • State staff do not base their evaluations on all of the new HCBS rules • Participant surveys need to be developed focusing on compliance with the HCBS final rules with mechanisms in place to eliminate provider influence

Current Monitoring Process			
Waiver	*Current Oversight Process*	*Participant and Provider Surveys*	*Areas Requiring Revision*
SCL	• Every agency must be certified by state staff prior to the initiation of a service • Every agency is recertified at least once during their certification period (bi-annually, annually, or biennially) • The citation and sanctions process is outlined in regulation	• Providers are required by regulation to participate in all department survey initiatives, including surveying participants	• The tools, including checklists used during on-site monitoring, do not include all of the new HCBS rules • Participant surveys need to be developed focusing on compliance with the HCBS final rules with mechanisms in place to eliminate provider influence
PDS (All waivers)	• Every agency is evaluated annually • The monitoring process includes reviewing participant records, incident reports, and complaints • Home visits or phone interviews with waiver participants are completed • The citation and sanctions process is outlined in regulation	• Participant satisfaction surveys are distributed by the provider prior to monitoring and are reviewed by state staff during the monitoring process	• The tools, including checklists used during on-site monitoring, do not include all of the new HCBS rules • State staff do not base their monitoring on all of the new HCBS rules • Consumer PDS training is not based on the new HCBS rules • Participant surveys need to be developed focusing on compliance with the HCBS final rules with mechanisms in place to eliminate provider influence

IV. Provider Assessment

To determine the providers' compliance level, the workgroup used provider surveys as an initial estimate and followed up with more detailed compliance plan templates. Providers "self-assessed" their compliance with the HCBS final rules through surveys. The state staff reviewed the survey results, validated each provider's response, and assigned each provider a level of compliance. After the review of the provider surveys, the state required providers to complete a compliance plan template, where the providers were asked to provide more detailed information to demonstrate their current compliance or describe how they would become compliant. The state began reviewing compliance plan templates as they were received and used the following methods of validating the providers' responses:

- **Staff review:** State Quality Assurances (QA) staff who are familiar with the providers reviewed each of the surveys
- **Mapping:** Each setting location of the provider was mapped to determine its proximity to any non-HCB settings (institutions, nursing facilities, etc.) as well as co-located and operationally related HCB settings

For providers who remain in category 4 after the state's validation process, the state will be conducting an on-site visit to confirm that the provider will need to undergo heightened scrutiny. During that on-site visit, the state staff will seek to conduct interviews with participants about their experiences to assist with the heightened scrutiny process. Any setting that remains in category 4 after the on-site visit will be published for public comment in the next iteration of the statewide transition plan. After the public comment period is complete, the DMS will submit the providers and all documentation to CMS for heightened scrutiny.

Below are the updated categorizations of provider compliance for both residential and non-residential providers, based upon initial surveys, compliance plan templates, and the state's validation process. Providers will have ample opportunity to review their compliance level and make modifications where possible to come into compliance. Providers were notified of their updated compliance level in November 2015.

A. Residential Settings

As part of evaluating provider compliance with the HCBS final rules, the workgroup conducted a web-based survey in June 2014 for residential providers to measure each provider's compliance level with the rules. The workgroup drafted questions using language provided by CMS, and included text boxes for providers to offer additional information for each requirement of the rule. The survey had 100% participation from HCBS residential waiver providers in KY (ABI, ABI-LTC, and SCL) and is included in Appendix A. Achieving 100% participation required individual outreach to each provider by members of the workgroup. The workgroup then summarized the provider data to establish initial estimates of compliant/non-compliant providers.

After analyzing the providers' self-reported compliance level, state QA staff from each residential waiver thoroughly reviewed provider responses. The purpose of this review was to validate that the survey responses submitted align with what has been observed by QA staff during regular on-site provider evaluations. The workgroup selected the QA staff to complete this validation because of their deep knowledge and experience with the residential providers. After completing survey validation, the workgroup categorized each residential provider into one of four compliance levels, as defined by CMS:

- Fully align with the federal requirements
- Do not comply with the federal requirements and will require modifications
- Cannot meet the federal requirements and require removal from the program and/or the relocation of individuals
- Are presumptively non-HCB but for which the state will provide evidence to show that those settings do not have the characteristics of an institution and do have the qualities of HCB settings (to be evaluated by CMS through the heightened scrutiny process)

In order to most accurately evaluate providers, the state required each provider to complete a compliance plan template. After the compliance plan templates were reviewed and validated through the state's process, each provider's compliance category was updated based on the additional information. The updated results of the residential provider survey, validation by QA staff, compliance plan template, and mapping are outlined in Tables 4.1 and 4.2 below. The total number of providers is captured in Table 4.1 while the total number of setting locations is captured in Table 4.2.

Table 4.1 All residential providers

Compliance Level	Number of Providers	Main Areas of Non-Compliance
Provider only has settings that fall under Category (1) Fully align with the federal requirements	**0**	
Provider only has settings that fall under Category (2) Do not comply with the federal requirements and will require modifications	Level I (Staffed Residence, Group Home): **75**	• The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community • Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices • Lease agreement • Individuals have the freedom and support to control their own schedules and activities
	Level II (Adult Foster Care, Family Home Provider): **25**	
Provider only has settings that fall under Category (3) Cannot meet the federal requirements and require removal from the program and/or the relocation of individuals	**0**	
Provider only has settings that fall under Category (4) Are presumptively non-HCB but for which the state will provide evidence to show that those settings do not have the characteristics of an institution and do have the qualities of HCB settings (to be evaluated by CMS through the heightened scrutiny process)	Level I (Staffed Residence, Group Home): **4**	• Multiple settings co-located and operationally related • Operated in multi-family properties with more than one unit occupied by individuals receiving Medicaid HCBS • Operated in a remote location (farmstead)
	Level II (Adult Foster Care, Family Home Provider): **0**	
Provider has settings that are in both categories (2) and (4)	Level I (Staffed Residence, Group Home): **33**	
	Level II (Adult Foster Care, Family Home Provider): **8**	

1. The large majority of Level I providers are staffed residences. There are only 14 group home providers in the Commonwealth of Kentucky.

Table 4.2 All residential settings

Compliance Level	Number of Settings	Main Areas of Non-Compliance
(1) Fully align with the federal requirements	**0**	
(2) Do not comply with the federal requirements and will require modifications	Level I (Staffed Residence, Group Home): **1,090**	• The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community • Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices • Lease agreement • Individuals have the freedom and support to control their own schedules and activities
	Level II (Adult Foster Care, Family Home Provider): **372**	
(3) Cannot meet the federal requirements and require removal from the program and/or the relocation of individuals	**0**	
(4) Are presumptively non-HCB but for which the state will provide evidence to show that those settings do not have the characteristics of an institution and do have the qualities of HCB settings (to be evaluated by CMS through the heightened scrutiny process)	Level I (Staffed Residence, Group Home): **226**	• Multiple settings co-located and operationally related • Operated in multi-family properties with more than one unit occupied by individuals receiving Medicaid HCBS • Operated in a remote location (farmstead
	Level II (Adult Foster Care, Family Home Provider): **0**	

1. The large majority of Level I setting locations are staffed residences. There are only 14 group home providers in the Commonwealth of Kentucky.

B. Non-Residential Settings

In addition to a survey targeted for residential providers, the workgroup created a similar survey for non-residential providers that focused on the HCB setting requirements. The workgroup developed this survey using CMS' toolkits and distributed it to non-residential providers via email and provider letters. The non-residential survey is outlined in Appendix B. The target provider types for this survey were ADHCS, home health agencies, day training (DT), and other non-residential waiver providers, such as case managers, who render services to the waiver population. Approximately 40% of the total non-residential waiver providers in the state completed the survey. The providers who responded to the survey render a variety of services, including DT, ADHC, home health agencies, case management, behavior supports, and physical/occupational/speech therapy.

Since there was not 100% participation by non-residential providers, DMS required 100% participation of the compliance plan template from all providers who render services to HCBS waiver participants. Similar to the residential survey data, after receiving providers' responses, the workgroup analyzed the providers' self-reported compliance level. The QA staff reviewed and validated the survey responses and the workgroup then categorized each non-residential provider into one of four compliance levels, as defined by CMS:

- Fully align with the federal requirements
- Do not comply with the federal requirements and will require modifications
- Cannot meet the federal requirements and require removal from the program and/or the relocation of individuals
- Are presumptively non-HCB but for which the state may provide evidence to show that those settings do not have the characteristics of an institution and do have the qualities of HCB settings (to be evaluated by CMS through the heightened scrutiny process)

The results of the non-residential provider survey, compliance plan templates, and the state's validation process are outlined in Table 4.3. If a provider serves participants across waivers, and/or renders both DT and ADHC, the provider was only counted once. The number of providers used in Table 4.3 represents the number of provider agencies, while Table 4.4 represents the number of non-residential setting locations. Please note, case management and home health agencies who provide services only in the home are not included in the counts. If a provider operates both residential and a non-residential day program, they were counted twice: once in table 4.1 as a residential provider and once in table 4.3 as a non-residential provider.

Table 4.3 All non-residential providers

Category	Number of Providers	Main Areas of Non-Compliance
Provider only has settings that fall under Category (1) Fully align with the federal requirements	ADHC: **3**	
	DT: **4**	
	Supported Employment: **2**	
	Behavior/Community Support: **6**	
Provider only has settings that fall under Category (2) Do not comply with the federal requirements and will require modifications	ADHC: **62**	• The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community • Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices
	DT: **110**	
	Supported Employment: **4**	
	Behavior/Community Support: **36**	
Provider only has settings that fall under Category (3) Cannot meet the federal requirements and require removal from the program and/or the relocation of individuals	**0**	
Provider only has settings that fall under Category (4) Are presumptively non-HCB but for which the state will provide evidence to show that those settings do not have the characteristics of an institution and do have the qualities of HCB settings (to be evaluated by CMS through the heightened scrutiny process)	ADHC: **1**	• Multiple settings co-located and operationally related
	DT: **1**	
	Supported Employment: **0**	
	Behavior/Community Support: **0**	
	ADHC: **8**	• Located in a building that is also a facility that provides in-patient institutional treatment • On the grounds of, or immediately adjacent to a public institution
Provider has settings that are in both categories (2) and (4)	ADHC: **0**	
	DT: **2**	
	Supported Employment: **0**	
	Behavior/Community Support: **0**	

Table 4.4 All non-residential settings

Category	Number of Settings	Main Areas of Non-Compliance
(1) Fully align with the federal requirements	ADHC: **13**	
	DT: **4**	
	Supported Employment: **2**	
	Behavior/Community Support: N/A	
(2) Do not comply with the federal requirements and will require modifications	ADHC: **73**	• The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community • Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices
	DT: **191**	
	Supported Employment: **12**	
	Behavior/Community Support: N/A	
(3) Cannot meet the federal requirements and require removal from the program and/or the relocation of individuals	**0**	
(4) Are presumptively non-HCB but for which the state will provide evidence to show that those settings do not have the characteristics of an institution and do have the qualities of HCB settings (to be evaluated by CMS through the heightened scrutiny process)	ADHC: **1**	• Multiple settings co-located and operationally related
	DT: **3**	
	Supported Employment: **0**	
	Behavior/Community Support: N/A	
	ADHC: **8**	• Located in a building that is also a facility that provides in-patient institutional treatment • On the grounds of, or immediately adjacent to a public institution

V. Remedial Strategies

DMS will implement several strategies over the next five years to transition policies and operations into compliance with the HCBS final rules. The strategies identified in this section are the results of assessments completed by the workgroup over the past five months.

A. State Level Remedial Strategies

1. Policy

The workgroup completed a thorough review of waiver regulations and applications, as outlined in section III. The overarching goal is for each regulation and waiver application to be in compliance with the HCBS final rules. The following table includes the identified changes to each regulation and application that are required to transition KY's waiver policies into compliance with each HCBS rule related to settings.

DMS is implementing the HCBS final rules in two rounds to assure that providers have adequate time to become compliant with all rules. While the second round of changes will not be effective in KY regulations until 2019, DMS and its operating agencies will be educating providers of these requirements and providing technical assistance to help them move toward compliance beginning in 2015. This education will be conducted through webinars, forums throughout the state, as well as through individual site visits and discussions with providers. The timeline of 2019 was selected primarily to allow more time for providers to implement these more time-consuming changes. Additional reasons for the extended timeline are as follows.

1. The rules included in the second round may have a significant impact on KY HCBS providers and create an access issue depending on the number of providers who will lose the ability to render services because of the rules, if adequate time is not allowed for implementation.
2. DMS has allotted a full year to work with the high volume of providers who will need to undergo heightened scrutiny to assure that DMS can spend adequate time working with each provider.
3. DMS is giving time for providers to stabilize the first round of changes before moving into the second round.
4. DMS will be educating providers as soon as the rules are fully defined and operationalized. The education and compliance process for the second round changes will start before 2018, giving providers ample time to become compliant.

Table 5.1 Potential waiver regulation and application actions for compliance

Waiver Regulation and Application			
Rule	Potential Actions to be Compliant	Timeline	Status
The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek	ABI (907 KAR 3:090), ABI-LTC (907 KAR 3:210), HCB (907 KAR 1:160), MPW (907 KAR 1:835), SCL (907 KAR 12:010): • Clarify indicators of integration into the greater community and incorporate into the regulation	7/15/2017 – 1/1/2018 (Second Round)	In Progress

Waiver Regulation and Application			
Rule	Potential Actions to be Compliant	Timeline	Status
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;	• Add stronger language that focuses on outcomes related to the participant's experience • Identify potential opportunities to use technology to promote integration ABI (907 KAR 3:090), ABI-LTC (907 KAR 3:210), and MPW (907 KAR 1:835): • Add required documentation to ensure an participant's integration into the community, including how opportunities and resources were presented, and the choice(s) made by the participant HCB (907 KAR 1:160): • Include clarifying language that community integration is individualized, appropriate, and outlined in the service plan SCL (907 KAR 12:010): • Note: Language in the SCL manual is very close, but needs to include access to personal resources		
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;	ABI (907 KAR 3:090), ABI-LTC (907 KAR 3:210), HCB (907 KAR 1:160), MPW (907 KAR 1:835), SCL (907 KAR 12:010): • Include assurance that participants must be informed of every available setting option each time s/he is selecting a new setting, every time the participant moves or changes service provider • Require case manager to document all available settings options considered and selected by the participant in the service plan • Include explanation of how informed choice should be provided ABI (907 KAR 3:090), ABI-LTC (907 KAR 3:210), and SCL (907 KAR 12:010): • Include assurance that the participant is included in both the selection of the provider and setting (location), taking into account individual resources and provider restrictions HCB (907 KAR 1:160) and MPW (907 KAR 1:835):	1/1/2015 – 4/30/2015 (First Round)	Complete

Waiver Regulation and Application			
Rule	Potential Actions to be Compliant	Timeline	Status
	• Include assurance that the participant is included in both the selection of the provider and setting (location), and describe how the setting options were presented to the participant		
Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint;	ABI (907 KAR 3:090), ABI-LTC (907 KAR 3:210), HCB (907 KAR 1:160), MPW (907 KAR 1:835), SCL (907 KAR 12:010): • Add language ensuring the participant's privacy, dignity, and respect	1/1/2015 – 4/30/2015 (First Round)	Complete
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.	ABI (907 KAR 3:090), ABI-LTC (907 KAR 3:210), HCB (907 KAR 1:160), MPW (907 KAR 1:835), SCL (907 KAR 12:010): • Add general language to clearly define this rule • Add language allowing the participant to select daily activities and with whom they interact	1/1/2015 – 4/30/2015 (First Round)	Complete
Facilitates individual choice regarding services and supports, and who provides them.	ABI (907 KAR 3:090), ABI-LTC (907 KAR 3:210), HCB (907 KAR 1:160), MPW (907 KAR 1:835): • Add clear and centrally located definition of freedom of choice All Waivers (Regulation and Application): • Use HCBS rule language	1/1/2015 – 4/30/2015 (First Round)	Complete
Home and community-based settings do not include the following: (i) A nursing facility; (ii) An institution for mental diseases; (iii) An intermediate care facility for individuals with intellectual disabilities; (iv) A hospital; or (v) Any other locations that have qualities of an institutional setting, as determined by the Secretary. Any setting that is located in a building that is also a publicly or privately operated facility that provides	ABI (907 KAR 3:090), ABI-LTC (907 KAR 3:210), HCB (907 KAR 1:160), MPW (907 KAR 1:835), SCL (907 KAR 12:010): • Include restrictions for providers that have qualities of an institutional setting • Include restrictions for providers that are located within, on the grounds of, or immediately adjacent to a public institution, or any other setting that has the effect of isolating individuals receiving HCBS • Include HCBS rule language	7/15/2017 – 1/1/2018 (Second Round)	In Progress

Waiver Regulation and Application			
Rule	Potential Actions to be Compliant	Timeline	Status
inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution unless the Secretary determines through heightened scrutiny, based on information presented by the State or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings.			
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	ABI (907 KAR 3:090), ABI-LTC (907 KAR 3:210), and SCL (907 KAR 12:010): • Add a lease agreement requirement for all residential services • Outline lease agreement process and standards	7/15/2017 – 1/1/2018 (Second Round)	In Progress

Waiver Regulation and Application			
Rule	Potential Actions to be Compliant	Timeline	Status
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	ABI (907 KAR 3:090), ABI-LTC (907 KAR 3:210), and SCL (907 KAR 12:010): • Add specific language: "Individual has the right to privacy in their living unit"	1/1/2015 – 4/30/2015 (First Round)	Complete
Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors	ABI (907 KAR 3:090), ABI-LTC (907 KAR 3:210), and SCL (907 KAR 12:010): • Add requirement requiring the participant to have keys/locks for both their bedroom door and main house door • Require that only appropriate staff have bedroom door keys	1/1/2015 – 4/30/2015 (First Round)	Complete
Individuals sharing units have a choice of roommates in that setting	ABI (907 KAR 3:090), ABI-LTC (907 KAR 3:210), and SCL (907 KAR 12:010): • Add clarifying language allowing the participant to choose to live alone or with a roommate • Add clarifying language allowing the participant to choose roommates and housemates where applicable and based on available resources for room and board • Include requirement that providers show documentation of how they presented roommate options to the participant	1/1/2015 – 4/30/2015 (First Round)	Complete
Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement	ABI (907 KAR 3:090), ABI-LTC (907 KAR 3:210), and SCL (907 KAR 12:010): • Add requirement allowing participants the freedom to decorate/furnish their living unit as outlined in their lease	1/1/2015 – 4/30/2015 (First Round)	Complete
Individuals have the freedom and support to control their own schedules and	ABI (907 KAR 3:090), ABI-LTC (907 KAR 3:210), and SCL (907 KAR 12:010):	7/15/2017 – 1/1/2018	In Progress

Waiver Regulation and Application			
Rule	Potential Actions to be Compliant	Timeline	Status
activities, and have access to food at any time	• Add additional language clarifying that participants must have freedom to control their own schedules • Service plan should take into account participant preferences for schedule and activities, including food preferences • Add requirement allowing participants access to food/kitchen at any time or as outlined in the service plan • Include requirement that providers show documentation of agency policy relating to how participants can control their own schedules and activities, and have access to food at any time	(Second Round)	
Individuals are able to have visitors of their choosing at any time	ABI (907 KAR 3:090), ABI-LTC (907 KAR 3:210), and SCL (907 KAR 12:010): • Add language allowing participants to have visitors of their choosing at any time • Include language regarding responsibility of the participant and respect for others living in the residential setting	1/1/2015 – 4/30/2015 (First Round)	Complete
The setting is physically accessible to the individual	ABI (907 KAR 3:090), ABI-LTC (907 KAR 3:210), and SCL (907 KAR 12:010): • Define physical accessibility • Add language requiring the participant to be able to physically access their building and other appropriate buildings at all times	1/1/2015 – 4/30/2015 (First Round)	Complete
Any modification of the additional residential conditions except for the setting being physically accessible requirement, must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:	ABI (907 KAR 3:090), ABI-LTC (907 KAR 3:210), and SCL (907 KAR 12:010): • Add language that treats service plan residential modifications like a “rights restriction”	1/1/2015 – 4/30/2015 (First Round)	Complete

Waiver Regulation and Application			
Rule	Potential Actions to be Compliant	Timeline	Status
• Identify a specific and individualized assessed need. • Document the positive interventions and supports used prior to any modifications to the person-centered service plan. • Document less intrusive methods of meeting the need that have been tried but did not work. • Include a clear description of the condition that is directly proportionate to the specific assessed need. • Include regular collection and review of data to measure the ongoing effectiveness of the modification. • Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated. • Include the informed consent of the individual. • Include an assurance that interventions and supports will cause no harm to the individual.			

DMS will submit revised ordinary regulations for setting-related rules in two rounds in order to allow stakeholders time to review and providers time to implement. The HCBS final rules will be implemented in two rounds based on the ease of implementation and complexity of the change. DMS will draft the regulation language for the first round from January 1, 2015 to February 28, 2015. The first round of revised ordinary regulations will be submitted in August 2015 and effective in February 2016. DMS will draft the regulation language for the second round from

January 2017 to May 2017. The second round of revised ordinary regulations will be submitted in January 2018, with an effective date in July 2018, and an implementation date of January 2019. The implementation date of January 2019 is when all providers must be compliant with all HCBS settings final rules.

2. Operations

State staff and the workgroup will be preparing operational practices for compliance over the next three years. This includes developing a tool for providers that outlines the federal requirements and how they will be evaluated, along with hosting a webinar for waiver providers. Once updated state policies take effect, state staff will transition from current operational practices to revised, compliant protocols to administer the HCBS waivers. The HCBS final rules affect several areas of DMS' waiver operations including, but not limited to, internal processes, monitoring, and service delivery. Below is a list of operational changes required for each waiver to bring their practices into compliance.

Table 5.2 Potential waiver operational actions for compliance

All Waivers			
Item	**Potential Actions to be in Compliance with HCBS Rules**	**Timeline**	**Status**
Internal Processes:			
Prior authorizations (PA)	All Waivers: • Update PA processes to incorporate new HCBS rules in regards to the participant setting selection process	1/1/2015 – Ongoing	In Progress
State staff training	All Waivers: • Train PA staff, focusing on the service plan and case management in relation to PAs • Train state staff, including waiver and QA staff, on HCBS rules • Train state staff, including waiver and QA staff, on the transition process, new monitoring processes and checklists, related to the HCBS rules	1/1/2015 – Ongoing	In Progress
Capacity, resources, and services	All Waivers: • Evaluate provider capacity throughout the state • Determine appropriateness of resources for providers	10/1/2015 – Ongoing	In Progress

All Waivers			
Item	**Potential Actions to be in Compliance with HCBS Rules**	**Timeline**	**Status**
	• Evaluate if covered services are adequately meeting the needs of the participants, in view of any changes required by the HCBS final rules		
Provider Processes:			
Requirements (mission/values)	All Waivers: • Providers should update their mission/values and policies/procedures to align with the new DMS regulations	1/1/2015 – Ongoing	In Progress
Trainings	All Waivers: • Update relevant provider trainings and offer providers all relevant information and trainings	1/1/2015 – Ongoing	In Progress
Transition process	All Waivers: • Develop HCBS evaluation tool (monitoring tool) and HCBS compliance plan template to be used by providers, outlining their plan for complete compliance • Host webinars for waiver providers • Validate each provider's compliance level during annual evaluation • Notify providers outlining their compliance level • Complete on-site reviews for all groups based on provider and waiver staff provider evaluations • Review, track, and approve/deny the providers' HCBS compliance plans • Assist providers to ensure compliance and resolve any access issues found • Use processes outlined in state regulations for provider corrective action or actions not to certify or to terminate non-compliant providers	1/1/2015 – Ongoing	In Progress
Monitoring Processes:			
Requirements	All Waivers:	1/1/2015 – Ongoing	In Progress

All Waivers			
Item	**Potential Actions to be in Compliance with HCBS Rules**	**Timeline**	**Status**
	• Validate that the current monitoring processes are sufficient to monitor new and existing providers against the HCBS rules and modify as necessary		
Tools (on-site items, checklists, etc.)	• Update provider checklists and survey tools for provider sites (residential, ADT, ADHC, etc.) based on the revised regulations that comply with the HCBS rules • Implement provider requirements using the CMS toolkit to determine the materials/documentation providers need to submit as validation of HCB setting under heightened scrutiny	1/1/2015 – Ongoing	In Progress
Surveying process	All waivers: • Update PDS provider on-site surveys • Establish process for participant surveys	1/1/2015 – Ongoing	In Progress
Grievance process	All waivers: • Review grievance process and implement updates as needed for participants to file complaints about non-compliant providers • Determine method to confirm participants are aware of grievance process	10/1/2015 – Ongoing	In Progress
Miscellaneous:			

Communication plan for additional stakeholders (advocacy groups, provider associations, etc.)	• Develop stakeholder engagement process to obtain input on implementation of the final rules, focusing on defining and operationalizing rules before policies and tools are established
	  • Host public forums and/or focus groups for providers and participants, representatives, family members, and advocates
	  • Attend meetings of established public consumer, advocacy, and provider groups to review and provide feedback on key changes
	  • Accept public comments from stakeholders during public comment periods for waiver regulations, waiver amendments, and waiver renewals
		1/1/2015 – Ongoing	In Progress

All Waivers			
Item	**Potential Actions to be in Compliance with HCBS Rules**	**Timeline**	**Status**
	• Communication activities could include periodic email updates with rule summaries, educational materials, webinars, and presentations at conferences and advocacy group meetings upon request		
Relocation Process (due to HCBS rules)	All Waivers: • Determine relocation process ABI, ABI-LTC, and SCL: • Determine how the lease agreement requirement will affect the availability of services and the relocation process • Require the service plan team/case manager to be involved in every move of the participant, ensuring the participant has a choice in every move or change in service provider	2/1/2016 – Ongoing	Not Started

3. Participants

The significance of the changes to DMS' HCBS waivers warrants continuous communication with waiver participants and advocacy groups that communicate with participants and their families. Communicating regularly with participants also provides opportunities for state staff to conduct further monitoring of providers. In addition to public notices, state staff will organize outreach to participants to inform them of the key changes to their programs, and confirm they understand their rights. In certain cases, participants may need to be relocated based upon the results of the provider assessments. If the provider falls under compliance level three (not compliant and never will be), state staff will follow the same protocols to relocate participants as currently are in place when providers are terminated.

Table 5.3 Potential participant actions for compliance

All Waivers			
Rule	**Potential Actions to be in Compliance with HCBS Rules**	**Timeline**	**Status**
All HCBS rules	All Waivers:	1/1/2015 – Ongoing	In Progress

All Waivers			
Rule	**Potential Actions to be in Compliance with HCBS Rules**	**Timeline**	**Status**
	• Develop stakeholder engagement and education plan and implement process for informing participants of the HCBS rules • Send information to waiver participants targeted to each participant's situation explaining waiver changes related to HCBS rules • Include information outlining the new participant rights, provider requirements, and links to all related information		

Residential rules	ABI, ABI-LTC, and SCL:
	• Develop and implement communication process for informing residential waiver participants of waiver changes related to HCBS rules
	  • Include information outlining the list of new participant rights, provider requirements, and links to related information
	  • Include lease information and sample leases
		1/1/2015 – Ongoing	In Progress

4. Technology

Kentucky has operated the Kentucky Health Benefit Exchange (KHBE), also known as kynect, since October 2013. Included in the next release of KHBE in April 2015, was the Medicaid Waiver Management Application (MWMA), which converts the majority of waiver processes to a central online system. The system tracks the application, assessment, and service plan process. Many of DMS' existing waiver forms have been switched from paper to electronic through MWMA, and the HCBS setting final rules impact the language that must be included in the MWMA screens. Below are the primary changes required for the MWMA to comply with the federal requirements.

Table 5.4 Potential technology actions for compliance

Medicaid Waiver Management Application			
Forms:	**Potential Actions to be in Compliance with HCBS Rules**	**Timeline**	**Status**

Medicaid Waiver Management Application			
Plan of care/prior authorization form, long term care facilities and home and community based program certification form, Medicaid waiver assessment form, SCL demographic and billing information form, and SCL freedom of choice and case management conflict exemption form	All Waivers: • Modify forms/screen within MWMA to comply with HCBS rules	1/1/2015 – 12/15/2015	Complete

B. Provider Level Remedial Strategies

As described in section III, the workgroup categorized providers into four compliance levels on a preliminary basis: 1) fully aligned with federal requirements and require no changes, 2) do not comply with federal requirements and require modifications, 3) cannot meet the federal requirements and require removal from the program and relocation of individuals, and 4) presumed not to be HCB and requires heightened scrutiny. The preliminary compliance level of each provider was determined based on surveys and state staff knowledge, but it may change over time, as additional information is obtained and providers present documentation of their compliance.

The compliance plan template is a tool that the HCBS workgroup will be developing with input from stakeholders to assist providers in identifying potential areas of non-compliance. This tool is meant for collaboration and is not a corrective action plan. The HCBS workgroup is developing templates for each type of provider (case management, residential, non-residential, and any combination of these). Then, each provider will receive an individualized template containing their responses to the surveys, if the provider participated in the survey, as well as additional questions that the provider must answer. These additional questions will assist in providing sufficient information to DMS about the current compliance of the provider. Lastly, the provider will be asked their plan for compliance for each of the federal rules that apply. The completed compliance plan template will be continuously used to facilitate discussions with providers about their compliance as well as assist DMS with ongoing monitoring of providers.

State staff will implement the following activities from January 2015 to July 2018 to assist providers in transitioning to compliance.

1. Develop an HCBS evaluation tool (monitoring tool) and HCBS compliance plan template for providers to be notified of their initial compliance and identify actions they will complete to address areas of non-compliance

   a. Distribute HCBS compliance plan template to providers and inform them of their compliance levels
   b. First round: January 2015 to March 2015
   c. Second round: July 2017 to September 2017
2. Develop and implement HCBS final rule communication plan for providers and stakeholders through webinars, presentations at conferences, and provider association meetings
   a. The HCBS compliance plan template will follow similar protocols to the current waiver provider corrective action plan (907 KAR 7:005 – section 4)
   b. First round: April 1, 2015 to April 30, 2015
   c. Second round: October 2017 to January 2018
3. State staff will review and approve/deny providers' plans
   a. First round: May 2015 to October 2015
   b. Second round: January 2018 to June 2018
4. Conduct routine evaluations and on-site assessments with the updated HCBS evaluation tool to validate each provider's compliance plan and level of compliance
   a. Both rounds: March 2015 to ongoing

For providers in compliance level one (fully align with federal requirements), there will be no changes required of the provider and they can continue providing services. State staff will continue to monitor these providers and participants with on-site visits to verify compliance based on each waiver's updated monitoring process (as outlined in section III).

For providers in compliance level two (do not comply and require modifications), changes are required for the provider to become compliant with the HCBS setting rules. These changes may be short-term (0-3 months) or long-term (3-12 months), but all changes must be completed before the updated state policies are implemented in January 2019. The remedial activities included in Table 5.5 below are examples of activities that the providers may complete to come into compliance with the HCB setting rules. State staff will implement the following activities from January 2015 to July 2018:

1. Track provider compliance plans
   a. First round: May 2015 to October 2015
   b. Second round: January 2018 to June 2018
2. Conduct routine on-site monitoring to review providers' progress towards complete compliance
   a. Both rounds: March 2015 to ongoing
3. For non-compliant providers, each waiver will follow the termination process outlined in Kentucky regulations

For providers in compliance level three (not compliant and never will be), state staff will complete an additional on-site meeting with the provider to confirm that the setting does in fact fall under compliance level three. If state staff determine the provider should not be in compliance level three, then they will fall under compliance level four and will require heightened scrutiny. If after the on-site meeting, the setting is confirmed to be in compliance level three, state staff will offer the opportunity for the provider to relocate the setting before the updated state policies become effective. If the provider is able to successfully relocate to a setting that complies with the federal requirements and is able to assure that operations in that setting comply with the HCBS rules, the provider will not be terminated. Should a provider not comply or qualify with HCBS rules for a particular service, they could potentially provide other HCBS services, as long as they comply with the applicable HCBS requirements for those services. However, if the provider chooses not to relocate, is unable to find an appropriate setting, or is unable to come into compliance with the HCBS rules, the provider will be terminated. The provider's termination will be based on 907 KAR 7:005 (Certified waiver provider requirements) or 907 KAR 1:671 (Conditions of Medicaid provider participation; withholding overpayments, administrative appeal process, and sanctions) after revised waiver regulations are effective.

Participant Relocation Process: DMS will identify the waiver participants who will be impacted by provider termination and the process will be outlined. All affected participants will be relocated following the current relocation process. The process will include a person-centered team meeting, where the participant will be given the opportunity, the information, and the supports necessary to make an informed choice of an alternate setting. The state staff will provide reasonable notice and due process to all parties. The transition from the non-compliant provider will not occur until all critical services and supports are in place for the participant to assure consistency in services.

1. **Settings presumed not to be HCB (heightened scrutiny process)**

For settings in compliance level four (presumed not to be HCB), providers will be required to submit documentation to the state first, outlining how their settings do not have the qualities of an institution and do have the qualities of a HCB setting. State staff will conduct an additional on-site assessment, from 2/1/16 to 7/31/16, and will coordinate closely with these providers to verify they are providing the necessary documentation to prove they have the qualities of a HCB setting. DMS will corroborate provider documentation and send the documentation to CMS for the heightened scrutiny process by 8/15/16. To assist providers in establishing documentation that they have the qualities of a HCB setting, state staff will complete the following activities from November 2015 to November 2016.

1. Notify providers that they may need to undergo heightened scrutiny
2. Collaborate with providers on additional documentation that must be presented as evidence of being HCB

3. Develop the tool for on-site reviews of providers in category 4
4. Conduct additional detailed on-site visits to obtain further compliance documentation
5. Submit provider's documentation to CMS for determination

For non-compliant providers or providers determined not to be a HCB setting after heightened scrutiny is conducted by CMS, the termination process outlined in regulation 907 KAR 7:005 (Certified waiver provider requirements) or 907 KAR 1:671 (Conditions of Medicaid provider participation; withholding overpayments, administrative appeal process, and sanctions) will be followed. If the provider is terminated, the aforementioned participant relocation process will be implemented.

Table 5.5 below includes examples of suggested provider level remedial activities that providers may need to complete to come into compliance with the HCBS federal final rules. These examples are based upon state staff observations in reviewing the providers' compliance plan templates.

Table 5.5 Potential provider actions for compliance

Provider Requirements	
Rule	**Potential Actions to be Compliant & Timeline**
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;	Staffed Residence/Adult Foster Care (AFC)/Family Home Provider (FHP)/Group Home Providers: • Facilitate participation in the greater community by providing transportation or assisting the participant with accessing public transportation • Encourage community integration by assisting participants to make real connections to their community with the goal of increasing independence and decreasing need for paid supports ADHC/DT Providers: • Facilitate participation in the greater community • Bring the greater community to the day site to interact with the participants in a meaningful way in areas of interest to them All Providers: • Ensure participants receive the support and information needed to make choices about the kinds of work and activities they prefer • Support participants in their job search with supported and customized employment • Encourage participants to participate in community activities of their choosing and explore community integration opportunities • Ensure participants have access to personal resources

Provider Requirements	
	• Work with participants to help them establish valuable relationships within the community • Update mission/values to meet the rule
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;	Staffed Residence/AFC/FHP/Group Home Providers: • Ensure that the participant has options that include non-disability specific settings and a private unit if available in the selected setting • Ensure that the participant is given enough information to make an informed choice based on available options and resources. ADHC/DT Providers: • Document all setting options that were considered in the service plan All Providers: • Provide participants with all setting options available and ensure the participant makes an informed choice for both setting and provider • Case manager must offer each participant a private unit if available in the setting selected • Ensure setting options align with participant's needs and preferences • Provide staff training
Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint;	Staffed Residence/AFC/FHP/Group Home Providers: • Ensure that the participant has privacy in his/her bedroom and living areas ADHC/DT Providers: • Train staff on how to treat participants with respect and dignity All Providers: • Ensure participant has privacy in all areas • Encourage the participant to come and go as s/he wishes, consistent with the service plan and provide necessary supports to facilitate those needs • Update and implement mission/values and policies to meet the rule
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;	Staffed Residence/AFC/FHP/Group Home Providers: • Empower the participant to make choices about their living arrangements and activities ADHC/DT Providers: • Ensure that the participant has choice of daily activities at the day site All Providers:

Provider Requirements	
	• Encourage the participant to create his/her own schedule and provide necessary supports to facilitate choice of activities • Encourage the participant to make independent choices during service plan planning and on a daily basis • Establish policies and procedures which encourage individual choice of activities • Update and implement mission/values to meet the rule
Facilitates individual choice regarding services and supports, and who provides them.	Staffed Residence/AFC/FHP/Group Home Providers: • Ensure that the participant has a choice of not only provider setting, but also the direct service provider within that setting • Actively solicit participants' preferences regarding services and staff that provide them All Providers: • Provide necessary information (documents, site visits, etc.) that allows the participant to indicate his/her preferences for services and supports and who provides them • Document all setting and provider options presented and considered by the participant in the service plan • Provide staff training
Home and community-based settings do not include the following:(i) A nursing facility; (ii) An institution for mental diseases; (iii) An intermediate care facility for individuals with intellectual disabilities; (iv) A hospital; or (v) Any other locations that have qualities of an institutional setting, as determined by the Secretary. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving	Staffed Residence/AFC/FHP/Group Home Providers: • Consider alternate housing locations when Medicaid HCBS homes are clustered together • Document all integration activities as evidence that the participants are not isolated and that the setting does not have the qualities of an institution ADHC Providers: • Consider integration options for participants who require a high level of medical services DT Providers: • Consider options for bringing non-Medicaid HCBS individuals to the setting for meaningful interaction based on participants' interests All Providers: • Depending on compliance level, develop compliance plan to become compliant with HCBS rules • Consolidate documentation of community integration among recipients • Provide documentation that the setting does not have qualities of an institution • Remove isolating barriers or institutional qualities

Provider Requirements	
Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution unless the Secretary determines through heightened scrutiny, based on information presented by the State or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings.	• Cooperate with state staff and CMS on-site assessments

Table 5.6 Potential residential provider actions for compliance

Provider Owned/Controlled Setting Requirements	
Rule	**Potential Actions to be Compliant**
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 the jurisdiction's landlord/tenant law.	Staffed Residence/AFC/FHP/Group Home Providers: • Research state laws for leases to understand how to comply • Draft lease or legally enforceable document that provides participants the same responsibilities and protections from eviction that tenants have under KY law • Include furnishing/decorating guidelines within each lease • Review lease document with each participant or guardian and his/her case manager to reach agreement on the rights and responsibilities included in the lease • Finalize and agree to lease with each participant residing in the home

Provider Owned/Controlled Setting Requirements	
Rule	**Potential Actions to be Compliant**
Each individual has privacy in their sleeping or living unit;	Staffed Residence/AFC/FHP/Group Home Providers: • Continue to offer the participant a private bedroom or explore other options with the service plan team • Define and implement what privacy means to each participant both in bedroom and living areas • Provide staff training on privacy for participants
Units have entrance doors lockable by the individuals, with only appropriate staff having keys;	Staffed Residence/AFC/FHP/Group Home Providers: • Ensure that each participant has a key to his/her sleeping unit based on factors in the person-centered plan • Provide keys to participant rooms only to appropriate provider staff • Provide staff training on when it is appropriate to enter the participants' rooms • Require each sleeping unit to have a lockable entrance door and ensure that the participant has a key based on factors in the person-centered plan
Individuals sharing units have a choice of roommates in that setting;	Staffed Residence/AFC/FHP/Group Home Providers: • Continue to ensure that each participant has chosen his/her roommate and/or housemate • Re-locate participants to a different room or home if a change is desired • Include the participant in new housemate discussions
Individuals have freedom to furnish and decorate their sleeping and living areas within the lease or other agreement;	Staffed Residence/AFC/FHP/Group Home Providers: • Allow participants to furnish and decorate sleeping and living areas • Provide staff training • Include furnishing/decorating guidelines within each lease
Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time;	Staffed Residence/AFC/FHP/Group Home Providers: • Encourage participants to control their own schedule as indicated in the service plan and provide support to facilitate • Give participants an option to help plan, shop, and cook meals • Give participants support needed to exercise their rights as a citizen • Allow access to appropriate areas of kitchen and food at any time as indicated in the service plan • Provide staff training

Provider Owned/Controlled Setting Requirements	
Rule	**Potential Actions to be Compliant**
	• Provide supports to enable participants to do unscheduled social/community activities
Individuals are able to have visitors of their choosing at any time;	Staffed Residence/AFC/FHP/Group Home Providers: • Create standard policies related to visitors that are respectful of all participants who are living in the residence, while specifying that participants may have visitors at any time based on factors in the person-centered service plan • Discuss roommate preferences to set appropriate limits to visitor hours, if the participant has a roommate
The setting is physically accessible to the individual.	Staffed Residence/AFC/FHP/Group Home Providers: • Assure that the participants can enter the home at any time, no matter if they are alone or with staff • Consider participants' abilities and safety in the environment and make any needed design modifications to promote access and safety. • Comply with all ADA requirements • Determine how all participants residing in the home will be given independent access to all entrance doors, such as keys or keypads

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VI. Public Comment Process

Initial Public Comment – November-December, 2014

This Statewide Transition Plan is submitted to CMS and posted on December 19th, 2014. The following website can be used to view the plan: http://www.chfs.ky.gov/dms.

In order to allow stakeholders time to provide input in a convenient and accessible manner, DMS submitted this Statewide Transition Plan for public comment through an announcement on the DMS website, publication in newspapers, public forum, and informal channels. The public notice was published and posted on November 5, 2014 and provided stakeholders a 30-day public notice and comment period. CHFS distributed individual emails to waiver providers, provider associations, members of the HB144 Commission and the Commonwealth Council on Developmental Disabilities (CCDD), and DMS' advocacy distribution list to notify those stakeholders of the Statewide Transition Plan. The following website can be used to view the proposed Statewide Transition Plan: http://www.chfs.ky.gov/dms.

The following is the public comment process instructions for stakeholders that was included in the initial posting of the Statewide Transition Plan.

If you wish to submit written comments regarding this public notice please do so by emailing them to CMSfinalHCBRule@ky.gov or by mailing them to the following address by December 5, 2014.

Department for Medicaid Services
HCB Final Rule Statewide Transition Plan
Commissioners Office
275 E. Main Street, 6W-A
Frankfort, Kentucky 40621

To ask additional questions during the public comment period, please attend the scheduled public meeting. The HB144 Commission member meeting (Kentucky Commission on Services and Supports for Individuals with Intellectual and Other Developmental Disabilities) is open to all citizens and scheduled for December 4, 2014. The meeting will be from 1:00 to 3:00 PM at the following location:

Room 131 of the Capitol Annex Building
Frankfort, Kentucky

The public notice and comment period was published in six newspapers (*Lexington Herald Leader, Cincinnati/Northern KY Enquirer, Louisville Courier Journal, Bowling Green Daily News, Owensboro Messenger, Kentucky/Cincinnati Enquirer*) on November 5, 2014. The evidence for both statements of public notice is outlined in Appendix C and D. DMS and the workgroup also promoted and made informal communication about the transition plan and comment period to the following groups: waiver providers, provider associations, HB144 Commission members, the Commonwealth Council on Developmental Disabilities, and other advocacy groups.

A. Public Comments

All public comments were submitted to DMS through mail, email, advocacy groups, and the HB144 Commission meeting and were evaluated by the workgroup. The workgroup categorized similar comments together, summarized the comments, and responded and/or updated the transition plan accordingly. The summary and response of all comments is described in Table 6.1. If the state's determination differed from the public comment, then additional evidence and the rationale the state used to confirm its determination was included. If the state's determination agreed with the public comment, then the location of the supporting evidence in the transition plan was indicated. All public

comments on the transition plan will be retained and available for CMS review during the duration of the transition period or approved waiver, whichever is longer.

Table 6.1 Summary of public comments and response (Initial Public Comment – November-December, 2014)

Comment Summary (Number Received)	Response	Update to Transition Plan
One commenter inquired about the missing evidence (statements of public notice) in Appendix C or D.	Thank you for your response. The evidence (statements of public notice) was not available at the time the transition plan was posted for public comment. The evidence has been included in the final submission to the Centers for Medicare & Medicaid Services (CMS).	Yes, DMS agrees that documentation in Appendix C and D was missing. Appendix C and D have been updated with the appropriate evidence.
Multiple (6) commenters inquired about why the proposed Statewide Transition Plan did not include a plan or process to match resources/funding with any changes that may be indicated or required. What resources or funding mechanisms (including the US Department of Housing and Urban Development (HUD) funding) will be provided to support mandated changes and processes?	Thank you for your comment. Medicaid's budget does not include the expansion of any Medicaid program, so if additional funding is necessary, then a budget expansion request would be required. Once the specific provider requirements associated with the HCBS final rules are identified, the necessary funding and/or resources will be evaluated.	Yes, DMS agrees that additional waiver services and resources evaluation is required. Table 5.2 has been updated to include a capacity, resources, and services analysis section and action.
One commenter stated that the cost of background checks ($372) for PDS providers deters or prevents participants from selecting participant directed services (PDS). Medicaid should review the regulations that require the individual to pay for this, and recommend a different source of funding for this cost.	Thank you for your comment. This is not a component of the transition plan, but rather relates to the operations of the waivers. It has been brought to the attention of waiver staff and DMS is actively working on alternative options.	Not applicable to the transition plan.
One commenter inquired about giving participants the same rights as non-participants in regards to having a direct care worker paid for time assisting the participant when the participant goes on a vacation	Thank you for your comment. The Department for Medicaid Services (DMS) has not seen any guidance from CMS on this topic.	Not applicable to the transition plan.

Comment Summary (Number Received)	Response	Update to Transition Plan
out of state or goes out of state for any purpose. CMS should clarify that this is allowable.		
Multiple (4) commenters would like KY to continue to recognize that pre-vocational services may be provided in a variety of community settings and requests that the following language be included in the Plan under nonresidential services: “Consistent with an individualized planning process, pre-vocational services will continue to be regarded as having the potential to be considered community-based to the extent such services are compliant with the guidance for pre-vocational services as contained in the CMS Informational Bulletin published September 16, 2011."	Thank you for your comment. Specific details about individual waiver services are not addressed in the transition plan. Any changes in individual waiver services associated with the new HCBS final rules will be addressed in regulations and will be open for public comment as part of the overall stakeholder involvement process and throughout the Kentucky regulation review process.	Not applicable to the transition plan.
Multiple (15) commenters feel that there is a lack of respite, applied behavioral analysis (ABA) therapy, behavior support, affordable housing, community access, and transportation in their area, specifically for Michelle P Waiver (MPW) and members with autistim spectrum disorders. They also feel that DMS should allow both PDS and traditional agencies to provide respite.	Thank you for your comment. Specific details about individual waiver services are not addressed in the transition plan. Any changes in individual waiver services associated with the new HCBS final rules will be addressed in regulations and will be open for public comment as part of the overall stakeholder involvement process and throughout the Kentucky regulation review process. Your comment will be passed along to the appropriate waiver staff.	Not applicable to the transition plan.
One commenter inquired why the seventh waiver (Home and Community-Based Services (HCBS) Transitions) which provides services for individuals with physical disabilities (and the aged) that have left medical facilities through the Kentucky Transitions Program was not included in the transition plan.	Thank you for your comment. All active Kentucky HCBS waivers were addressed in the transition plan. The Transitions waiver was never funded/implemented in the Commonwealth and was terminated on 9/30/14.	No, DMS disagrees with this comment since the HCBS transition waiver was terminated on 9/30/14.

Comment Summary (Number Received)	Response	Update to Transition Plan
One commenter's son has met people, gone places, made friends and experienced life with other people outside of his family that he would have never been able to do with just the assistance from his immediate family. They are great supporters of these and other services (MPW) because they have witnessed first-hand the impact that they make on individuals.	Thank you for your comment. DMS appreciates your input.	DMS interprets that the comment does not warrant a change to the transition plan.
Multiple (2) commenters inquired if members will still have the freedom to choose and use consumer directed option (CDO). If so, the commenter asked if there are restrictions on who can provide the services.	Thank you for your comment. Specific details about consumer or participant directed services are not addressed in the transition plan. Any changes in this option associated with the new HCBS final rules will be addressed in regulations and will be open for public comment as part of the overall stakeholder involvement process and throughout the Kentucky regulation review process. Your comment will be passed along to the appropriate waiver staff.	Not applicable to the transition plan.
One commenter expressed the importance of waiver services to individuals on the autism spectrum and emphasized the importance of waiver members being able to live in the community and having the choice of living situations.	Thank you for your comment. Choice is intended to be a key component of the HCBS final rules. Specific details about individual waiver services are not addressed in the transition plan. Any changes in individual waiver services associated with the new HCBS final rules will be addressed in regulations and will be open for public comment as part of the overall stakeholder involvement process and throughout the Kentucky regulation review process. Your comment will be passed along to the appropriate waiver staff.	Not applicable to the transition plan.

Comment Summary (Number Received)	Response	Update to Transition Plan
One commenter wondered if the MPW transition plan will be updated with more specifics or is the specificity deemed to be found in the Statewide Plan.	Thank you for your comment. The specificity for all waivers is contained in the Statewide Transition Plan.	DMS interprets that the comment does not warrant a change to the transition plan.
Multiple (4) commenters urge the Cabinet for Health and Family Services (CHFS) to develop the person-centered planning (PCP) and self-directed components as soon as possible. They feel that through the PCP process the independent assessments of an individuals' needs and strengths will allow them to receive the services they need in a manner that they choose. A commenter inquired if there will be any anticipated changes or new requirements in this area.	Thank you for your comment. Person-centered planning is not a component of the transition plan and CHFS is working expeditiously on these areas. Your comment has been passed along to the appropriate waiver staff.	Not applicable to the transition plan.
One commenter inquired about giving participants and families access to provider statuses when citations or corrective actions have been issued.	Thank you for your comment. This is not a component of the Kentucky Statewide Transition Plan and your comment will be passed along to the appropriate waiver staff. .	Not applicable to the transition plan.
Multiple (5) commenters inquired about day programs, including that the transition plan should address how the adult day services will be modified to assure that participants have the opportunity to interact with individuals without disabilities. Another commenter indicated that they have many questions about congregate day programs level of funding. One commenter asked how the transition plan will affect safety net programs in Kentucky.	Thank you for your comment. As indicated in the transition plan, there are a number of federal rules that impact all provider types, including day programs. DMS is currently waiting for guidance from CMS related to non-residential services, including day programs. DMS will give each provider the opportunity to come into compliance. Medicaid's budget does not include the expansion of any Medicaid program, so if additional funding is necessary, then a budget expansion request would be required. Once the	Yes, DMS agrees that additional waiver services and resources evaluation is required. Table 5.2 has been updated to include a capacity, resources, and services analysis section and action.

Comment Summary (Number Received)	Response	Update to Transition Plan
	specific provider requirements associated with the HCBS final rules are identified, the services and/or necessary resources will be evaluated.	
One commenter inquired if the Medicaid Waiver Management Application (MWMA) will interface with electronic health records (EHR).	Thank you for your comment. Specific details about systems supporting the waivers are not addressed in the transition plan. Your comment will be passed along to the appropriate waiver staff.	Not applicable to the transition plan.
One commenter inquired if there are ways to use technology to help Kentucky achieve these requirements and promote integration.	Thank you for your comment. DMS will continue to look at additional options to achieve and promote integration.	Yes, DMS agrees and Table 5.1 has been updated to include a state action of identifying potential opportunities to use technology to promote integration.
One commenter inquired about the SCL cutbacks and thinks there needs to be changes to SCL.	Thank you for your comment. Specific details about overall funding and policies for individual waivers are not addressed in the transition plan. Any changes in individual waiver services associated with the new HCBS final rules will be addressed in regulations and will be open for public comment as part of the overall stakeholder involvement process and throughout the Kentucky regulation review process. Your comment will be passed along to the appropriate waiver staff.	Not applicable to the transition plan.
Multiple (3) commenters want to require that all individuals have an option for residential and non-residential services. They feel that Kentucky should require each provider that refuses to provide a service to put the refusal in writing with the reason for the	Thank you for your comment. This is not a component of the Kentucky Statewide Transition Plan and your comment will be passed along to the appropriate waiver staff.	Not applicable to the transition plan.

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denial so Kentucky can review the causes of failure to provide services and develop a plan to address the issues.		
Multiple (3) commenters inquired about if there are different ways to let residents and families know of HCBS, its services, and its availability.	Thank you for your comment. This is not a component of the Kentucky Statewide Transition Plan and your comment will be passed along to the appropriate waiver staff.	Not applicable to the transition plan.
One commenter stated that there is a possibility that the HCBS final rule impact will cause little to [no] significant change for Kentucky provider agencies.	Thank you for your comment.	The comment did not request a change to the transition plan.
Multiple (2) commenters stated that the plan states that Supports for Community Living (SCL) "participants are individuals who have an intellectual disability", but that it should also include individuals who have other developmental disabilities.	Thank you for your comment. DMS apologizes if the brief summary included in the transition plan did not fully describe the population served through the SCL waiver. The complete definition of the population served in the SCL waiver is outlined in 907 KAR 12:010.	Yes, DMS agrees and the purpose section (section I, page 2) has been updated to include the waiver regulation number for reference.
Multiple (6) commenters commended Kentucky on several positive elements of the Statewide Transition Plan. They liked the use of multiple sources of information for its evaluation of settings, including review of regulations, information from state staff who conduct on-site licensing visits of these settings, and engagement with providers. They believe the Transition Plan proposes to build an on-going monitoring of compliance with the HCBS regulations into its oversight system. The plan outlines a relocation process for individuals who are being provided services in settings that cannot come into compliance with the regulations and includes an initial	Thank you for your comment. DMS appreciates your input.	Yes, DMS agrees.

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analysis and transition plan for non-residential settings.		
Multiple (3) commenters asked how changes in provider compliance level will be assessed and communicated, while another inquired about the appeals process. DMS received a question asking how controlling schedules and activities will work with ADT and how providers who did not respond to the survey were evaluated.	Thank you for your comment. DMS is still developing the provider compliance and heightened scrutiny processes, but information and technical assistance will be shared with providers on a routine basis. DMS is currently waiting for additional guidance from CMS related to the heightened scrutiny process. DMS made an assumption that the remaining providers not surveyed reflect the same distribution of compliance levels as the providers surveyed. Providers who did not respond to the survey will have additional opportunities to provide information at a future point. The Kentucky sanctions regulation (907 KAR 1:671) provides more information on the appeals process. The determination of a compliance level is not one of the actions that can be appealed. However, the initial compliance level is an estimate and DMS will work with providers to come into compliance. Providers will have an opportunity to review their initial compliance level and take actions come into compliance.	Yes, DMS agrees additional information is needed regarding the provider compliance and heightened scrutiny process. The provider assessment (section IV, page 14), the provider level remedial strategies (section V, page 31), and the settings presumed not to be HCB (section V, page 34) sections have been updated to include additional details.

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Multiple (5) commenters asked for more details regarding the heightened scrutiny process for those providers who will be presumed not to be home and community-based. The transition plan does not indicate that it is the state who determines whether to submit evidence to CMS. Commenters stated that the heightened scrutiny process does not explain how DMS will seek input from stakeholders, such as participants and families and some suggested that DMS collect input from participants, families, and advocates when evaluating providers under heightened scrutiny.	Thank you for your comment. DMS has the responsibility to review findings and consolidate sufficient evidence for providers who qualify for heightened scrutiny before submission to CMS. DMS is still developing the provider compliance and heightened scrutiny processes, but information and technical assistance will be shared with providers on a routine basis. The initial compliance level results are targeted to be shared with providers during the first quarter of calendar year 2015. The compliance level of providers is expected to change over time as provider survey responses are validated, additional information is collected, and providers change their practices to comply with the HCBS final rules. The workgroup is developing the compliance plan template and evaluating provider responses. DMS is developing a stakeholder engagement process to obtain input on the implementation of the setting-related HCBS final rules. There will be public forums for providers and for advocates, participants, and families before policies and tools are established. The forums will be focused on Kentucky's plan for defining and operationalizing the setting-related HCBS final	Yes, DMS agrees additional information is needed regarding the heightened scrutiny, compliance plan template, and stakeholder engagement process. The provider assessment (section IV, page 14 and 18), the provider level remedial strategies (section V, page 31), the settings presumed not to be HCB (section V, page 32), and the Table 5.2 sections have been updated to include additional details.

Comment Summary (Number Received)	Response	Update to Transition Plan
	rules. Prior to implementation of policies, DMS will use established public consumer, advocacy, and provider groups to review and provide feedback on key changes as well.	
Multiple (29) commenters asked who will be developing the compliance plan template and if providers will have the opportunity to provide input into the template. Another commenter suggested that DMS build off of the surveys and develop the compliance plan template to be very detailed and contain specific checklists and criteria. One commenter requested that the public have an opportunity to give input to the compliance plans before they are approved by DMS.	Thank you for your comment. The workgroup is developing the compliance plan template/tool and evaluating provider responses. The provider compliance plans are not formalized corrective action plans, but draft documents that DMS will use as a means of communicating and assisting the providers' effort to become compliance. When stakeholders were referenced in the transition plan, DMS meant legal guardians, families, participants, parents, siblings, wives, husbands, advocacy groups, friends, and providers. The definition of stakeholders has been added to the Statewide Transition Plan on page 2. DMS is developing a stakeholder engagement process to obtain input on the implementation of the setting-related HCBS final rules. There will be public forums and/or focus groups for providers and for advocates, participants, and families before policies and tools are established. The forums will be focused on Kentucky's plan for defining and operationalizing the setting-related HCBS final	Yes, DMS agrees additional information is needed regarding the workgroup and stakeholder engagement process. The purpose (section I, page 2), regulation and waiver application assessment (section III, page 6), provider assessment (section IV, page 14 and 18), provider level remedial strategies (section V, page 31), Table 5.2, and Table 5.3 sections have been updated to include additional details.

Comment Summary (Number Received)	Response	Update to Transition Plan
	rules. Prior to implementation of policies, DMS will use established public consumer, advocacy, and provider groups to review and provide feedback on key changes as well. DMS is also working on a plan to educate participants and/or legal guardians about the HCBS final rules and the potential impacts. Moving forward participants, legal guardians, families, and legal guardians will be involved in defining key elements of the rule. All revisions to the transition plan and updates regarding the HCBS final rules will be posted to the DMS website. There will be many opportunities over the five year transition timeframe when comments may be submitted regarding waivers. Stakeholder comments can be submitted each time changes are proposed to any waiver regulation, waiver application, and waiver renewal.	
Several (18) commenters inquired about when and how DMS will notify providers of their level of compliance with the HCBS final rules. DMS received similar comments asking if providers will be able to submit additional information to justify their level of compliance. Some commenters suggested publishing the list of providers that fall within each category of compliance, while others urged DMS to conduct on-site reviews to validate provider level of compliance.	Thank you for your comment. Given the large number and varying types of non-residential providers in the Commonwealth, calculating percentages provided the most accurate representation of the compliance level. DMS fully intends to complete on-site visits of all providers, regardless of compliance level to confirm compliance with the HCBS final rules. The on-site visits will use an updated	Yes, DMS agrees additional information is needed regarding the provider compliance survey, on-site visits, provider level categorization, and the opportunity for providers to provide additional information. The provider assessment (Section IV, page 18), provider level remedial strategies (section V, page 33), and

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DMS received a suggestion of listing isolating factors and specific areas of non-compliance for each provider. Several commenters provided feedback on the process for determining provider's category of compliance. Some commenters stated that participants and families should be involved in the categorization of the settings. Overall, commenters requested more details describing how providers' level of compliance will be evaluated and what modifications must be made to providers' settings for them to achieve compliance.	monitoring tool and will occur through regular monitoring visits. Providers identified as non-compliant will potentially require additional on-site visits. Training will be conducted for waiver staff to incorporate new rules into monitoring tools. The categorization of provider compliance included in the transition plan was based on survey and waiver staff data, and is not final. The provider compliance level is an initial estimate and the final categorization will not be based solely on survey data. The compliance plan template is still being developed, and DMS will be seeking provider and participant input on the template. When the plan templates are distributed to providers, providers will be notified of their initial categorization, during the first quarter of calendar year 2015. Providers will have opportunities to work with the state to complete the template and identify and resolve areas of non-compliance.	Table 5.2 sections have been updated to include additional details.
Several (13) commenters inquired about the federal regulation requirement of community integration. Comments include that the plan is unclear and does not go far enough to see significant change and that there needs to be clear definitions around expectations and outcomes and what full community access means. One commenter stated that providers	Thank you for your comment. Integration is a critical component of the new rules and a key part of Medicaid waivers today. Per the HCBS final rules, the individual needs of the waiver participants should be included in the person-centered plan.	Yes, DMS agrees that integration is important. Table 5.1 (page 21) outlines the potential actions each waiver must complete in order to be compliant. Table 5.2 has been updated to include additional details

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will need more information regarding how to become more integrated in the greater community. Several participants commented that they do not always have the opportunity to go into the community, even when they want to. Questions from commenters include what the requirements for integration look like, if providers must calculate ratios of patients with disabilities versus no disabilities to determine integration, and how the state will take into account the varying needs of waiver participants when identifying integration. One commenter described that if a Community Living Support (CLS) staff person is out with an illness, the participant cannot go out into the community.	The Statewide Transition Plan outlines DMS' implementation of the plan for the next five years. DMS agrees that more information regarding how community integration will be operationalized and measured is needed. The development of these definitions and requirements is part of the transition process. Stakeholders will be involved in the process prior to the implementation of policies as outlined on page 31. CMS has provided additional information and resources regarding residential services: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html We have referred your comment to the appropriate waiver staff who will be following-up on your comment.	about stakeholder engagement as well.
Multiple (5) commenters stated that there should be a grievance process for participants and their families to file complaints about non-compliant settings.	Thank you for your comment. There is an established grievance and/or complaint process for each waiver. Based on public comments received, DMS will further analyze the process, ensuring it is clearly defined and publicized. Please see page 31 of the Statewide Transition Plan for additional details.	DMS agrees that more awareness of the grievance process on the participant side is needed. Table 5.2 has been updated to include a section on reviewing and publicizing the grievance processes.

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Several (12) commenters inquired about participant surveys. These include that all compliance monitoring should involve participant surveys, the surveys must be free of influence from providers, and that the participants should be involved in the initial assessment of provider compliance. Some commenters suggested that DMS create an online survey tool specifically for participants, while others suggested submitting questionnaires to participants to evaluate how much choice they have in settings and services, as well as allow them to rate the settings. One commenter recommended that consumer organizations be involved in the creation of the participant surveys.	Thank you for your comment. DMS is working to establish a participant surveying process that will be used to validate provider compliance. The survey process will include mechanisms to minimize potential provider influence. The survey will be developed with input from participants and families. DMS will explore the various options of tools for conducting a participant survey. DMS also recognizes the importance of advocacy group engagement in the creation of participant surveys and the implementation of the HCBS final rules.	Yes, DMS agrees a participant surveying process needs to be developed and/or updated. Table 3.5 and Table 5.2 have been updated to include the development of a participant surveying process.
Several (6) commenters expressed concern over settings presumed not to be HCB. One commenter noted that the transition plan should address in detail how the settings should be modified while another questioned the process that would be implemented if the current programs could not comply with the new rules. One commenter noted that the transition plan should recognize that some of the settings may need to be removed from HCBS.	Thank you for your comment. The Statewide Transition Plan is intended to be a planning roadmap of how CHFS will bring HCBS waivers into compliance with the setting-related HCBS final rules. Please refer to page 36 in the Statewide Transition Plan. The specific details of how settings must be modified has yet to be determined and will vary based on the specific areas of non-compliance for each setting. Providers and participants will have opportunities to provide input into the process. Please refer to page 35 of the Statewide Transition Plan for more information about compliance level 3 and the relocation process	Yes, DMS agrees that additional information regarding how settings should be modified to become compliant is needed. The provider level remedial strategies (section V, page 34) section and Table 5.5 outline the process for settings presumed not to be HCB and potential actions to become compliant.

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	for information on what will occur if settings need to be removed from the HCBS.	
Multiple (3) commenters expressed concern regarding the provider surveys. One commenter noted that the questions for providers to self-assess were inadequate, while another suggested conducting a second non-residential survey to capture more of the providers.	Thank you for your comment. The provider assessment and compliance level determination is a continuous process that will change as new information is presented and changes are made. DMS made an assumption that the remaining providers that did not respond to the survey reflect the same distribution of compliance levels as the providers who responded. Providers who did not respond to the survey will have additional opportunities to provide information. The provider compliance plan template process, which is still under development, will facilitate the communication and documentation of the providers' compliance level with DMS. The questions from the surveys were modeled from CMS suggested questions. Providers will have additional opportunities to provide input and information on their compliance levels throughout the process.	DMS disagrees with the comment since the survey questions were modeled off the CMS toolkit and ample time was provided for providers to complete the survey. The provider assessment - non-residential settings (section IV, page 18) section describes the provider surveying process.
One commenter suggested that the waiver participant be involved in the relocation process for providers who will not be able to comply with the HCBS final rules.	Thank you for your comment. DMS agrees that participant involvement is very important, and will follow the person-centered planning process for individuals who may need to be relocated. Please refer to page 35 of the Statewide Transition Plan for more information on the relocation process.	Yes, DMS agrees that the relocation process will follow the person-centered planning process and that the individual will be included. The provider level remedial strategies (section V, page 33) section has been updated with additional information.

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Multiple (3) commenters offered feedback about participants controlling their own schedules. Some participants are not able to control their own schedule, depending on staffing, and one participant indicated s/he wanted to work but staff would not allow him/her to have supported employment. Another commenter asked how this requirement would work with the current ADT program.	Thank you for your comment. DMS believes that choice is a critical component of the HCBS final rules and a key part of Medicaid waivers today. The lack of flexibility and autonomy in residential services is being addressed by the HCBS final rules outlined in Table 5.1 (page 26). DMS is still in the process of operationalizing the definitions and the requirements of the HCBS final rules, but information and technical assistance will be shared with providers on a routine basis. DMS will pass your comment to the appropriate waiver staff.	The comment did not request a change to the transition plan.
Several (6) commenters suggested that the timeline for implementation of some of the setting rules is too extended. Suggestions include addressing the most problematic settings earlier to achieve compliance by 2019.	Thank you for your comment. DMS has selected the timeline outlined in the Statewide Transition Plan for the following reasons: 1. The rules included in the second round may have a significant impact on KY HCBS providers and create an access issue depending on the number of providers who will lose the ability to render services because of the rules, if adequate time is not allowed for implementation. 2. DMS has allotted a full year to work with the high volume of providers who will need to undergo heightened scrutiny to assure that	DMS disagrees because the extended timeline allows more providers to come into compliance, ensuring access to HCB services. The state level remedial strategies section (section V, page 21) has been updated to include the reasons for the extended timeline.

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	DMS can spend adequate time working with each provider. 3. DMS is giving time for providers to stabilize the first round of changes before moving into the second round. 4. DMS will be educating providers as soon as the rules are fully defined and operationalized. The education and compliance process for the second round changes will start before 2018 giving providers ample time to become compliant.	
Multiple (2) commenters stated that trainings will be critical for providers and asked how provider trainings will be conducted. Another commenter suggested that organizations will need guidance on how to become more integrated into the greater community. One commenter suggested that webinar technology needs to be updated if information is going to be disseminated to providers through that channel.	Thank you for your comment. DMS is developing the training process and a stakeholder education plan. Part of the planning process will include evaluating different options for broadcasting the information. DMS will work to reduce technological issues moving forward. Additionally, all meetings are recorded and available on the DMS website.	Yes, DMS agrees a training and education plan is required. Table 5.3 has been updated to include the development of a communication and education plan for participants.
Several (4) commenters highlighted the importance of transportation as it relates to access. Suggestions include making transportation a more prominent component of the transition plan and clarifying the payment and performance mechanism for provision of transportation.	Thank you for your comment. DMS agrees that transportation is an important part of HCBS waivers. The Statewide Transition Plan outlines DMS' implementation strategy and will not address the specific details about waiver services. Once the specific provider requirements associated with the HCBS final rules are identified, the services will be evaluated.	Yes, DMS agrees that additional evaluation of waiver services and resources is required. Table 5.2 has been updated to include a resources analysis section and action.

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One commenter inquired about how the transition plan will affect home health and adult day care facilities, as well as “non-mental health” patients.	Thank you for your comment. The setting-related HCBS final rules have two sections, one that applies to all settings, including non-residential settings and one section that only applies to residential settings. The first five requirements of the rules listed in Table 3.2 and 3.3 apply to all settings and services, including adult day care facilities. All patients who receive services from an HCBS waiver are affected in the same way, regardless of diagnosis.	DMS interprets that the comment does not warrant a change to the transition plan.
Several (2) commenters stated that the rule changes need to be more specific, which will make the requirements more easily enforceable. Additionally, one commenter suggested that DMS utilize guidance from CMS and update the transition plan as more guidance is released.	Thank you for your comment. The Statewide Transition Plan outlines DMS' implementation strategy for the setting-related HCBS final rules over the next five years. DMS agrees that more information regarding the rules is needed and that further development of the definitions and requirements is part of the transition process. Stakeholders will be involved in the process prior to the implementation of policies as outlined in Table 5.2.The Statewide Transition Plan will be updated and assessed as additional guidance is provided by CMS. The workgroup used CMS toolkits to develop the Statewide Transition Plan and will continue to use CMS guidance as a reference. CMS has provided additional information and resources regarding residential services:	DMS is still developing the specific requirements of the rules and the transition plan will not be updated at this time.

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	http://www.medicaid.gov/Medicaid-CHIPso-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html	
One commenter noted it takes over three weeks to get a criminal record check for employees in the CDO program.	Thank you for your comment. This is not a component of the Kentucky Statewide Transition Plan and your comment will be passed along to the appropriate waiver staff.	Not applicable to the transition plan.
Multiple (4) commenters inquired about freedom of choice for participants. Comments include a participant who was told by staff that s/he could not live alone, even if s/he were to get married, while another participant said s/he has never been given a choice of where to live or roommates. Another comment was that participants cannot have freedom of choice without capacity, and so, capacity will need to be evaluated and increased. The transition plan needs to be made clear that the provider is not allowed to evade the requirement of giving the participants the choice of a private room.	Thank you for your comment. DMS believes that choice is a critical component of the HCBS final rules and a key part of Medicaid waivers today. The implementation of the HCBS final rules ensures that each individual has the option to select a private room and that roommate selection is an individual choice. Once the specific provider requirements associated with the HCBS final rules are identified, services and provider capacity will be evaluated. A section in Table 5.2 has been added to the Statewide Transition Plan outlining the evaluation process.	Yes, DMS agrees the language needs to be strengthened. Table 5.2 has been updated to include a capacity, resources, and services analysis section and action. Table 5.5 has been updated with clarifying language.
Multiple (3) commenters asked what information would need to be presented in order to determine that the provider does not have characteristics of an institution. Another commenter expressed concern that DMS is defining an area where there is more than one residence occupied by individuals receiving HCBS	Thank you for your comment. CMS released additional information regarding potential isolating and non-HCBS settings that provides clarification. All settings identified as presumed not to be HCBS will have the opportunity to	DMS interprets that the comment does not warrant a change to the transition plan.

Comment Summary (Number Received)	Response	Update to Transition Plan
as potentially having the characteristics of an institution. Further, the commenter stated that having a couple of houses on the same road or some neighborhood does not meet the definition of isolating.	complete the heightened scrutiny process and provide evidence of compliance. Please follow the below link for more information regarding settings that have the potential to isolate: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/settings-that-isolate.pdf	
Several (2) commenters discussed heightened scrutiny. One commenter stated that providers with numerous homes on one street would fall under heightened scrutiny while another confirmed his/her understanding that providers who fall under heightened scrutiny will need to submit evidence to the state first.	Thank you for your comment. Yes, DMS agrees that providers presumed not to be in compliance must submit evidence to DMS first and then DMS will corroborate the evidence. DMS will make the decision to submit evidence to CMS. DMS is however still waiting on further clarification from CMS on the specific heightened scrutiny process. Additional information regarding potential isolating settings and the heightened scrutiny process can be found at the following link: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html	DMS interprets that the comment does not warrant a change to the transition plan.

Comment Summary (Number Received)	Response	Update to Transition Plan
Several (4) commenters asked questions related to the lease requirement. These include other requirements that will be developed, if the lease will hinder the individual moving to another provider, and if a provider who owns multiple houses may have one lease for all of their locations, and what is required in the case of a room change. One commenter suggested that the state implement consistent tenant rights and responsibilities.	Thank you for your comment. Lease options will be considered when lease requirements are defined. Kentucky's interpretation of the rule is that an individual will have the option of choice each time s/he moves residences. The requirements of the lease agreement are still being developed, but should reflect the actual residence where the individual resides.	DMS interprets that the comment does not warrant a change to the transition plan.
Several (4) commenters summarized key components of the plan and noted positive aspects. Comments include that stakeholders are pleased that modifications will be considered rights restrictions. Other commenters noted the transparency that Kentucky is assuring with the details of the plan.	Thank you for your comment. DMS appreciates your input.	DMS interprets that the comment does not warrant a change to the transition plan.
Multiple (3) commenters stated their concern of individuals having keys to the exterior of the house, for fear that the key would be lost, stolen, or copied and potentially leading to breaking and entering. Another suggestion is to clarify who “appropriate staff” having keys are. Another comment stated that the discussion of physical accessibility is inadequate and to be accessible, a setting must meet certain construction standards.	Thank you for your comment. The HCBS final rule requires physical accessibility and a potential example of implementing this rule is by giving individuals residence keys. This is just an example and DMS agrees that it will be important to identify options that allow accessibility and promote safety. As part of the person-centered planning process the individual’s team should decide the appropriate individuals and staff who can have full access to keys. More details/definitions will be developed and discussed as a part of the implementation process.	DMS agrees that additional examples of implementation actions are needed. The specific requirements are still being developed, but Table 5.6 has been updated with clarifying language.

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One commenter stated that the transition plan is not detailed about how it will ensure individuals are offered choices of non-disability specific settings.	Thank you for your comment. DMS will update the Statewide Transition Plan to address provider capacity and service assessment as we implement the HCBS final rules.	Yes, DMS agrees that an evaluation of additional waiver services, capacity, and resources is required. Table 5.2 has been updated to include a capacity, resources, and services analysis section and action.
Several (5) commenters stated that they do not have a choice of roommate in their residential setting. Other commenters asked for clarification around what choice of roommate means, and if participants will be able to live alone if they choose. Overall, commenters are requesting more detail of how this rule will be implemented.	Thank you for your comment. DMS believes that choice is a critical component of the HCBS final rules and a key part of Medicaid waivers today. The HCBS final rules are focused on choice and DMS hopes that individuals will have multiple service and setting options. The individual will have to weigh his/her options, including residential providers, locations, availability, resources, and roommate options. The implementation of the HCBS final rules ensures that each individual has the option to select a private room and that roommate selection is an individual choice. Kentucky's interpretation is that choice to live alone means a private room in a house occupied by other waiver recipients. Based on a person's needs and desires, it may also be appropriate for a person to choose to live alone with necessary supports.	DMS is still developing the specific requirements of the rules and the transition plan will not be updated at this time.
One commenter inquired about the process for setting selection, how individuals will select settings, and what informed consent means for individuals. The questions include how legal guardians and parents or	Thank you for your comment. Legal guardians are an integral part of the process, as well as parents, family members and/or individuals identified by the member. More detail/definition is needed for informed	Yes, DMS agrees that legal guardians are synonymous with participants and that they play an integral part of the process. The purpose section (section 1, page 2) has been updated.

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other family members are involved in the setting selection process.	consent and setting selection, which will be part of the development process.	
One commenter asked if the rule allowing visitors at any time will require a 24-hour staffed residence.	Thank you for your comment. Currently, the opportunity to have visitors at any time is addressed through the person-centered process for providers to accommodate the person's choices. This opportunity should be afforded to anyone receiving residential services and does not require a 24 hour setting. This expectation is stated in the HCBS final rules and will continue in the future	DMS interprets that the comment does not warrant a change to the transition plan.
One commenter urged DMS and CHFS to support improvements without undermining existing safety net programs.	Thank you for your comment. The goal of the HCBS final rules is to improve home and community based services, including public safety net programs.	Yes, DMS agrees with the comment, but interprets that the comment does not warrant a change to the transition plan.
Multiple (5) commenters asked who the members of the workgroup are and what opportunities are available for stakeholders to be a part of the process.	Thank you for your comment. At this time the workgroup is an internal CHFS group comprised of staff from three departments representing each HCBS waiver operated in the Commonwealth. DMS is developing a stakeholder engagement process to obtain input on the implementation of the setting-related HCBS final rules. There will be public forums and/or focus groups for providers and for advocates, participants, and families before policies and tools are established. The forums will be focused on Kentucky's plan for defining and operationalizing the setting-related HCBS final rules. Prior to implementation of policies,	Yes, DMS agrees additional information is needed regarding the workgroup and stakeholder engagement process. The regulation and waiver application assessment (section III, page 6) and Table 5.2 sections have been updated to include additional details.

Comment Summary (Number Received)	Response	Update to Transition Plan
	DMS will use established public consumer, advocacy, and provider groups to review and provide feedback on key changes as well.	
Several (5) commenters inquired about participant/legal guardian/family involvement in the implementation of the HCBS final rules. These include the importance of seeking input from waiver participants and families, and specifically giving these individuals opportunities to provide input on the compliance plan template. One commenter noted that the transition plan does not include sufficient opportunities for input and suggested that additional steps be taken to ensure that these stakeholders have meaningful opportunities to comment. Another commenter suggested written notice be provided to participants and that educational forums be hosted.	Thank you for your comment. When stakeholders were referenced in the transition plan, DMS meant legal guardians, families, participants, parents, siblings, wives, husbands, advocacy groups, friends, and providers. The definition of stakeholders has been added to the Statewide Transition Plan on page 2. DMS is developing a stakeholder engagement process to obtain input on the implementation of the setting-related HCBS final rules. There will be public forums and/or focus groups for providers and for advocates, participants, and families before policies and tools are established. The forums will be focused on Kentucky's plan for defining and operationalizing the setting-related HCBS final rules. Prior to implementation of policies, DMS will use established public consumer, advocacy, and provider groups to review and provide feedback on key changes as well. The workgroup will develop the evaluation tools and surveys based on the finalized definition and operationalization of the rules.	Yes, DMS agrees additional information is needed regarding stakeholders and their engagement process. Table 5.2 has been updated to include additional details.

Comment Summary (Number Received)	Response	Update to Transition Plan
	The provider compliance plans are not formalized corrective action plans, but draft documents that DMS will use as a means of communicating and assisting providers with compliance.	
Several (7) commenters offered feedback on the public comment process. One commenter asked how updates will be posted on the DMS' webpage, while another suggested adding a public comment link to the homepage. Some commenters stated that they believe the 30 day timeframe was too short to provide meaningful comments and that there was a lack of public input into the creation of the transition plan. Two commenters noted that there were no Kentucky-sponsored public meetings to inform stakeholders of changes. One commenter urged DMS to seek stakeholder input as regulations are being developed. In addition to comments, DMS received several questions about the public comment, including if comments may only be made in reference to the subject of the public comment period, if there are only two one-month periods where comments may be submitted on the waivers, and if family members should have expanded opportunities to comment.	Thank you for your comment. DMS is working on tight timelines established by CMS. The Kentucky Statewide Transition Plan was open for public comment from November 5th through December 5th and publicized via newspapers, DMS website, emails to individual waiver providers, provider associations, members of the HB144 Commission and the Commonwealth Council on Developmental Disabilities (CCDD), DMS' advocacy email distribution list, a presentation to the CCDD, and the HB 144 meeting. There will be many opportunities over the five year timeframe when comments may be submitted regarding waivers. Stakeholder comments can be submitted each time changes are made to any waiver regulation, waiver application, and waiver renewal.	DMS interprets that the comment does not warrant a change to the transition plan.
A commenter suggested that Kentucky provide written notice to participants and provide educational forums throughout the state. Additionally, one commenter requested that Kentucky inform participants that their comments may also be directed to CMS.	Thank you for your comment. DMS is working on a plan (materials and dissemination options) to educate participants and/or legal guardians about the HCBS final rules and the potential impacts. Moving forward participants, legal	Yes, DMS agrees additional information regarding participant education is needed. Table 5.3 has been updated with additional information.

Comment Summary (Number Received)	Response	Update to Transition Plan
	guardians, and families will be involved in defining key elements of the rule.	
A commenter stated it is hard to tell how DMS determined if a setting was isolating. The commenter requested DMS to list the specific isolating factors of each setting, that the specific setting under each category should be made public, and that public input should be sought before the categorization of the setting is finalized.	Thank you for your comment. DMS is further developing the definitions and requirements of the HCBS final rules. The categorization of providers in compliance level four (presumed not to be HCB) was based on the below rules (outlined in the settings section starting on page 17). • Located in a building that is also a facility that provides in-patient institutional treatment • On the grounds of, or immediately adjacent to an institution • Setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS • Operated in an area (e.g., a neighborhood, a street or a neighboring street, etc.) where there is more than one residence in the area that is occupied by individuals receiving HCBS • Operated in multi-family properties with more than one unit occupied by individuals receiving Medicaid HCBS • Operated in a remote location (rural, farmstead, etc.) Additional information regarding potentially isolating settings can be found at the following	DMS interprets that the comment does not warrant a change to the transition plan. Links to additional information was provided. As processes are developed, information will be shared with stakeholders.

Comment Summary (Number Received)	Response	Update to Transition Plan
	link: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/settings-that-isolate.pdf The provider compliance level is an initial estimate and the final categorization will not be based solely on survey data. Providers will be notified of their estimated compliance level when the provider compliance plan template is released.	

Summary of modifications based on public comments:

- I. Background – more details added
- II. Introduction – references added
- II. Introduction
    - A. Purpose – more details added
        - Table 2.1 – more details and public forums added
- III. Assessment Process Systemic Review
    - A. Regulation and Waiver Application Assessment – more details added
        - Table 3.5 – participant surveys added
- IV. Provider Assessment – more details added
- IV. Provider Assessment
    - B. Non Residential Settings – more details added
- V. Remedial Strategies
    - A. State Level Remedial Strategies
        - 1. Policy – more details added

- Table 5.1 – more details added
- Table 5.2
    - State staff training – more details added
    - Capacity, resources, and services – section added
    - Surveying process – participant surveys added
    - Grievance process – section added
    - Communication plan for stakeholders – stakeholder engagement process added
- Table 5.3 – education plan added

- B. Provider Level Remedial Strategies – more details added
    - 1. Settings presumed not to be HCB – clarifications added
    - Table 5.5 – clarifications added

At the time the Statewide Transition Plan is filed with CMS, the transition plan will also be posted to the state website. The URL for the filed transition plan is http://www.chfs.ky.gov/dms. The Statewide Transition Plan, with any modifications made as a result of public input, will be posted for public information no later than the date of submission to CMS.

VII. Appendix

A. Residential Provider Survey

The below survey questions were administered to all residential waiver providers through a web-based survey tool. The providers were notified of the survey either by email or provider letter.

1. Name
2. Agency (if identified)
3. Are any of your residences on the grounds of, or adjacent to, an institution?
    i. If yes, please provide the name and address of the residence(s):
    ii. Comments:
4. Do any of your residences operate in an area (e.g., a neighborhood, a street or a neighboring street, etc.) where there is more than one residence in the area that is occupied by individuals receiving Medicaid Home and Community-Based Services
    i. If yes, please provide the name and address of the residence(s)
    ii. Comments:
5. Do you operate any multi-family properties with more than one unit occupied by individuals receiving Medicaid HCBS?
    i. If yes, please provide the name and address of the properties:
    ii. Comments:
6. Do you operate a residence in a rural setting?
    i. If yes, please provide the name and address of the residence(s):
    ii. Comments:
7. Do individuals participate in unscheduled and scheduled community activities in the same manner as individuals not receiving Medicaid HCBS?
    i. Consider the following in your response.
        1. Does the individual regularly access the community?
    ii. Comments:
8. For how many people does your agency provide residential services?
    i. Comments:
9. Of those members receiving residential services, how many does your agency provide day services for?
    i. Comments:
10. Of those members receiving residential services, how many people attend a sheltered workshop?
    i. Comments:

11. Are individuals employed or active in the community?
    i. Consider the following in your response.
        1. Does the individual work in an integrated community setting?
        2. If the individual would like to work, is there activity that ensures the opportunity to work?
    ii. Comments:
12. Of those members receiving residential services, how many work in the community making minimum wage or better?
    i. Comments:
13. Of those members receiving residential services, how many people volunteer in the community?
    i. Comments:
14. (Q11) 12. Do individuals choose and control a schedule that meets his or her wishes in accordance with a person-centered plan?
    i. Consider the following in your response.
        1. How is it made clear that the individual is not required to adhere to a set schedule?
    ii. Comments:
15. Do individuals control their personal resources?
    i. Consider the following in your response.
        1. Does the individual have a checking or savings account or other means to control his/her funds?
        2. Does the individual have access to his or her resources?
    ii. Comments:
16. Does the individual have choice of meal time, place and menu?
    i. Comments:
17. Does the individual have full access to typical home facilities such as kitchen, dining area, laundry?
    i. Comments:
18. Is assistance provided to an individual in private when needed and in such a language the individual understands?
    i. Comments:
19. Is the individual's health information kept private?
    i. Comments:
20. Do you create a lease agreement or residential contract with individuals receiving Medicaid HCBS living in any of your residences? Please email your lease agreement as instructed in the cover email by May 29th.
    i. Comments:
21. Are individuals protected from eviction and afforded appeal rights in the same manner as all persons in the State who are not receiving HCBS?
    i. Please describe policy or procedure:

22. Name:
23. Agency Name:

B. Non-Residential Provider Survey

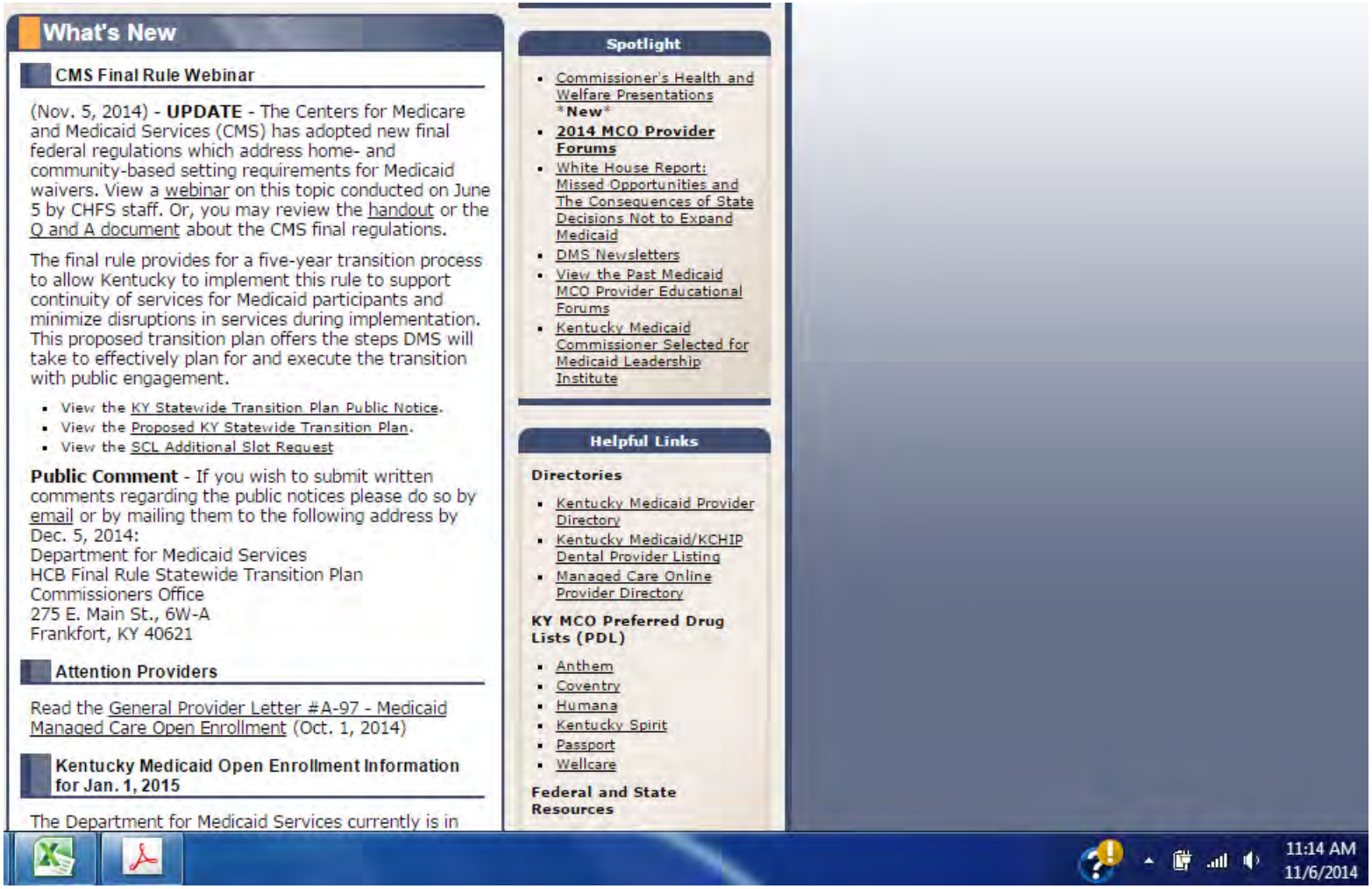
The below survey questions were administered to all non-residential waiver providers through a web-based survey tool. The providers were notified of the survey either by email or provider letter.

1. Name:
2. Agency:
3. Email Address:
4. Please provide the addresses of all of your settings, if applicable:
5. Please select the Medicaid HCB waiver for which your agency/organization provides services: ABI, ABI-LTC, HCB, MPW, MII or SCL
6. Please select which of the following provider types best describes your agency: ADHC, Home Health Agency, or Other
    i. Other Non-residential Provider (specify here): ADT, Case Management, OT, PT, ST, CLS, etc.
7. Are participants' schedules for PT, OT, medications, restricted diet, etc., posted in a general open area for all to view?
    i. Please explain how privacy is ensured/protected:
8. As part of your waiver services, do your participants participate in activities in the greater community?
    i. Please provide examples of activities that participants engage in in the greater community:
9. Do participants have the freedom to make their own choices while receiving services at your program (if s/he is able to make independent choices)?
    i. Consider the following in your response:
        1. Do participants have autonomy to choose daily activities?
        2. Do participants choose who they interact with?
    ii. Please provide examples of how participants have freedom of choice:
10. Do you facilitate the participants' choice of services, supports, and who provides them?
    i. Please explain:
11. Are participants given a choice of available options regarding where to receive services (not applicable to ADHCs)?
    i. Please explain how the participants are given choice:
12. Is it made clear that participants are not required to adhere to a set schedule for activities, etc.?
    i. Please explain your response to set schedules for participants:

13. Do participant schedules vary from others in the same setting?
    i. Please explain your response to varying schedules among participants:
14. Do participants have access to things that interest them and can they schedule such activities at their convenience?
15. Are any of your programs within, on the grounds of, or adjacent to, an institution (nursing facility, institution for mental disease, intermediate care facility for participants with intellectual disabilities, or hospital)?
    i. Please provide address/addresses of any programs within, on the grounds of, or adjacent to, an institution:
16. Do any of your programs operate in an area (e.g. a neighborhood, a street or a neighboring street, etc.) where there is more than one facility/program in the area providing services to individuals receiving Medicaid Home and Community-Based Services (HCBS)?
    i. If you answered yes in the previous question, please provide examples of how your agency helps participants engage in the broader community:
    ii. Please provide the address/addresses of your programs where there is more than one facility/program in the area providing services to individuals receiving Medicaid HCBS:
17. Is the non-residential site considered to be remote and outside of a city limits?
18. Do you ensure that participants have rights of privacy, dignity and respect, and freedom from coercion and restraint?
    i. Please provide justification that you ensure participants have rights of privacy, dignity and respect and freedom from coercion and restraint:
19. Does staff converse with participants while providing assistance and during the regular course of daily activities?
20. Does staff address participants in the manner in which they would like to be addressed?
21. Is individual choice facilitated in a manner that leaves the participant feeling empowered to make decisions?
    i. Please provide justification that individual choice is facilitated to make the participant feel empowered:
22. Does staff ask participants about their needs and preferences?
23. Does your program accommodate the participant's needs and preferences?
    i. Please explain how your program does, or does not, accommodate the participant's needs and preferences:
24. Do participants know how to change or request a change to their program, service, or activity they receive?
25. Does the participant know how and to whom to make a request for a new provider?
    i. Please explain the process for how participants request a new provider:
26. Do you ask your participants if they are satisfied with their services, outside of surveying?
    i. If yes, please explain how you use that information:
    ii. If no, please explain why you do not ask the participants if they are satisfied:

C. Proof of Public Notice

27. Website posting



What's New

CMS Final Rule Webinar

(Nov. 5, 2014) - **UPDATE** - The Centers for Medicare and Medicaid Services (CMS) has adopted new final federal regulations which address home- and community-based setting requirements for Medicaid waivers. View a webinar on this topic conducted on June 5 by CHFS staff. Or, you may review the handout or the Q and A document about the CMS final regulations.

The final rule provides for a five-year transition process to allow Kentucky to implement this rule to support continuity of services for Medicaid participants and minimize disruptions in services during implementation. This proposed transition plan offers the steps DMS will take to effectively plan for and execute the transition with public engagement.

- View the KY Statewide Transition Plan Public Notice.
- View the Proposed KY Statewide Transition Plan.
- View the SCL Additional Slot Request

Public Comment - If you wish to submit written comments regarding the public notices please do so by email or by mailing them to the following address by Dec. 5, 2014:
Department for Medicaid Services
HCB Final Rule Statewide Transition Plan
Commissioners Office
275 E. Main St., 6W-A
Frankfort, KY 40621

Attention Providers

Read the General Provider Letter #A-97 - Medicaid Managed Care Open Enrollment (Oct. 1, 2014)

Kentucky Medicaid Open Enrollment Information for Jan. 1, 2015

The Department for Medicaid Services currently is in

Spotlight

- Commissioner's Health and Welfare Presentations *New*
- **2014 MCO Provider Forums**
- White House Report: Missed Opportunities and The Consequences of State Decisions Not to Expand Medicaid
- DMS Newsletters
- View the Past Medicaid MCO Provider Educational Forums
- Kentucky Medicaid Commissioner Selected for Medicaid Leadership Institute

Helpful Links

Directories

- Kentucky Medicaid Provider Directory
- Kentucky Medicaid/KCHIP Dental Provider Listing
- Managed Care Online Provider Directory

KY MCO Preferred Drug Lists (PDL)

- Anthem
- Coventry
- Humana
- Kentucky Spirit
- Passport
- Wellcare

Federal and State Resources

11:14 AM
11/6/2014

28. Newspaper posting

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES

DEPARTMENT FOR MEDICAID SERVICES

PUBLIC NOTICE

The Cabinet for Health and Family Services (CHFS), Department for Medicaid Services (DMS), in accordance with 42 CFR 441.301, hereby provides a 30-day public notice and comment period for its Statewide Transition Plan for all Home and Community-Based Services waivers to comply with the requirements set forth in *Final Rule - CMS 2249-F – 1915(i) State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, Setting Requirements for Community First Choice, and CMS 2296-F 1915(c) Home and Community-Based Services Waivers* (Final Rule).

The Final Rule provides for a five-year transition process that will allow Kentucky to implement this rule in a manner that supports continuity of services for Medicaid participants and minimizes disruptions in service during implementation. This proposed Statewide Transition Plan offers the steps that DMS will facilitate in order to effectively plan for this transition and then successfully execute the transition, with the engagement of the public.

DMS also provides a 30-day public notice and comment period for the Supports for Community Living (SCL) waiver amendment to add 200 additional slots in state fiscal years 2014-2015 and 240 additional slots in state fiscal years 2015-2016.

The following website can be used to view the proposed Statewide Transition Plan and the SCL waiver amendment: http://www.chfs.ky.gov/dms.

Public Comment

If you wish to submit written comments regarding this public notice please do so by emailing them to CMSfinalHCBRule@ky.gov or by mailing them to the following address by December 5, 2014:

Department for Medicaid Services

HCB Final Rule Statewide Transition Plan

Commissioners Office

275 E. Main Street, 6W-A

Frankfort, Kentucky 40621

D. Proof of Public Comment

29. Email and mail
30. HB144 commissioner meeting

ANNOUNCEMENT

KENTUCKY COMMISSION ON SERVICES AND SUPPORTS FOR INDIVIDUALS WITH INTELLECTUAL OR OTHER DEVELOPMENTAL DISABILITIES (HB 144 COMMISSION)

ACCEPTING APPLICATIONS

The HB 144 Commission serves in an advisory capacity to the Governor and the General Assembly concerning the needs of persons with an intellectual or other developmental disability. The Commission is accepting applications to represent the following groups:

- Direct Service Provider
- Family Member of an adult with an intellectual/developmental disability residing in a facility-based residential setting
- Family Member of an adult with an intellectual/developmental disability
- Family Member of a child with intellectual/developmental disability residing in the home or community-based setting
- Self-Advocate to represent individuals with intellectual/developmental disabilities
- Business Leader
- Statewide Advocacy Group

Information regarding the work of the HB 144 Commission along with application information may be obtained at:

http://dbhdid.ky.gov/ddid/commission.aspx

Deadline for submission of applications is February 15, 2016.

COMMONWEALTH OF KENTUCKY
INFORMATION FOR BOARDS AND COMMISSIONS

Return Completed Form To:
Claudia Johnson, Assistant Director
DBHDD/DDID
275 East Main St – 4CF
Frankfort, KY 40621
Phone: 502-564-7700
Fax: 502-564-8917
Claudia.Johnson@ky.gov

Please indicate Boards/Commissions you wish to consider

Kentucky Commission on Services and Supports for Individuals with Intellectual and Other Developmental Disabilities

Your Name (Last, First, Middle) Mr. Ms. Mrs.		*County	*Congressional District
Home Address	City	State	Zip
Date of Birth		*Party Affiliation: Dem. Rep. Ind.	Race
Your Occupation	Business Phone Number & Fax Number		Residence Phone Number
Email address			Mobile Number
Current Employer	Business Address		
Spouse's Name	Spouse's Employer		

EDUCATION AND GENERAL QUALIFICATIONS:

Level	Name of School	No. Years Attended	Did you Graduate	Major Course(s) of Study
High School				
College/Other				
Memberships in Organizations. Also Indicate Current Positions With Political Party or Organization. Indicate Any Public Office Currently Held.				

HAVE YOU EVER BEEN CONVICTED OF A FELONY? ____ IF YES, PLEASE INDICATE CHARGE, DATE AND PLACE.

_____

REFERENCES (List two persons not related to you, whom you have known for at least one year)

Name	Address	Phone Number	Years Acquainted

*Necessary for certain boards to comply with state law in regard to balance
CURRENT RESUME MAY ALSO BE SENT

DATE: _____ SIGNATURE: _____

ANNUAL STATUS REPORT

The Kentucky Commission on Services and Supports for Individuals with Intellectual and Other Developmental Disabilities

Submitted in Accordance with KRS 210.577 to:

Governor Steven L. Beshear
and the General Assembly
October 2015

KENTUCKY COMMISSION ON SERVICES AND SUPPORTS FOR INDIVIDUALS WITH INTELLECTUAL AND OTHER DEVELOPMENTAL DISABILITIES

FY15

INTRODUCTION

The Kentucky Commission on Services and Supports for Individuals with Intellectual and Other Developmental Disabilities was created and established by KRS 210.575 through the enactment of House Bill 144 by the 2000 General Assembly. The Commission, referred to as the HB 144 Commission, serves in an advisory capacity to the Governor and the General Assembly concerning the service system that impacts the lives of people with intellectual and developmental disabilities.

The Commission's current membership includes 24 individuals, nine of whom are appointed by the Governor. These individuals represent family members, legislators, provider organizations, advocacy groups, and leaders from various state agencies. During FY 15, the following legislators were appointed to serve on the Commission: Senator Julie R. Adams, Representative Joni Jenkins, and Representative David Watkins.

During FY 2012, the Commission formed three subcommittees to address issues and concerns identified from data collected through the National Core Indicator (NCI) project, which Kentucky has participated in since 1999. The NCI survey provides a variety of data that is reported by individuals with intellectual and developmental disabilities, family members, and caregivers about the quality of services and supports received through a variety of funding sources. An NCI Quality Improvement Committee was established to analyze the data and subsequently provide the Commission with information that resulted in the identification of three priority areas and subsequent subcommittees: (1) Health and Wellness; (2) Participant Directed Supports; and (3) Community Integration. These three subcommittees continued to meet throughout FY 15.

FY 2015 GOALS, STATUS, and ACTIVITY UPDATES

In 2012 HB 144 Commission members, in collaboration with the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID), established five long-term initiatives for the next 5-10 years. The following goals, updates, and subcommittee reports reflect Commission activities in FY2015.

Goal 1: Community education and outreach must be a combined effort to create an awareness of need and available services for people with intellectual and developmental disabilities (I/DD).

Status Update 1

The Division of Developmental and Intellectual Disabilities (DDID) within DBHDID presented at local, regional, and statewide forums and conferences throughout FY 15. Staff presented information related to services and supports available through the Supports for Community Living (SCL) Medicaid Waiver program, which had been revised and was referred to as SCL2. These forums included topics related to Community Access and Supported Employment. Examples of community forums include the ARC of Kentucky Chapter meetings, Advocates in Action (AIA) meetings, ARC of Kentucky Annual Conference, and the American Association on Intellectual and Developmental Disabilities Conference.

Status Update 2

DBHDID, in conjunction with the Office of Vocational Rehabilitation (OVR) and the Office for the Blind, is moving forward with the process of developing standard policies and procedures for the provision of Supported Employment in Kentucky. These activities have been initiated with the assistance of the Office for Disability Employment Programs through its Community of Practice initiative and the National Association of State Directors of Developmental Disabilities Services' (NASDDDS) Employment Learning Communities. Activities have included:

Activity: Asset Management and Economic Self Sufficiency, which incorporates financial education and asset development into the vocational rehabilitation process and SCL Waiver Employment Process:

- Conducted a series of regional asset development summits to start a dialogue between asset builders and the disability community;
- Developed an on-line resource directory on asset development and financial education for individuals with disabilities and service providers;
- Developed specific asset building tools for individuals with disabilities, such as individual development accounts and a benefits planning network; and
- Maintained a dialogue among disability service providers and organizations such as the Office of Vocational Rehabilitation, the Department for Behavioral Health and Developmental and Intellectual Disabilities, the Commonwealth Council on Developmental Disabilities, and the Statewide Independent Living Council (SILC), among others, to encourage asset development and economic self-sufficiency as a policy priority.

Activity: Development of Local and Regional Leadership

- Began the process of educating the Department of Education's Nine Regional Transition Teams about Employment First and their role in the Employment First process;

- Worked to expand the Kentucky Association of People Supporting Employment First (APSE) Communities of Practice which currently include Rehabilitation Counselors, Employment Specialists, and Case Managers; and
- Conducted cross-training between Medicaid Waiver technical Support Staff and OVR Supported Employment Consultants which resulted in OVR and SCL cooperatively conducting reviews and annual visits.

Activity: Training and Technical Assistance - including consultation resources to provider organizations to assist in expanding or improving employment outcomes.

- A framework for information sharing has been developed through Communities of Practice (COP). These have occurred in a number of areas including a mass COP event at the KY APSE Conference.
- The "Take Your Legislator to Work" program was initiated and implemented.
- With the assistance of HDI and Kentucky APSE, a new webpage is being initiated to serve as a clearinghouse for information about employment services in Kentucky.
- The SCL waiver regulation established a requirement for an annual orientation to employment and community integration to be provided to all day training participants. A presentation detailing the requirements of this orientation has been completed and distributed statewide.
- A new presentation entitled "The Truth about Working while Disabled" has been developed and utilized with local organizations across Kentucky and at national conferences.
- A revised Supported Employment credentialing program designed to make the process more accessible and streamlined, including making it possible for employment specialists to become credentialed while providing billable services, has been implemented.
- The existing Supported Employment training is in the process of being converted in an effort to take full advantage of available technological resources, training, modeling, and mentoring. This training will result in the attainment of a credential and replace our existing credentialing process.

Activity: Transition from School to Work

- Worked to Develop a Memorandum of Agreement, Memorandum of Understanding, or Cooperative Agreement to achieve a centralized, cross-system, collaborative approach to Seamless Transition from high school to employment (at high school and/or postsecondary education exit) that will guide new and existing transition efforts that are in compliance with the Workforce Investment Opportunity Act (WIOA);

- Combined the membership of the Kentucky Interagency Transition Council and Regional Interagency Transition Teams to more effectively advocate for people receiving SCL services; and
- Participated in a revision to the seamless transition framework features in a process being developed by Kentucky's College and Career Readiness for the 1% low incidence Special Education Population Project - State Personal Development Grant (SPDG).

Status Update 3

The Participant Directed Supports Subcommittee seeks to promote the principles and tools of self-determination that are used in the Participant Directed Services Program to assist participants in the creation of meaningful, culturally appropriate lives within their community in which they can develop relationships, learn, work and earn income, and actively participate in the community life. The Participant Directed Supports (PDS) Subcommittee continued to meet during the reporting period to address the following subcommittee goal:

Participants should be provided information on any new process as early as possible to avoid misunderstanding or lapse in services.

Activity: The Participant Directed Supports Subcommittee met on a regular basis to address the above goal and to address other issues pertaining to services and supports for people with disabilities. The PDS meetings included members of the HB 144 Commission, staff from the Department for Aging and Independent Living, the Division of Developmental and Intellectual Disabilities, other interested participants receiving services, and family members. The meetings included discussion of major issues and opportunities regarding the Supports for Community Living Medicaid Waiver program and how Participant Directed Services applies to those currently receiving services and to new applicants to the program. Discussions included new employment training, pre-employment costs, the MAP 532 form required for immediate family members, owning and living in one's own home, transportation, increased awareness of services, and the availability and need for consistency of Participant Directed Services monitoring throughout the state.

Activity: In May 2015 members of the PDS Subcommittee and others testified before the General Assembly's House Informational Committee on Developmental Disabilities. The six member House Committee, chaired by Representative David Watkins, met twice in May of 2015. Subcommittee members also participated in webinars and conference calls with the National Resource Center for Participant Directed Services.

Activity: The PDS Subcommittee continued its outreach efforts to ensure that participants would be provided a user-friendly Participant Directed Program Manual.

The manual has been distributed to various state entities, field workers/case managers, individuals with developmental and intellectual disabilities, family members, guardians, local educational agencies, and others as identified throughout the state. Information and resource packets were shared at various venues and exhibits which included The ARC of Kentucky's Annual Best Practices Conference, the Kentucky Self-Advocates for Freedom Annual Conference, the Kentucky Autism Center Regional Conferences, the Regional Parent/Professional Conference, the Down Syndrome Association meetings, and agency-sponsored events.

Activity: The PDS Subcommittee requested and received information regarding the number of individuals self-directing supports and services accessed through Medicaid Waiver programs. At the time the statistics were gathered, approximately 10,800 individuals self-directed their support services in the following waiver programs: Acquired Brain Injury, Acquired Brain Injury Long-Term Waiver, Michelle P. Waiver, Supports for Community Living Waiver, and Home and Community Based Waiver program.

Status Update 4

A quality assurance program entitled Quality Indicator Tools was designed to encourage the provision of high quality SCL Waiver services. Based upon the Joint Commission "Follow the Person" protocol, the Quality Indicator Tools are currently being tested.

Each support is evaluated in three (3) distinct performance groups:

- Expectation (provider meets basic regulatory requirements);
- Effort (provider demonstrates establishment of systems that give participants the opportunity to be successful); and
- Excellence (the participant is experiencing positive outcomes).

The Quality Indicator Tool utilizes a scoring process on a 4.0 scale for each service. The quality score will be mapped to show progress on the overall SCL outcome model.

Goal 2: Promote inclusion of citizens with disabilities to increase natural supports in the community and in the workplace.

Status Update 1

The Community Integration Subcommittee identified the following goal for the subcommittee:

Beating Loneliness through Community Integration – Increase by 10% the overall percentage of people who report having friends who are not staff or family as reported in the next NCI 12-month data cycle.

Activity: An initiative known as, "Endeavor for Excellence," which included a partnership with the University of Kentucky's, Human Development Institute (HDI) [a University Center for Excellence in Developmental Disabilities] and the Division of Intellectual and Developmental Disabilities, was implemented. The initiative, a branded curriculum that evolved over a five-year period through the joint efforts of Hope Leet Dittmeir and the Irish entity Genio (see www.Genio.ie), was implemented in FY2015. The lead trainer of the course, Hope Leet Dittmeir, was accompanied by facilitator Milton Tyree from HDI. The partnership entities invited SCL providers to apply to participate in an extensive eight-month training and mentoring course designed to enhance the capacity of providers to impact the lives of the individuals they support in significant and meaningful ways through community relationships. The course focused on the information, ideology, strategy, and skill necessary to design and provide high quality human services in partnership with individuals with I/DD and their families. The initiative emphasized implementation and was consistent with the provision of Community Access services in the SCL Medicaid waiver program. The following are results of the initiative:

- Seven applications from SCL provider agencies (from a total of 235 SCL certified provider agencies) were submitted and accepted.
- Five of the SCL providers and one non-SCL agency participated in the eight-month initiative. Each agency had a team of four people comprised of one individual with I/DD receiving supports from the agency [referred to as Learning Partner] and three team members who represented implementers, managers, and executive leadership of the agency.
- At the conclusion of the training in February 2015, 18 of 24 team members completed the training.
- Evaluation information collected at the conclusion of the training indicated on a scale of 1 to 4, with 4 being highest, that 83% of the 18 respondents had increased their knowledge, understanding, and ability in the integration of individuals with I/DD in their communities.

Goal 3: Advocate for adequate funding for a system of services and supports throughout the individual's lifespan.

Status Update 1

The Commission advocated for additional SCL waiver appropriations. The legislature approved 300 additional slots for FY13 and 300 additional slots for FY14, bringing the total appropriated slots to 4,501. During those two fiscal years, 221 individuals from the urgent category were allocated funding, and all 778 who met emergency criteria were allocated funding. The legislature approved additional slots to be phased in over the Fiscal Years 2015 and 2016 as noted in Table 1.

Fiscal Year	SCL Waiver	Michelle P Waiver
July 1, 2014-June 30, 2015	200	250
July 1, 2015-June 30, 2016	240	250

Table 1: Legislature approved additional slots

Goal 4: People with disabilities and their families will have continued access to services and supports that meet their needs and expectations.

Status Update 1

DBHDID continued its focus on continuity of care in FY15 by emphasizing timely access to an appropriate level of quality care. DDID liaisons are assigned to each state Intermediate Care Facility (ICF) and psychiatric hospital to provide technical assistance and promote networking designed to lead to a successful transition to community based supports. Liaisons provide guidance to individual teams concerning support options, discharge planning, and exceptional support request development.

The Olmstead Act is a federal mandate ensuring that individuals do not reside in institutions longer than is necessary for treatment to take place. An individual included in the Olmstead Act once he/she has surpassed a 90-day stay in a psychiatric hospital, has had frequent psychiatric admissions within the past 12 months, and/or who are at risk of institutionalization. During each Olmstead meeting, particular individuals' progress needs and barriers to community placement are discussed with the goal being community integration as soon as the person's team deems it appropriate. Therefore, each liaison participates in Olmstead meetings and meetings concerning transitions from Personal Care Homes.

Status Update 2

The Supports Intensity Scale (SIS) assessment was developed by the American Association on Intellectual and Developmental Disabilities (AAIDD) and measures the supports an individual needs to be successful in a variety of life domains. As of June 30, 2015, there have been a total of 8,974 SIS assessments completed.

A Supports Intensity Scale assessment is conducted for each SCL participant at the time of entry to the SCL program and again every other year. All areas of typical adult life are evaluated through the SIS process. The SIS assessment also considers extraordinary supports that may be necessary in regard to a participant's medical and behavioral support needs, as well as a supplemental section regarding protection and advocacy items. As of June 30, 2015, a total of 159 Exceptional Support Decisions had been determined:

- Approved – All Services 106 (70.65%)
- Denied – All Services 45 (29.3%)
- Partial Deny/Approve 8 (0.05%)
- 1 appeal was made and was dismissed without hearing

The SIS assessment report is available to the case manager and the interdisciplinary team for use during the person centered plan of care development process and helps to identify the supports that are most likely to be needed in order for the participant to achieve his/her identified outcomes.

Status Update 3

The Community Integrations Subcommittee focused their efforts during FY15 on the continued access to services and supports that meet their needs and expectations.

On the federal level, The Centers for Medicare & Medicaid Services (CMS) implemented new regulations for Medicaid's 1915(c) Home and Community-Based Services (HCBS) waivers on March 17, 2014, "to ensure waiver participants have full access to the benefits of community and services in the most integrated settings (https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2014-Press-releases-items/2014-01-10-2.html.

Key elements include:

- ***Person-centered planning*** requirements, such as the individual should lead the process to the maximum extent possible and be provided with information and support to make informed choices regarding his/her services, including providers of those services.
- ***Person-centered service plan*** requirements that establish key elements of the service plan, including the participant's needs identified through an assessment, as well as the individual's strengths, preferences, identified goals, and desired outcomes.
- ***Conflict-free Case Management*** which means that a provider of HCBS for the individual is not allowed to also provide case management or develop the person-centered service plan to that same individual, unless the provider is the only willing and qualified provider within 30 miles of the participant's residence.
- ***Residential and non-residential setting*** requirements, such as the setting must be integrated in and support full access of individuals receiving HCBS to the greater community, giving the individual initiative and independence in making life choices.

Person-centered planning, person-centered service plan, and conflict-free case management must be implemented by states as soon as possible, but CMS is allowing five years for states to implement residential and non-residential setting requirements.

States were required to submit a waiver-specific transition plan detailing their plans to implement the setting requirements at the time of the first waiver renewal or amendment to CMS. Kentucky submitted a Michelle P. waiver amendment to CMS on August 28, 2014, which included the Michelle P. waiver-specific transition plan. After that submission, Kentucky had 120 days to submit its statewide transition plan for all waivers, which details the Commonwealth's plan to bring all waiver settings into compliance with the HCBS federal final rules within the five year timeframe. Kentucky submitted this statewide transition plan to CMS on December 19, 2014. Kentucky's statewide transition plan gives providers the maximum time allowable to implement the most complex and potentially challenging aspects of the HCBS setting requirements.

The Commission has worked closely with the Cabinet for Health and Family Services and others to ensure that changes are made in a manner that supports continued access to services and supports that meet the needs and expectations of individuals and families.

The Community Integration Committee partnered with the cabinet to host a series of forums to ensure that individuals and families:

1) Have basic information about the "New Final Rules"; and
2) Have an opportunity to give input about how these changes should be implemented in Kentucky.

Four forums were provided throughout Kentucky, and over 250 people participated, with more than half representing individuals and family members. Using materials developed for the forums, CHFS personnel presented information to other organizations and family groups throughout the year.

Status Update 4

During FY15, the waiting list for Michelle P. waiver services, which provide services for individuals who reside in the community increased significantly from its inception on March 15, 2014 to 4395 individuals as of September, 2015.

The waiting list for SCL waiver services has remained fairly steady with 1,947 on the waiting list as of September 2015. The majority of those people are receiving services and all people in crisis that have submitted applications to date have been funded.

Because the Michelle P. waiver program waiting list presents tremendous barriers for individuals and their families seeking access to services and supports, the Community Integration Subcommittee studied the operation of the Michelle P. Waiver Program and submitted the following findings and recommendations in January 2015:

"The operation of the Michelle P Waiver Program has been negatively impacted by problems with access, unclear criteria for certification and an unclear process for

addressing its future. First, the certification process entails coordination between multiple state agencies which often requires persistent monitoring by the applicant, and in some cases requires the assistance of personnel from KY Protection and Advocacy. Second, denials are issued with no substantive explanation. Third, nearly half of the 10,000 individuals participating in the Michelle P. Waiver are children and young adults with Autism who need Community Living Supports (CLS) services, but do not fit the original eligibility criteria. Despite this, no clear plan has emerged to address the needs of these individuals or ensure that services continue to be available to those for whom the waiver was developed.

Our overarching concern is that problems with the Michelle P. Waiver process may prevent some individuals who are both eligible and needing Michelle P. Waiver services from accessing the services needed. To help address this situation, we recommend the following five (5) steps and offer the assistance of the Community Integration Committee in addressing them:

First, we recommend that letters of denial should provide substantive reasons for denial and be written in easily understood language. Also, the appeal process and timeline should be outlined in the denial letter. The denial letter should be sent to the individual applicant, family members as appropriate and any provider or organization which assisted the individual with the application process.

Second, we recommend that a statement of the criteria for certification with an outline of the process be developed. In addition, this document should be written in clear language and should be made available to clients, their parents, and caseworkers involved in the certification process. Furthermore, a tool appropriate for assessing children should be developed to reflect these criteria.

Third, we recommend that the Cabinet for Health and Family Services (CHFS) provide on its website a "dashboard" of current waiver allocations similar to what has been distributed to the HB 144 Commission so that everyone – individuals with disabilities, parents, and providers – understands the availability of waiver services.

Fourth, we recommend that the website should provide clear recommendations for alternative supports, given that most or all of the waiver slots are currently allocated. In addition, the electronic case management system being developed by CHFS should incorporate all available supports appropriate for individual applicants.

Fifth, and most importantly – we recommend that CHFS in collaboration with individuals with disabilities, family members, advocates and providers should initiate a process with a well-defined timeline to address the future of the

Michelle P. Waiver and the development of possible alternatives for children and young adults with Autism Spectrum Disorders. This initiative could be incorporated into KY's effort in addressing the HCBS Federal Final Rules."

Some progress has been reported by the Department for Medicaid Services regarding Recommendations 1 through 4. However, it does not appear that any progress has been made related to Recommendation 5. The Community Integration Subcommittee will continue to prioritize the need for a plan to address the needs of the nearly 6,000 Kentuckians who have been placed on the Michelle P and SCL waiting lists for waiver services.

Status Update 5

The Commission's Health and Wellness Subcommittee continued to meet and make advances toward the following subcommittee goal:

Increase the overall percentage of SCL recipients who engage in moderate physical activity for 30 minutes a day at least three times a week by 5%, as reported in the next NCI 12-month data cycle.

The 2013-2014 National Core Indicators (NCI) data indicated that 19% of all Kentuckians with I/DD and 18% of individuals receiving SCL supports engaged in moderate physical activity for 30 minutes a day at least three times a week, which remains below the national average of 22%. The 2013-2014 breakdown by setting was:

SETTING	KENTUCKY	NATIONAL
Community Based Setting	13%	21%
Individual Homes	7%	26%
Parent's Homes	23%	24%

Activity: In partnership with the University of Illinois-Chicago, the Human Development Institute at the University of Kentucky, and the Division of Developmental and Intellectual Disabilities, the statewide Health and Wellness Coordinator became a certified master trainer for the Health Matters program.

Activity: Twelve provider agencies applied for participation in a statewide pilot: HealthMatters, Kentucky Scale-Up Research Project. This was one a one-year study evaluating the usefulness of an interactive webinar HealthMatters Program: Train the Trainer online course aimed at Direct Support Professionals (DSPs) working in the provider agencies. The following are associated with this pilot project:

- Three 90-minute online webinars were offered in January and February of 2015 with accompanying surveys on health promotion advocacy, confidence, and

benefits before and after both the training and implementation of the 12-week HealthMatters curriculum. The Health and Wellness Coordinator participates in online webinar trainings to offer support and answer questions.

- Participating organizations are required to have an on-site wellness committee and conduct monthly meetings. The organizations were to devote a minimum of three staff to receive training and implement the curriculum, which required 4-6 hours per week to teach the 12-week personalized health promotion program that was required to begin within two weeks of the final webinar.

Out of the initial 12 agencies, 10 completed the program in its entirety.

Activity: The Health and Wellness Coordinator, through the Human Development Institute, submitted three separate grant applications to further the statewide network.

Activity: The Health and Wellness Coordinator continues to update wellness website: www.wellness4ky.org. Included in the website updates are:

- Lesson summaries and supplemental HealthMatters information;
- Community health resources;
- Links to adaptive exercises; and
- Links to videos produced through the Human Development Institute.

Goal 5: The primary focus for public intermediate care facilities will shift to expand networks providing a continuum of health care within the individual's community.

***Status Update 1**:*

As individuals transition from facility to community supports, the state ICF's continue to focus on becoming Centers of Excellence to serve as a resource to, and increase the capacity of, the community.

Status Update 2:

DBHDID partnered with the Department for Medicaid Services to submit an amendment to the Medicaid State Plan requesting approval from the Center for Medicare and Medicaid Services for specialty clinics providing medical, dental, and other therapeutic services for individuals with I/DD residing in the community. The departments received CMS approval for the state plan amendment; regulations have been promulgated; Hazelwood and Oakwood Specialty Clinics are now operational; and the Lee Specialty Clinic became fully operational on July 1, 2014.

The Oakwood, Hazelwood, and Lee Specialty Clinics provide core services such as primary care, psychiatry, epilepsy, and dental services in accordance with the administrative regulation. Specialists also provide onsite services in physical,

occupational, and speech therapy; nutritional counseling; behavior therapy; pharmacological counseling; lab services; and wound and foot care. These clinics have reached out to their respective communities by providing information and referral services to current and potential patients.

The Lee Specialty Clinic is working on maximizing outreach and marketing, expanding service capacity, and expanding the identification of undiagnosed neurodevelopmental syndromes. It has also created the first-ever continuing education course focused on the interdisciplinary care of adult patients with I/DD, co-sponsored by a medical school and a dental school. The Lee Specialty Clinic was the focus of an article printed by The New York Times, December 31, 2014, entitled "An Oasis of Care and Caring for People with Intellectual Disability."

STATISTICS

Following is the status of programs providing supports to individuals with intellectual and/or developmental disabilities through FY15.

CMHC State General Fund Service Provision FY 2015

- Based upon data reported by the Community Mental Health Centers, 9291 people with intellectual or other developmental disabilities were supported with State General Fund dollars.
- DBHDID staff work with CMHC staff on an ongoing basis to address issues related to data accuracy.
- CMHC adult I/DD crisis services were utilized by 565 individuals.

ICF Average Census FY 2008 through FY 2015

The number of people who reside in state Intermediate Care Facilities for individuals with Intellectual/Developmental Disabilities (ICFs/IID) has decreased significantly with the implementation of a statewide transition process designed to transition individuals into the community.

Facility	FY08	FY09	FY10	FY11	FY12	FY13	FY14	FY15
Oakwood	226	205	173	133	120	121	119	114
Hazelwood*	168	162	161	158	146	135	123	116
Bingham Gardens	32	34	32	28	24	23	21	21
Outwood	65	63	59	50	46	42	40	38
Total	491	464	425	369	336	321	303	289

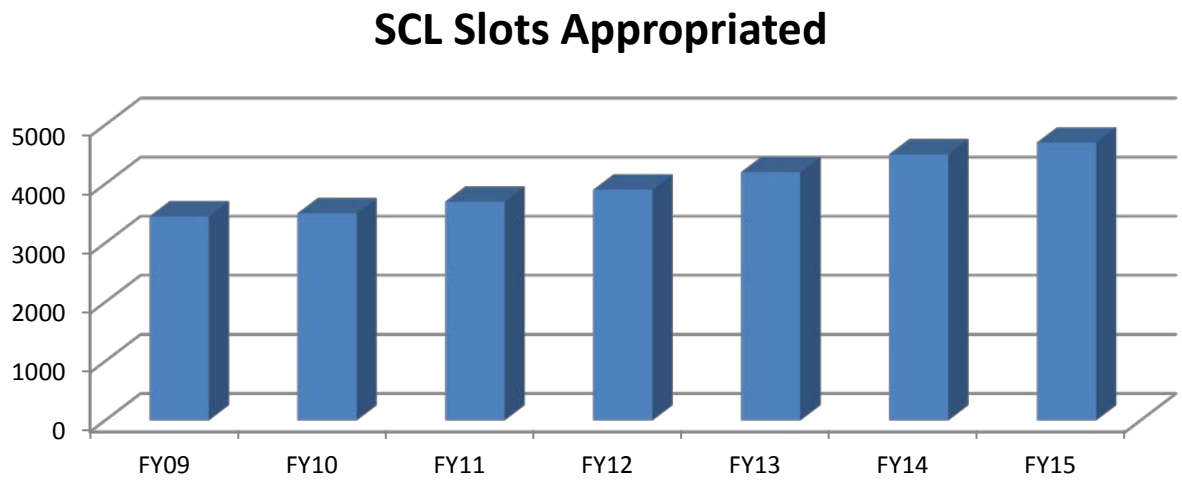
*Hazelwood Center census includes the three 8-bed ICF community homes.

As part of the settlement agreement with the US Department of Justice, each of the state-owned ICFs/IID is in the process of transforming into a Center of Excellence. These centers serve as a resource to individuals, families, and community providers by offering specialized supports and services that otherwise are not accessible in the community.

SCL Waiver

SCL Waiting List as of June 30, 2015			
Total	Emergency	Urgent	Future/Planning
1974	0	40	1924

As of June 30, 2015 there were 1,964 people on the SCL waiting list. Only 3% reported receiving no paid supports. Over half (58.8%) received services through the Michelle P Waiver.



SCL Slots	FY09	FY10	FY11	FY12	FY13	FY14	FY15
Total # Slots	3451	3501	3701	3901	4201	4501	4701
New Slots Funded	50	50	200	200	300	300	200

Michelle P, Home and Community Based, and Acquired Brain Injury Waivers

Acquired Brain Injury (ABI) Waivers as of June 30, 2015 (all over age 18)

ABI Rehab Waiver

Individuals meeting Level of Care without receiving services = 7
Individuals prior authorized for 'Blended Services' (traditional and participant directed) = 13
Individuals prior authorized for 'Traditional Services' = 152
Individuals prior authorized for participant directed services only = 15
Total = 185

ABI Long Term Care Waiver

Individuals meeting Level of Care without receiving services = 7
Individuals prior authorized for 'Blended Services' (traditional and participant directed) = 16
Individuals prior authorized for 'Traditional Services' = 159
Individuals prior authorized for participant directed services only = 40
Total = 222

Michelle P Waiver (MPW) Summary as of June 30, 2015

47.9% (4,747) are younger than 18 and 52.1% (5,161) are older than 18
Individuals meeting Level of Care without requesting services = 172
Individuals prior authorized for “Blended Services” (traditional and participant directed) = 2,432
Individuals prior authorized for “Traditional Services” = 2,560
Individuals prior authorized for participant directed services only = 4,745
Total = 9,909

Home and Community Based Waiver (HCB) Summary as of June 30, 2015

11.1% (1,059) are younger than 18 and 88.9% (8,467) are older than 18
Individuals meeting Level of Care without requesting services = 406
Individuals prior authorized for “Blended Services” (traditional and participant directed) = 199
Individuals prior authorized for “Traditional Services” = 5,792

Individuals prior authorized for participant directed services only = 3,129
Total = 9,526

Money Follows the Person (MFP)/Kentucky Transition

Kentucky no longer utilizes MFP for transitioning those with an intellectual disability. People with intellectual or other developmental disabilities residing in facilities who wish to move to the community apply directly to the SCL waiver program.

CLOSING THOUGHTS

It has been a privilege for the Kentucky Commission on Services and Supports for Individuals with Intellectual and Other Developmental Disabilities to serve in an advisory capacity to the Governor and the General Assembly regarding the needs of persons with Intellectual and Developmental Disabilities. Commission members extend their gratitude to the Governor and the General Assembly for their continued support. Along with the Department for Behavior Health, Developmental, and Intellectual Disabilities, we look forward to meeting our goals to improve the quality of supports for citizens of Kentucky.