Kentucky Cabinet for Health and Family Services
1915(c) Home- and Community-Based Services Appendix K Update Webinar
Frequently Asked Questions – Updated March 12, 2024

Overview:

During the COVID-19 Public Health Emergency (PHE), the Kentucky Department for Medicaid Services (DMS) made temporary changes to 1915(c) home- and community-based services (HCBS) waiver policy through an emergency amendment known as Appendix K.

The federal COVID-19 PHE officially ended on May 11, 2023. The Centers for Medicare and Medicaid Services (CMS) allowed states to keep Appendix K policies in effect for up to six months, or through November 11, 2023. To make some of the temporary Appendix K changes permanent, DMS submitted amended waiver applications to CMS the week of November 6, 2023. Per CMS guidance, any Appendix K policy not included permanently in the waiver application will be discontinued upon the approved waiver application's effective date. Provider operations and participant services should largely be back to pre-PHE levels. If a provider or participant is still operating under an Appendix K policy that is not becoming permanent, efforts should be made to return to the pre-PHE policy. Additional guidance is available in the Appendix K Transition and Guidance provider letter issued on December 21, 2023.

DMS requested an effective date of January 1, 2024, for Modell II and April 1, 2024, for all other 1915(c) HCBS waivers, however, **these dates are subject to change**. DMS is working with CMS to confirm exact effective dates and will notify stakeholders as soon as possible to allow adequate time for transition and implementation.

DMS held a public webinar on this topic on September 25, 2023. Questions from the webinar are included in this Frequently Asked Questions (FAQ) document. If you have a general Appendix K question that has not been answered in this document, please email DMS at MedicaidPublicComment@ky.gov. If you have a case-specific question, please contact the 1915(c) Waiver Help Desk at 1915cWaiverHelpDesk@ky.gov or (844) 784-5614.

Glossary of Acronyms:

Phrase	Acronym
Acute Brain Injury Waiver	ABI
Acute Brain Injury Long-Term Care Waiver	ABI LTC
Adult Day Health Center	ADHC
Adult Day Training	ADT
Applied Behavior Analysis	ABA
Centers for Medicare and Medicaid Services	CMS
Department for Aging and Independent Living	DAIL
Department for Behavioral Health, Developmental and Intellectual Disabilities	DBHDID
Direct Support Professionals	DSP
Home and Community Based Waiver	HCB
Home and Community Based Services	HCBS
Home-Delivered Meals	HDM
Kentucky Administrative Regulation	KAR
Kentucky Department for Medicaid Services	DMS
Legally Responsible Individual	LRI
Level of Care	LOC
Michelle P. Waiver	MPW

Model II Waiver	MIIW
Person Centered Service Plan	PCSP
Public Health Emergency	PHE
Supports for Community Living Waiver	SCL
Tuberculosis	TB

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Version	**Date**	**Additions/Modifications**	**Prepared, Revised, and/or Reviewed By**
1.0	01/30/2024	Initial Documents	DMS Division of Long-Term Services Staff, DAIL Division of Quality Living Staff, DBHDID Division of Developmental and Intellectual Disabilities Staff
1.2	01/31/2024	Corrected typo on limit for Home Delivered Meals and clarified CPR and First Aid requirements	DMS LTSS Staff
1.3	03/12/2024	Corrected typo on the question related to CPR and First Aid requirements	DMS LTSS Staff

Contents:

Section 1: General Questions

1. Where can I find more information about the Appendix K changes?

On September 25, 2023, DMS held a public webinar to describe the changes to all existing 1915(c) HCBS waivers. Stakeholders can review the Appendix K webinar recording and presentation from this webinar. A summary of Appendix K policies that were made permanent and other changes to amended waivers is available as well to help stakeholders quickly reference what is happening.

Sept. 25 Webinar Recording
https://www.youtube.com/watch?v=r_zoo0F9QzU

Sept. 25 Webinar Presentation
https://bit.ly/KYAppKSept25Webinar

Appendix K Policy Decisions at a Glance
https://bit.ly/KYAppKPolicyDecisions

2. Where can I go to get answers to individual questions?

Waiver / Topic	Agency	Contact Information
ABI, ABI LTC, or MIIW	DMS	(844) 784-5614 1915cWaiverHelpDesk@ky.gov
HCB or PDS	Department for Aging and Independent Living	(877) 315-0589, option 3 HCBInquiries@ky.gov
MPW or SCL	Department for Behavioral Health, Developmental and Intellectual Disabilities	Contact your Quality Administrator
Medicaid Waiver Management Application – Technical Assistance	DMS	(844) 784-5614, option 1 MedicaidPartnerPortal.Info@ky.gov

3. Which waivers are impacted by changes based on implementing Appendix K flexibilities?

All six (6) of Kentucky's 1915(c) Home and Community Based Services waivers are impacted in different ways:
Acquired Brain Injury (ABI)
Acquired Brain Injury Long Term Care (ABI LTC)
Home and Community Based (HCB)
Model II Waiver (MIIW)
Michelle P. Waiver (MPW)
Supports for Community Living (SCL)

Please refer to https://bit.ly/KYAppKPolicyDecisions to review the specific changes for each waiver.

4. Is there any additional guidance about waiver changes, written in plain language, to be posted for public use? Where can I find the most current guidance on this topic?

Please refer to https://bit.ly/KYAppKPolicyDecisions to review the specific changes for each waiver and next steps.

5. Are waiver program eligibility requirements changing?

No, DMS did not make changes to program eligibility as a part of Appendix-K related updates.

6. What is the timeline to implement Appendix-K related changes?

DMS submitted all six (6) waivers to CMS during the week of November 6, 2023. Per CMS guidance, all Appendix K flexibilities will remain in place after November 11, 2023, while the updated waivers are under federal review. Any flexibility not included in the updated waiver application permanently will be discontinued once a new effective date has been confirmed for the updated waivers. Only those Appendix K changes written directly into the waiver application will continue. DMS is working with CMS to determine a future effective date for each of the updated waivers. Provider operations and participant services should largely be back to pre-PHE levels. If a provider or participant is still operating under an Appendix K policy that is not becoming permanent, efforts should be made to return to the pre-PHE policy. Please review the Appendix K Transition and Guidance provider letter issued on December 21, 2023, for details.

7. When will the Appendix K flexibilities that are not being made permanent be transitioned out?

All Appendix K flexibilities will remain in place until the effective dates of the updated waiver applications. The flexibilities that are not included in the updated waiver application permanently will be discontinued once a new effective date has been confirmed for the waivers. DMS is working with CMS to determine a future effective date for each of the updated waivers. Provider operations and participant services should largely be back to pre-PHE levels. If a provider or participant is still operating under an Appendix K policy that is not becoming permanent, efforts should be made to return to the pre-PHE policy. Please review the Appendix K Transition and Guidance provider letter issued on December 21, 2023, for details.
https://www.chfs.ky.gov/agencies/dms/ProviderLetters/AppendixKFollowUpLetter.pdf

8. When should providers return to pre-PHE policies for Appendix K flexibilities that are not being made permanent.

While providers can continue to make use of Appendix K flexibilities as appropriate, provider operations and participant services should largely be back to pre-PHE levels. If a provider or participant is still operating under an Appendix K policy that is not becoming permanent, efforts should be made to return to the pre-PHE policy. Additional guidance is available at [link]. you should begin transitioning away from policies that will end once the amended waivers become effective.

In the waiver applications submitted to CMS the week of November 6, 2023, DMS proposed the following effective dates for the waiver applications:

Model II Waiver (MIIW)	January 1, 2024
Acquired Brain Injury (ABI) Acquired Brain Injury Long Term Care (ABI LTC) Home and Community Based (HCB) Michelle P. Waiver (MPW) Supports for Community Living (SCL)	April 1, 2024

DMS continues to work with CMS to confirm effective dates for each waiver. Please note **these dates are subject to change**. If these dates change, they will not be any earlier than those listed above.

Section 2: Rates and Billing

9. What rates can we bill going forward for which services? Which services qualify for the 85% pass-through?

All existing rate increases will continue after Appendix K expires and be made permanent in the amended waivers. Providers can continue billing these rates until any future waiver amendments that impact rates become effective.

Existing rate increases include:

- 50% rate increases for the following residential services:
- Supervised Residential Care, Levels I, II, and III (ABI and ABI-LTC only)
- Residential Support, Level I (SCL only)
- 50% rate increases for the following non-residential services when providers attest to pass through 85% of the rate to direct care workers:
- Attendant Care
- Case Management (HCB and MPW only)
- Community Access
- Community Guide
- Community Living Supports
- Community Transition
- Companion
- Homemaker
- Non-Specialized Respite
- Participant Directed Services (PDS) Coordinator
- Personal Assistance
- Personal Care
- Respite
- Skilled Services by a Licensed Practical Nurse
- Skilled Services by a Registered Nurse
- Specialized Respite

21% rate increases (10% increase applied twice) for all other services, excluding those in the MIIW.

Providers delivering non-residential service that are eligible for the 50% increase can choose to bill either the 50% or the 21%. These rate increases cannot be combined.
For a comprehensive list of rates by service, please refer to the “Home and Community Based Services Waiver Rates 2023-2024” document on the DMS Fee and Rate Schedule website at https://www.chfs.ky.gov/agencies/dms/Pages/feesrates.aspx.

10. Can DMS provide additional information about how to bill for services in the hospital setting?

Provision of HCBS in an acute hospital setting must be prior authorized and billed within the timeframe the participant is hospitalized. Providers cannot submit claims for payment retroactively. If a provider believes a participant meets the criteria below, contact the 1915(c) Waiver Help Desk at (844) 784-5614 or 1915cWaiverHelpDesk@ky.gov for further assistance.

The policy states:

"The state will allow waiver providers to deliver adhoc HCBS in acute care hospitals under extraordinary circumstances and the following conditions:
The HCBS must be prior authorized by the Department or its designee;
The HCBS may be provided in extraordinary, adhoc circumstances to meet needs of the individual that are not met through the provision of acute care hospital services and are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide. This may include supervision for extreme behaviors, repeated or continued attempts to commit serious self-harm or elopement, or when a participant is non-verbal and unable to use a communication device; and
The HCBS must be identified in the individual's person-centered service plan (PCSP).

This policy is not intended for continuing the participant's full person-centered service plan while they are hospitalized. The only waiver services delivered in hospital settings should be those required to address any emergent, non-medical needs and risks and there is not a family member or natural support available to assist. While the participant is hospitalized, the focus should be on addressing the condition that led to the hospitalization rather than addressing goals and objectives."

If a provider feels a participant's hospitalization meets the above criteria, please contact the 1915(c) Waiver Help Desk at (844) 784-5614 or 1915cWaiverHelpDesk@ky.gov.

11. If a certified Family Home Provider is supplying Respite services for an individual from another Family Home Provider, are those wages taxable?

Providers offering Respite services must qualify as certified waiver providers as described in the waiver application and the KAR. DMS recommends that questions about taxes for this service be directed to the accounting or payroll staff at the Family Health Provider agency.

Section 3: Participant Directed Services (PDS)

12. What do you mean by legally responsible individuals (LRIs)? Will the definition be changing as part of this update?

Per the CMS Instructions, Technical Guide, and Review Criteria for 1915(c) Home and Community-Based Waivers, an LRI typically refers to the parent or guardian of a minor child, a spouse, or any individual as defined in state law.

In the amended waiver applications submitted to CMS in November 2023, DMS clarified the definition of an LRI. An LRI is defined as:

a) the parent, stepparent, adoptive parent, or a court-appointed legal guardian of a minor child (younger than 18);
b) the court-appointed legal guardian of an adult (older than 18); or
c) the spouse of a waiver participant.

13. Are family members, including LRIs, still allowed to be hired as paid caregivers under PDS?

Yes. Family members and LRIs are allowed to be hired as paid caregivers for PDS. If an LRI was hired as a PDS employee under Appendix K, they will need to undergo a review process, Reviews will take place at the time of the participant's annual re-certification after the updated waivers have taken effect. LRIs will be allowed to keep working while undergoing the review process. Any individual hired as a PDS employee who is not also an LRI will not require review. DMS will communicate additional details on the LRI policy via written and video information soon.

14. What are the limits and requirements for a parent to become an employee for their child?

Parents of minor children (younger than 18) or parents of an adult child (older than 18) for whom they are also the court-appointed legal guardian are considered a legally responsible individual (LRI) for the participant. In the amended waiver applications submitted to CMS in November 2023, DMS clarified the definition of an LRI. An LRI is defined as:

a) the parent, stepparent, adoptive parent, or a court-appointed legal guardian of a minor child (younger than 18);
b) the court-appointed legal guardian of an adult (older than 18); or
c) the spouse of a waiver participant.

We understand how valuable it is to allow LRIs to be hired as PDS employees for their children and we will continue to allow this practice. Federal guidelines require us to put certain safeguards in place when allowing LRIs to be hired as PDS employees. Per CMS, LRIs can only be paid for services deemed "extraordinary care" and cannot be paid for supports they are ordinarily obligated to provide. The CMS definition of extraordinary care is "care exceeding the range of activities that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization." This means an LRI must provide additional care for their loved one, based solely on their disability. In this case, "extraordinary care" is not related to the quality of care delivered but the tasks not ordinarily performed to care for an individual.

If an LRI was hired as a PDS employee under Appendix K, the review process will take place at the time of the participant's annual re-certification after the updated waivers have taken effect. LRIs will be allowed to keep working while undergoing the review process. Any individual hired as a PDS employee who is not also an LRI will not require review.
DMS is working with CMS to determine a future effective date for each of the updated waivers and will allow adequate time for transition and implementation. DMS will communicate additional details on the LRI policy via written and video information soon.

15. What is an LRI review?

When requesting an LRI as an employee, the participant and/or the participant's PDS representative should complete the PDS Request for Legally Responsible Individual as Paid Service Provider form. The case manager will upload the form to the Medicaid Waiver Management Application and contact the Department for Aging and Independent Living (DAIL). DAIL staff will review these requests to determine if the request adheres to allowable criteria. Each question on the form should be answered with as much specific detail as possible. The PDS Request for Legally Responsible Individual as Paid Service Provider form will be released before the effective date of the updated waiver applications.

16. If an LRI did not have to go through the review process to be a PDS employee, will they need to go through the review process now?

Individuals will need to undergo the review process if:

- They are an LRI; and
- They have never undergone the review process either before or during the COVID-19 federal public health emergency.

Relatives or family members who do not meet the definition of an LRI will not be required to undergo review.

The LRI review process will take place at the time of the participant's annual re-certification after the updated waivers have taken effect. DMS is working with CMS to determine a future effective date for each of the updated waivers and will allow adequate time for transition and implementation. DMS will communicate additional details on the LRI policy via written and video information soon. You will be able to continue working as the participant's PDS employee until and during the review process.

17. Are PDS participants eligible for rate increases? How should they go about raising rates for their employees?

Yes, services delivered PDS are included in the 21% legislature-directed rate increase. Participants and/or PDS representatives can request pay increases for their employees, as long as pay does not exceed the maximum allowable rates listed in the "Home and Community Based Services Waiver Rates 2023-2024" document on the DMS Fee and Rate Schedule website at https://www.chfs.ky.gov/agencies/dms/Pages/feesrates.aspx.
If the participant and/or PDS representative is interested in increasing a PDS employee's pay, they should contact the participant's case manager to begin the process. Guidance regarding PDS and rate increases is available using the links below.
Appendix K Transition and Guidance Letter:
https://www.chfs.ky.gov/agencies/dms/ProviderLetters/AppendixKFollowUpLetter.pdf
PDS and Rate Increase Frequently Asked Questions:
https://www.chfs.ky.gov/agencies/dms/dca/waivers/PDSRateIncreaseFAQ.pdf

18. Is DMS considering allowing PDS Case Management to have an option for telehealth similar to traditional Case Management?

DMS recognizes the value of telehealth for participants and will continue to allow case management and PDS case management to be provided in person or via telehealth. The following language was added to the definition of Case Management and PDS Case Management in the amended waiver applications submitted to CMS in November 2023:

"This service may be provided in person or virtually via telehealth. Telehealth services may be provided under specific circumstances as described in regulation. In person services must be provided whenever possible and at minimum at least every other month. Participation in services via telehealth should be wanted by the participant, person-centered, meaningful and advance established goals. Participants who are offered telehealth by the provider have the right to request in-person services instead."
All telehealth visits must use a Health Information Portability and Accountability Act (HIPAA) platform.

19. What background checks are required for PDS employees?

All employees are required to undergo a background investigation at hiring and repeated as appropriate. Kentucky offers employers two options for conducting pre-employment background investigations.

a) The Kentucky Applicant Registry and Employment Screening (KARES) system: KARES is an electronic interface and nationwide background investigation and registry system. KARES enables automatic abuse registry checks, including continuous assessment (i.e. ongoing registry checks after employment date), as well as fingerprint-based background checks through Kentucky State Police (KSP) and the Federal Bureau of Investigation (FBI).
b) If KARES is not used, pre-employment background investigations must be conducted using all four (4) of the following:
    1. Administrative Office of the Courts (AOC) Background Check operated by Kentucky Court of Justice and an equivalent out-of-State agency if the individual resided or worked outside of Kentucky during the twelve (12) months prior to employment.
    2. Kentucky Child Abuse and Neglect (CAN) Registry operated by the Cabinet for Health and Family Services and an equivalent out-of-State agency if the individual resided or worked outside of Kentucky during the twelve (12) months prior to employment.
    3. Caregiver Misconduct Registry operated by the Cabinet for Health and Family Services.
    4. Nurse Aide Abuse Registry operated by the Kentucky Board of Nursing.

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

c) All PDS employees are required to pass a six-panel drug screening prior to employment.
d) All PDS employees must also undergo a risk assessment for tuberculosis per Department of Public Health guidelines found in 902 KAR 20:205. A TB risk assessment varies from a TB test in that it only requires the individual to answer a series of questions. The answers will help determine if the individual has a risk of TB and should receive a test.

Section 4: Case Management

20. When can traditional case management agencies begin providing PDS case management? What steps do traditional agencies need to take?

Traditional case management agencies can begin providing PDS case management at any time. Traditional case management agencies must be certified to provide PDS case management through DAIL. Training on becoming a PDS case management provider is available at https://www.chfs.ky.gov/agencies/dail/Documents/Traditional-PDS%20CM%20Training%20Slides%20&%20Notes.pdf and https://drive.google.com/file/d/1IdkNzslyWHG0GAmR8fcfI9KRc2UWpWUa/view.

Section 5: Level of Care (LOC) Assessment

21. When will Carewise Health take over level of care and plan of care reviews?

Carewise Health took over waiver LOC reviews and POC reviews on November 13, 2023.

22. How can DMS help improve the waiting period for LOC assessments?

DMS, along with DAIL and DBHDID, is working diligently to process LOC assessments in a timely fashion and eliminate any existing delays.

23 Is it possible to rectify the issue that DSP providers (with the exception of case managers) lack access to LOC letters, PA's, and other important documents on MWMA?

DSPs can access MWMA and view all documents associated with the participant they care for during the timeframe where the agency is prior authorized as the participant's servicing provider. Guides about onboarding DSPs and how to use MWMA are available in TRIS: https://tris.eku.edu/MWMA/documents.aspx.

Section 6: Service Limits

24. Can DMS provide more information about how service limits are impacted?

Providers can continue to bill the increased service limits until the effective date of the modified waivers. After the effective date of the modified waivers, service limits with minor exceptions will return to pre-Appendix K limits.

25. Can DMS clarify how the $40,000/$63,000 per year limit in MPW works with recent rate increases?

The $40,000/$63,000 service cap (excluding Respite) is no longer in place to avoid an unintentional reduction in needed services for participants.
The following services, alone or in combination, shall be limited to forty (40) hours per calendar week: Homemaker, Personal Care, Attendant Care, Supported Employment, Adult Day Health Care, Adult Day Training, Community Living Supports, Physical, Occupational, and Speech Therapy, and Behavior Supports.

A parent, parents combined, or a spouse shall not provide more than forty (40) hours of services per calendar week (Sunday to Saturday) regardless of how many children receive waiver services.

26. Can you clarify the 45-hour per week / $200 per day limit for Attendant Care in HCB? Are there any exceptions to this rule and this limit?

DMS initially issued guidance on September 25, 2023, notifying providers that a participant can only receive up to 45 hours of Attendant Care per week alone or in combination with Adult Day Health Care (ADHC). Based on stakeholder feedback during formal public comment on the 1915(c) HCBS waivers held from September 27 – October 27, 2023, DMS re-evaluated the limit and issued new guidance. **The limit information contained in the Appendix K Transition and Guidance letter supersedes the letter issued on September 25, 2023**. Please review the Appendix K Transition and Guidance letter for more information: https://www.chfs.ky.gov/agencies/dms/ProviderLetters/AppendixKFollowUpLetter.pdf.

Section 7: COVID-19

27. Why is DMS removing the requirement to report cases of COVID-19?

DMS is discontinuing the requirement to submit an incident report for positive COVID-19 cases, as the virus is no longer considered a public health emergency per the U.S. Department for Health and Human Services. Incident reports should still be filed for cases of COVID-19 that fall under the reporting requirements outlined in the Incident Reporting Instructional Guide for 1915(c) HCBS Waiver Services, found at the following link: https://www.chfs.ky.gov/agencies/dms/dca/Documents/irinstructionalguide.pdf.

Section 8: Telehealth

28. Can you provide more information about which services allow telehealth as a component and how frequently telehealth may be offered?

Following the effective date of each waiver, the providers can deliver the following services in-person or via telehealth:

- Behavioral Services,
- Case Management,
- Consultative Clinical and Therapeutic Services,
- Individual and Group Counseling,
- Occupational Therapy,
- Physical Therapy, and
- Speech Therapy.

As noted in each modified waiver, providers may deliver services via telehealth under specific circumstances to be described in updated regulations.[1] In-person services must be provided whenever possible and at a minimum at least every other month. Participation in services via telehealth should be wanted by the participant, person-centered, meaningful, and advance established goals. Participants who are offered telehealth by the provider have the right to request in-person services instead. Telehealth services must be providing using a HIPAA-compliant platform.

A list of telehealth services by waiver is included in the Appendix K Policy Decisions at a Glance document available at https://bit.ly/KYAppKPolicyDecisions.

29. Can team meetings be held virtually or must it be attended in-person?

The participant should be given the choice of whether the team meeting is held in-person or virtually and the chosen method should allow for active participation and engagement by the participant and all members of the person-centered planning team.

30. Can Assessments and Reassessments be conducted through telehealth?

DMS is requesting assessments and reassessments be conducted in-person, however, remote options are allowable until the effective date of the proposed waiver updates. Once the updated waivers take effect, providers must return to in-person assessments and reassessments. Please review the COVID-19 and Assessments Letter at https://www.chfs.ky.gov/agencies/dms/ProviderLetters/COVID19AssessmentUpdate.pdf for additional guidance.

[1] Note: DMS intends to modify existing waiver regulation to include these specific circumstances upon CMS' approval of each waiver.

31. After Appendix K is over, will virtual Adult Day Training (ADT) be available for certain individuals?

Virtual ADT is allowable until the effective date of the proposed waiver updates. Once the updated waivers take effect, virtual ADT will be discontinued.

Section 9: Waiver- and Service-Specific Questions

32. What are the requirements for CPR/First Aid training and TB risk assessments?

During the federal COVID-19 public health emergency, DMS allowed employees to begin working while undergoing these training and screenings. After the effective date of each modified waiver:

- Traditional agency employees must complete CPR and First Aid training before they begin working.
- For PDS employees, CPR and First Aid training will be optional at the discretion of the participant. PDS are only required to complete CPR and First Aid training if the participant requires it.
- TB risk assessments are still required for both Traditional and PDS employees per Department for Public Health regulation 907 KAR 20:205.

33. Would DMS consider a Case Management rate specifically for Adult Day Health Center (ADHC) nurses?

DMS is currently finalizing a rate study in which all rates will reflect costs associated with the team of providers required to provide the service. This will help reinforce rate adequacy for each service.

To align with CMS requirements regarding rate parity and the ability to retain a sufficient number of providers, DMS' objective is to align payment rates for like services across waiver programs. The development of one rate for a specific Case Management provider type would not align with CMS guidance on rate parity.

34. Can DMS provide additional information about yearly budgets for HCB?

The 1915(c) HCBS waivers, including HCB, do not have yearly budgets for each participant. Participants should receive services based on their person-centered service plan and needs assessments.

35. How will Home-Delivered Meals (HDMs) be impacted after Appendix K?

DMS made adjustments to the definition, provider qualifications, and limits for Home Delivered Meals in the amended HCB waiver application submitted to CMS in November 2023.

After the effective date of the HCB waiver, hot, shelf-stable, chilled, or frozen meals will be allowed when providing HDMs. Providers of HDMs may include a food establishment or a food

processing establishment. Participants will be able to receive two meals per day, up to ten meals per week. Participants in the HCB Waiver cannot receive HDMs while they are at ADHC, however, they can receive one meal during the timeframe when they are not at ADHC.

36. What are the requirements and service limits for Respite for individuals enrolled in SCL Residential Level II services?

Respite for individuals enrolled in Residential Level II services in SCL will operate the same as Respite for other SCL waiver participants. Providers must be certified waiver providers. Respite may not exceed 830 hours per each authorized person-centered service plan period. For additional information about current respite services, please refer to the SCL KAR.

37. What locations are approved for case management visits for individuals enrolled in Medicaid waivers?

The requirements for the approved monthly case management visit vary by waiver and are as follows:

- ABI
  - The case manager/support broker must conduct two face-to-face meetings per calendar month. Face-to-face meetings must occur at a covered service site.
  - One visit per quarter must take place at the participant's residence, except for participants receiving Supervised Residential services. If a participant receives Supervised Residential Levels I, II, or III, one of the two monthly visits must occur at the residential site.
- ABI LTC
  - The case manager/support broker must conduct one face-to-face meeting per calendar month. Face-to-face meetings must occur at a covered service site.
  - One visit per quarter must take place at the participant's residence.
- HCB
  - For participants receiving traditional services only, the case manager must contact the participant monthly by telephone or through a face-to-face visit. At a minimum, the case manager must meet with the participant face-to-face at least every other month at either the participant's ADHC or residence and at least three meetings per calendar year must take place at the participant's residence.
  - For participants receiving PDS or blended services, the service advisor must conduct one face-to-face visit with the participant at least monthly and at the participant's residence at least once every three (3) months.
- MPW
  - The case manager/support broker must conduct one face-to-face visit per month at the participant's residence, ADHC, or day training site.
- SCL
  - The case manager must conduct one visit per month at a location where the participant is engaged in services.

38. Are guardians required to be present for every home visit with participants?

Guardians should be present for every home visit for participants who are under the age of 18. Guardians are not required to be present for every home visit for participants age 18 or older but would need to be available to communicate with a case manager to confirm any person-centered service planning changes or decision-making within their purview. Guardians are

encouraged to co-attend home visits as the party with legal decision-making authority on behalf of participants.

39. Are individuals providing direct services to waiver participants considered Direct Support Professionals (DSPs)? Does this include legally responsible individuals?

Yes, all staff who are paid to provide direct care to waiver participants are considered DSPs. Legally responsible individuals would be considered DSPs if they provide services to a participant via PDS.

40. Are there any proposed changes to therapy services provided under the ABI and ABI-LTC waivers?

The changes communicated in the ABI Waiver Renewal Information Letter released in 2022 remain in both the ABI and ABI LTC waiver applications submitted to CMS on November 11, 2023.

41. What Goods and Services are allowed under HCB? Can you please give a few examples?

According to the modified HCB waiver, goods and services shall:

- Be services, equipment, or supplies that are individualized to a participant who chooses to use participant-directed services;
- Be utilized to reduce the need for personal care or to enhance independence within a participant's home or community;
- Not be a good or service available to a recipient outside of the waiver program;
- Meet the following requirements:
    - The good or service shall decrease the need for other Medicaid services;
    - The food or service shall promote participant inclusion in the community;
    - The good or service shall increase a participant's safety in the home environment; and
    - The participant shall not have the funds to purchase the good or service;
- If participant directed and purchased from a participant-directed budget, be prior authorized;
- Not include experimental or prohibited treatments;
- Not include chemical or physical restraints;
- Be clearly linked to a participant need that is documented in the participant's person-centered service plan to ensure the health, welfare, and safety of the participant;
- Be individualized;
- Be coordinated and documented in the MWMA by a Case Manager by:
    - Description or itemized line item of purchase and cost;
    - Receipts for procurements that include the date of purchase;
    - The signature and title of the Case Manager; and
    - The date the entry was made in the record; and
- Not exceed the upper payment limit as identified on the 1915(c) HCBS Rate Schedule per one (1) year authorized person-centered service plan period.

Goods and services may not include equipment and supplies covered under the Kentucky Medicaid program's state plan, including:

- Durable Medical Equipment;

- Early and Periodic Screening, Diagnosis, and Treatment Services;
- Orthotics and prosthetics; or
- Hearing services.