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State/Territory Name: **Kentucky**

State Plan Amendment (SPA) #: **24-0010**

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

Medicaid and CHIP Operations Group

March 27, 2025

Leslie Hoffmann, Deputy Commissioner
Department for Medicaid Services
Kentucky Cabinet for Health and Family Services
275 E. Main Street 6W-A
Frankfort, Kentucky 40621

RE: Kentucky State Plan Amendment (SPA) KY 24-0010 New §1915(i) State Plan Benefit

Dear Ms. Hoffmann:

The Centers for Medicare & Medicaid Services (CMS) is approving the state's request to amend its state plan to add a new 1915(i) home and community-based services (HCBS) benefit, transmittal number KY 24-0010. The effective date for this 1915(i) benefit is July 1, 2025. Enclosed is a copy of the approved state plan amendment (SPA).

Since the state has elected to target the population who can receive these §1915(i) State Plan HCBS, CMS approves this SPA for a five-year period expiring June 30, 2030, in accordance with §1915(i)(7) of the Social Security Act. To renew the §1915(i) State Plan HCBS benefit for an additional five-year period, the state must submit a renewal application to CMS at least 180 days prior to the end of the approval period. CMS' approval of a renewal request is contingent upon state adherence to federal requirements and the state meeting its objectives with respect to quality improvement and beneficiary outcomes.

Per 42 CFR §441.745(a)(i), the state will annually provide CMS with the projected number of individuals to be enrolled in the benefit and the actual number of unduplicated individuals enrolled in the §1915(i) State Plan HCBS in the previous year. Additionally, at least 21 months prior to the end of the five-year approval period, the state must submit evidence of the state's quality monitoring in accordance with the Quality Improvement Strategy in their approved SPA. The evidence must include data analysis, findings, remediation, and describe any system improvement for each of the §1915(i) requirements.

It is important to note that CMS' approval of this new 1915(i) HCBS state plan benefit solely addresses the state's compliance with the applicable Medicaid authorities. CMS' approval does not address the state's independent and separate obligations under federal laws including, but not limited to, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, or the

Supreme Court's Olmstead decision. Guidance from the Department of Justice concerning compliance with the Americans with Disabilities Act and the Olmstead decision is available at http://www.ada.gov/olmstead/q&a_olmstead.htm.

If you have any questions concerning this information, please contact me at (410) 786-7561. You may also contact Alice Hogan at alice.hogan@cms.hhs.gov.

Sincerely,

[redacted]

George P. Failla, Jr., Director
Division of HCBS Operations and Oversight

Enclosure

cc:
Jessica Loehr
Ysabel Gavino
Shante Shaw

DEPARTMENT OF HEALTH ANDHUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 24 — 0010

2. STATE: KY

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2025

5. FEDERAL STATUTE/REGULATION CITATION
~~1915(i)(1)(D) of the Social Security Act~~ Section 1915(i) of the Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2025 $ 54,788,893
b. FFY 2026 $ 109,557,785

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
~~Please see the completed and uploaded 1915(i) State Plan Home and Community Based Services Administration and Operation Application~~
Attachment 3.1-i, Pgs 1-70 (new); Att. 4.19-B Pgs 1-3 (new)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

9. SUBJECT OF AMENDMENT
To offer HCBS to eligible individuals with severe mental illness and/or substance use disorder who require community support ~~but do not yet meet institutional level of care~~

10. GOVERNOR'S REVIEW *(Check One)*
( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(●) OTHER, AS SPECIFIED:

[redacted]NCY OFFICIAL

12. TYPED NAME
Lisa Lee

13. TITLE
Commissioner

14. DATE SUBMITTED
4/30/2024

15. RETURN TO
Lisa Lee
275 E. Main Street, 6W-B
Frankfort, KY 40621

FOR CMS USE ONLY

16. DATE RECEIVED
4/30/2024

17. DATE APPROVED
March 27, 2025

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
7/1/2025

19. SIGNATURE OF APPROVI [redacted]

20. TYPED NAME OF APPROVING OFFICIAL
George P. Failla, Jr.

21. TITLE OF APPROVING OFFICIAL
Director, Division of HCBS Operations and Oversight (DHCBSO)

22. REMARKS

P&I Changes authorized by the state on March 13 and March 27, 2025.

Instructions on Back

1915(i) State plan Home and Community-Based Services

Administration and Operation

The state implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit *for elderly and disabled individuals as set forth below.*

1. Services. *(Specify the state's service title(s) for the HCBS defined under "Services" and listed in Attachment 4.19-B):*

1. Assistive Technology	6. Supervised Residential Care
2. Case Management	7. Supported Education
3. In-Home Independent Living Supports	8. Supported Employment
4. Medication Management	9. Tenancy Supports
5. Planned Respite for Caregivers	10. Non-Medical Transportation

2. Concurrent Operation with Other Programs. *(Indicate whether this benefit will operate concurrently with another Medicaid authority)* ***Select one*:**

◉	**Not applicable**
○	**Applicable**
Check the applicable authority or authorities:	
☐	**Services furnished under the provisions of §1915(a)(1)(a) of the Act.** The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. *Specify:* *(a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1);* *(b) the geographic areas served by these plans;* *(c) the specific 1915(i) State plan HCBS furnished by these plans;* *(d) how payments are made to the health plans; and* *(e) whether the 1915(a) contract has been submitted or previously approved.*
☐	**Waiver(s) authorized under §1915(b) of the Act.** *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*
Specify the §1915(b) authorities under which this program operates (*check each that applies*):	
☐ §1915(b)(1) (mandated enrollment to managed care)	☐ §1915(b)(3) (employ cost savings to furnish additional services)
☐ §1915(b)(2) (central broker)	☐ §1915(b)(4) (selective contracting/limit number of providers)
☐	**A program operated under §1932(a) of the Act.** *Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:*
☐	**A program authorized under §1115 of the Act.** *Specify the program*:

3. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS. Benefit- *(Select one):*

○	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:
○	The Medical Assistance Unit *(name of unit)*:
○	Another division/unit within the SMA that is separate from the Medical Assistance Unit
	(name of division/unit) *This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.*
◉	The State plan HCBS benefit is operated by *(name of agency)* The Department for Behavioral Health, Developmental and Intellectual Disabilities a separate agency of the state that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.

4. Distribution of State plan HCBS Operational and Administrative Functions.

☑ *(By checking this box the state assures that):* When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

Check all agencies and/or entities that perform each function):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	●	●		
2 Eligibility evaluation	●	●		
3 Review of participant service plans	●	●		
4 Prior authorization of State plan HCBS	●	●		
5 Utilization management	●	●		
6 Qualified provider enrollment	●	●		
7 Execution of Medicaid provider agreement	●	●		
8 Establishment of a consistent rate methodology for each State plan HCBS	●	●		
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	●	●		
10Quality assurance and quality improvement activities	●	●		

Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

For the purposes of the table above, “Medicaid Agency” is the Department for Medicaid Services and “Other State Operating Agency” is the Department for Behavioral Health, Developmental and Intellectual Disabilities.

(By checking the following boxes the State assures that):

5. ☑ **Conflict of Interest Standards.** The state assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:

- related by blood or marriage to the individual, or any paid caregiver of the individual
- financially responsible for the individual
- empowered to make financial or health-related decisions on behalf of the individual
- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *(If the state chooses this option, specify the conflict of interest protections the state will implement):*

The state requires the following:

- The Kentucky Department for Medicaid Services (DMS) or its designee, the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) will ensure, on an individual basis, that participants who choose a case manager who could be conflicted will be free from undue influence when selecting a service provider.
    - DMS will supervise its designee, DBHDID, through a contractual agreement, outlining roles, responsibilities, and oversight.
- The case manager will need to upload a department or its designee-approved form requesting an exemption.
- The form includes the following information:

    - Documentation, including denials, showing that there are no willing case managers within thirty (30) miles of the participant's home.
    - Documentation of conflict-of-interest protections.
    - An explanation of how case manager functions are separated within the same entity.
    - Demonstration of the availability of a clear and accessible dispute resolution process that advocates for participants within a service or case management entity.

The DMS or its designee will review the request for a conflict-free exemption. Reviewers will use the Department or its designee -approved process to verify there are no willing case managers within thirty (30) miles of the participant's residence.

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

The following safeguards are instituted to assure participant's choice:

- Full disclosure to participants and assurance that participants are supported in exercising their right of free choice of providers and provided information on full range of waiver services and not just the services furnished by the entity that is the responsible for the development of the PCSP.
- Direct oversight of the process for periodic evaluation by the state agency.
- Requiring the agency that develops the PCSP to administratively separate the plan development function from the direct service provider functions. The same staff may not provide both case management and direct service care.
- An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that participant's provider to develop the PCSP through a clear and accessible alternative dispute resolution process.

6. ☑ Fair Hearings and Appeals. The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

7. ☑ **No FFP for Room and Board.** The state has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

8. ☑ **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. For habilitation services, the state includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. **Projected Number of Unduplicated Individuals To Be Served Annually.**
(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	07/01/2025	06/30/2026	5,000
Year 2			
Year 3			
Year 4			
Year 5			

2. ☑ **Annual Reporting.** *(By checking this box the state agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

Financial Eligibility

1. ☑ **Medicaid Eligible.** *(By checking this box the state assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act. States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.)

2. **Medically Needy** (*Select one*):

☐ The State does not provide State plan HCBS to the medically needy.
☑ The State provides State plan HCBS to the medically needy. (*Select one*):
☐ The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy since this election receive only 1915(i) services. ☑ The state does not elect to disregard the requirements at section 1902(a) (10)(C)(i)(III) of the Social Security Act.

Evaluation/Reevaluation of Eligibility

1. **Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*Select one*):

○	Directly by the Medicaid agency
●	By Other: Department for Behavioral Health, Development and Intellectual Disabilities

2. **Qualifications of Individuals Performing Evaluation/Reevaluation.** The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

The individual performing the evaluation/reevaluation of 1915(i) Recovery, Independence, Support & Engagement (RISE) Initiative eligibility is a contracted employee of the Department of Behavioral Health, Development and Intellectual Disabilities and must have:

- Master's degree in behavioral health/human services field with a minimum of one year's experience assessing individual's needs for services. OR
- Bachelor's degree in Behavioral Science and 5 years' experience providing service coordination or linking referrals for community-based services.

3. **Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

The evaluation/reevaluation process as performed by the contracted entity; University of Kentucky Human Development Institute is outlined below.

Kentucky has identified the InterRAI Community Mental Health (CMH) functional assessment instrument for individuals with a primary diagnosis of Serious Mental Illness (SMI) or co-occurring SMI and Substance Use Disorders (SUD) as the needs-based eligibility evaluation tool.

The Independent Assessor will conduct an in-person, face-to-face assessment for each referred individual, utilizing the InterRAI CMH functional assessment instrument. This functional assessment instrument will be utilized to determine eligibility for 1915(i) RISE Initiative services in additional to their specific support needs.

This instrument is utilized for initial and redetermination of 1915(i) RISE Initiative eligibility.

The contracted entity assesses a 1915(i) RISE Initiative applicant's need, based on the needs-based eligibility criteria outlined below. The State Medicaid Agency uses this information to determine if the participant meets the needs-based eligibility criteria required to receive 1915(i) RISE Initiative services. Individuals administering the InterRAI CMH are independent and meet qualifications determined by the State Medicaid Agency.

The initial evaluation may begin outside of the participant's residence but will be completed by the Independent

Assessor within the participant's residence. Once the assessment is completed by the Independent Assessor, it is reviewed by the State Medicaid Agency or its designee, the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities. If the assessment meets the needs-based eligibility criteria, then the State Medicaid Agency notifies the participant that their application has been approved.

The Independent Assessor will conduct a re-evaluation at least annually, or more frequently if the participant experiences a significant change in condition. The following circumstances are examples that could merit completion of a functional assessment outside of the annual assessment cycle:

a. Inpatient admission to an institutional care setting with changes at discharge in functional ability from previous assessment including:

   i. Decreased functional ability in one or more activities of daily living, or

   ii. Decreased functional ability in three (3) or more instrumental activities of daily living.

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

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

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

The re-evaluation process is the same as the initial evaluation process and the individual must meet the same eligibility criteria as those initially admitted to the 1915(i) RISE Initiative.

Services may not begin, nor will payment be rendered, until such time as the participant has met all eligibility requirements.

4. ☑ **Reevaluation Schedule.** *(By checking this box the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.

5. ☑ **Needs-based HCBS Eligibility Criteria.** *(By checking this box the state assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

The individual must demonstrate clear evidence of functional impairment as demonstrated by the individual needing assistance in two or more of the following: Societal/Role Functioning, Interpersonal Functioning, Daily Living/Personal Care Functioning, Physical Functioning and/or Cognitive/Intellectual Functioning as evidenced by criteria established within the InterRAI Community Mental Health assessment tool.

6. ☑ **Needs-based Institutional and Waiver Criteria.** *(By checking this box the state assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

State plan HCBS needs-based eligibility criteria	NF (& NF LOC** waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* (& Hospital LOC waivers)
The following scoring parameters indicate that the minimum threshold for needs-based criteria is less stringent than institutional LOC: Clear evidence of functional impairment as demonstrated by the individual needing assistance and support in two or more of the following: Societal/Role Functioning, Interpersonal Functioning, Daily Living/Personal Care Functioning, Physical Functioning and/or Cognitive/Intellectual Functioning as evidenced by criteria established with the InterRAI Community Mental Health assessment tool.	(KAR 907 1 022) Patient Status Criteria. A patient status decision shall be based on medical diagnosis, care needs, services and health personnel required to meet these needs, and the feasibility of meeting the needs through alternative institutional or noninstitutionalized services. For an admission and continued stay, an individual shall qualify under the preadmission screening and resident review criteria specified in 42 U.S.C. 1396r and 907 KAR 1:755. An individual shall be considered to meet the level of care criteria for high-intensity nursing care if: a. On a daily basis the individual's needs mandate: i. High-intensity nursing care services; or ii. High-intensity rehabilitation services.	An individual shall be considered to meet the level of care criteria for ICF-IID if the individual meets criteria for a diagnosis of an intellectual disability as defined by the current Diagnostic and Statistical Manual of Mental Diseases (DSM) with onset of condition prior to age eighteen (18) or meets criteria for a person with a related condition as defined by 42 C.F.R. 435.1010 with onset of condition prior to age twenty-two (22) and meets the following criteria: a. Requires physical or environmental management or habilitation; b. Requires a planned program of active treatment; c. Requires a protected environment; and d. Unrelated to age-appropriate dependencies with respect to a minor, has substantial deficits in adaptive functioning that, without ongoing support, limit functioning in one or more activities of daily life such as: communication, social participation, and independent living across multiple environments, such as	An individual shall be considered to meet the level of care criteria for inpatient hospital admission based upon the following: 1. Patient risk or severity of behavioral health disorder is appropriate to proposed level of care, as indicated by 1 or more of the following: a. Imminent danger to self for adult is present. b. Imminent danger to others for adult is present. c. Behavioral health disorder is present and appropriate for inpatient care with all of the following: i. Severe psychiatric, behavioral, or other comorbid conditions are appropriate for management at proposed level of care. ii. Severe dysfunction in daily living for adult is present, as indicated by 1 or more of the following: 1. Incapacitation because of grave disability (e.g., severe regression with inability to provide for self). 2. Extreme deterioration in social interactions (e.g., threatening behaviors with little or no provocation). 3. Complete withdrawal from all social interactions. 4. Complete neglect of self-care with associated impairment in physical

State plan HCBS needs-based eligibility criteria	NF (& NF LOC** waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* (& Hospital LOC waivers)
		home, school, work, and community.	status. 5. Extreme disruption in vegetative function (e.g., life-sustaining functions such as eating). 6. Complete inability to maintain any appropriate aspect of personal responsibility in any adult roles (e.g., occupational, parental). 7. Other evidence of severe dysfunction. 2. Treatment services available at proposed level of care are necessary to meet patient needs. 3. Situation and expectations are appropriate for inpatient care for adult.

*Long Term Care/Chronic Care Hospital

**LOC= level of care

7. ☑ **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5 year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(e)(2). (*Specify target group(s)*):

Target Groups: Kentucky is targeting by age and diagnosis group for this 1915(i) RISE Initiative. Individuals must be the age of 18 years or older and possess a primary diagnosis of Serious Mental Illness (SMI) or co-occurring SMI and Substance Use Disorder (SUD).

☐ **Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals

in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. *(Specify the phase-in plan):*

(By checking the following box the State assures that):

8. ☑ **Adjustment Authority.** The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

9. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.	**Minimum number of services.** The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is: 1
ii.	**Frequency of services.** The state requires (select one):
◉	**The provision of 1915(i) services at least monthly**
○	**Monthly monitoring of the individual when services are furnished on a less than monthly basis** If the state also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency:

Home and Community-Based Settings

(By checking the following box the State assures that):

1. ☑ **Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. (*Explain how residential and non-residential settings in this SPA comply with Federal home and community-based settings requirements at 42 CFR 441.710(a)(1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):*

(Note: In the Quality Improvement Strategy (QIS) portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home and community-based settings requirements, at the time of this submission and ongoing.)

All settings are confirmed to comply with the federal HCB settings requirement. DMS ascertains that all 1915(i) RISE Initiative service settings meet federal HCB settings requirements as part of the certification and recertification processes. Site visits are conducted as part of this process.

Kentucky will ensure compliance with the federal and state Home and Community-Based Settings requirements at 42 CFR 441.710(a)(1)-(2).

The state will communicate with the public, providers, and potential referral sources where HCBS services can be delivered and where they cannot. The operating agency's intent is to reflect all of the setting requirements in provider certification and review.

Kentucky will furnish the State Plan HCBS benefit to eligible individuals who receive HCBS in their own homes, in provider owned and controlled residential settings, and in the community at large. The state is allowing the modifications to the additional requirements for provider-owned home and community-based residential settings that will be supported by a specific assessed need and justified with documentation in the person-centered service plan.

All settings:
The setting is integrated in and supports full access of participants receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS at be 42 CFR 441.710(a)(1)(i).

The setting is selected by the participant 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 (PCSP) and are based on the participant's needs, preferences, and for residential settings, resources available for room and board at be 42 CFR 441.710(a)(1)(ii),

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 at 42 CFR 441.710(a)(1)(iv), and

Facilitates individual choice regarding services and supports, and who provides them at 42 CFR §441.710(a)(1)(v).

Any modifications to the settings requirements per 42 CFR 441. §710(a)(1)-(2) must be supported by a specific assessed need and justified in the PCSP. The requirements for modifications will also be documented in the plan.

Provider-owned or controlled residential settings:

Participants sharing units have a choice of roommate in that setting at 42 CFR §441.701(a)(1)(vi)(B)(2), and participants have the freedom and support to control their own schedules and activities at 42 CFR §441.701(a)(1)(vi)(C).

Providers must demonstrate compliance with the settings rule at the time of the initial provider certification for residential settings. The certification process for new providers involves policy review, on-site reviews of the provider owned or leased properties and interviews with staff. Thereafter providers are recertified every two years or more frequently as needed. In addition to the items identified during the initial certification, reviews of participant records and interviews with participants are also conducted to ensure compliance with the settings rule. All other services are provided individually in the owned or leased residence of the participant or within a variety of settings in the community, in accordance with the PCSP and provision of services complies with the settings rule.

Case managers are required to monitor all services and ensure that the services being provided are in accordance with the PCSP and meet all regulatory requirements, including compliance with the settings rule and to ensure the health safety and welfare of the participant

During certification reviews the on-site visits are completed by operating agency (DBHDID) staff. The monthly visits to monitor the participant's services and health and welfare are performed by the Case Manager.

Any modifications to the settings requirements must be supported by a specific assessed need and justified in the person-centered service plan. The requirements for modifications will also be documented in the plan.

Table 1. HCBS Settings and Compliance Monitoring

HCBS Setting Types	Monitoring Entity	Monitoring Frequency	Description
Private Residence: A private home or apartment that the participant lives in, which is owned by the participant or legal guardian.	Case Manager	• On-going monitoring with monthly review • Quarterly • Annually or more frequently	• In-person or telehealth. Case Manager will inquire with the participant about the services and their home environment. • In-person, site visit with the participant in the setting. Observe and assess the overall environment and the associated individuals. • Review lease or ownership documentation.
Provider Owned or Controlled Residential Setting: A setting where the participant is living with an unrelated caregiver in a provider-owned or controlled residential setting.	DMS or designee, the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities	• Prior to initial certification • Quarterly • Every 2 years (or more frequent if necessary	• In-person, site visit as part of the certification process. • Technical assistance monitoring review-In person, site visit as included in the review sample. • Recertification review-In person, site visit as included in the review sample.

Person-Centered Planning & Service Delivery

(By checking the following boxes the state assures that):

1. ☑ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.

2. ☑ Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

3. ☑ The person-centered service plan is reviewed and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

4. Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities. There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. *(Specify qualifications):*

The State Medicaid Agency requires providers that perform face-to-face assessments meet the following minimum requirements:

- Master's degree in behavioral health/human services field with a minimum of one year's experience assessing individual's needs for services. OR
- Bachelor's degree in Behavioral Science and 5 years' experience providing service coordination or linking referrals for community-based services. Bachelor level staff shall be supervised by a Behavioral Health professional.
- Behavioral Health professionals are defined as:

  i. Advanced Practice Registered Nurse (APRN)
  ii. Licensed Clinical Social Worker (LCSW)
  iii. Licensed Marriage and Family Therapist (LMFT)
  iv. Licensed Professional Clinical Counselor
  v. Licensed Psychological Practitioner
  vi. Licensed Psychologist
  vii. Licensed Professional Art Therapist
  viii. Physician
  ix. Psychiatrist
  x. Licensed Clinical Alcohol and Drug Counselor (LCADC)

5. Responsibility for Development of Person-Centered Service Plan. There are qualifications (that are reasonably related to developing service plans) for persons responsible for the development of the individualized, person-centered service plan. *(Specify qualifications):*

Providers responsible for developing the Person-Centered Service Plan shall be required to meet the following minimum requirements:

- **Case Management**
  - Personnel Requirements
    - Bachelor's degree in Behavioral Health/Human Services **OR**
    - Bachelor's degree in any field not closely related **AND** one (1) year of human services related experience, **OR**
    - An associate degree in a behavioral science, social science, or a closely related field **AND** two (2) years human services related experience, **OR**
    - Three (3) years of human services related experience. Relevant fields of study may include:
      - Social Work
      - Psychology
      - Rehabilitation
      - Nursing
      - Counseling
      - Education
      - Gerontology
      - Human Services
      - Sociology

Human Services Related experience may include:

- Experience as a case manager or in a related human services field.
- Certified Nursing Assistant experience
- Certified Medical Assistant experience
- Certified Home Health Aide experience
- Personal Care Assistant experience
- Paid professional experience with aging and/or disabled populations or programs as a Case Manager, a Rehabilitation Specialist or Health Specialist, and/or Social Services Coordinator.
- Assessment and care planning experience with clients
- Experience in working directly with persons with serious mental illness and/or substance use disorder.
- Work providing assistance to individuals and groups with issue such as economically disadvantaged, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural.

- Is a registered nurse, **OR**
- Is a licensed clinical social worker, licensed marriage and family therapist, licensed professional clinical counselor, licensed psychologist, or licensed psychological practitioner.

6. Supporting the Participant in Development of Person-Centered Service Plan. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. *(Specify: (a) the*

supports and information made available, and (b) the participant's authority to determine who is included in the process):

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

1. Is collaboratively developed by:
    a. A 1915(i) RISE Initiative participant and a 1915(i) RISE Initiative participant's legal guardian, if applicable;
    b. The case manager;
    c. The participant's person-centered team, which is comprised of representatives from each 1915(i) RISE Initiative, state plan or other provider entity who provides services and/or supports for the participant; and/or
    d. Any other person identified by the 1915(i) RISE Initiative participant or their legal guardian, if applicable.
2. Uses a process that:
    a. Providers necessary information and support to empower the participant and the participant's legal guardian, if applicable, to direct the planning process and to have the freedom and support to control their own schedules and activities without coercion or restraint;
    b. Is timely and occurs at times and locations of convenience to the participant;
    c. Reflects the cultural and educational considerations of the participant and is conducted by providing information in plain language and in a manner that is accessible to participants with disabilities and participants who have limited proficiency with the English language, consistent with 42 CFR 435.905(b);
    d. Offers informed choice, defined as choosing from options based on accurate and thorough knowledge and understanding, to the participant regarding the services and supports they receive and from whom; and
    e. Uses a process that provides support to the participant so the participant can lead the PCSP planning process and self-advocate for their goals, objectives, wishes, and needs to the maximum extent possible throughout the process.
3. It is the responsibility of the case manager to provide detailed information to the participant and the participant's legal guardian, if applicable, regarding available 1915(i) RISE Initiative services and providers to meet their identified needs, driven by statewide provider information included in the Department-maintained provider directory. Case managers can generate local lists from the directory to provide to the participant and have use of the directory to provide options counseling on available service providers. The case manager must ensure the information from the directory is made accessible to the participant. The case manager will provide detailed information to the participant about available non-1915(i) RISE Initiative services that may assist in reaching their goals and objectives.
4. All participants participating in the development and execution of the PCSP, including participants, any legal guardian, the case manager, and all providers responsible for implementing services, must sign the PCSP to indicate their involvement and understanding of the plan's contents. The signatures will be recorded on the Department or its designee, the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities-approved form, uploaded to, and housed in department-approved system. The signatures should not be obtained until the person-centered planning process and the PCSP are complete.

Enrollment Notice: The enrollment notice sent to the participant advises the participant and the participant's legal guardian, if applicable, that they must select a case manager to initiate service planning prior to receipt of services. The enrollment notice contains information on how to access information on case management agencies so that the participant may initiate contact and selection of a case manager. Once a case manager is

selected, they must associate themselves in department-approved system.

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

Person-Centered Planning Team Designations: The first step is to clarify the needed individuals and their roles on the participant's person-centered team. A participant is free to designate any family, friends, and other caregivers, both paid and unpaid, to participate in this process. The participant and the participant's legal guardian, if applicable, may remove any individuals at their discretion. The case manager must document the individuals included in the person-centered team on the Department-approved form and upload it to the Department- approved system. The case manager must document when a support is disinvited or removed from the person-centered planning team.

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

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

1. The team collectively reviews the findings of the participant's functional assessment. This process includes documenting any non-Medicaid paid or unpaid supports including information on the access and limitations of said supports and Medicaid State Plan services. For annual review meetings, the team should also review the participant's current PCSP.
2. The team works collectively under the leadership of the participant and the participant's legal guardian, if applicable, to complete an additional review of the participant's person-centered planning needs and wishes to establish goals and objectives that enhance health, safety, and welfare, community-based independence, community participation, and quality of life. Not all goals and objectives must be accomplished using 1915(i) RISE Initiative funded services.
3. The process of setting goals should include education and team support for the participant and the participant's legal guardian, if applicable. Goals and objectives for all services on the PCSP must be:
    a. **Stated Clearly:** The goal or objective should be understandable to the participant and in his/her own words.
4. Additionally, if a participant is receiving a service in order to improve upon current skills or acquire new skills, the goal and objectives must also be:
    b. **Measurable:** There should be markers of progress toward achieving a goal or objective that can be identified and quantified.
    c. **Attainable:** The goal or objective should be broken into small and actionable steps. Barriers to achieving the goal or objective should be identified and a plan put in place to help mitigate those barriers.
    d. **Relevant:** The goal or objective should be important to the participant. Steps toward the goal or objective should help the participant develop and use available resources to achieve it.
    e. **Time-Bound:** There should be a defined period for when the participant is expected to achieve the goal or objective, keeping in mind that reaching the goal or objective can take time and several steps. There should also be an agreed upon schedule in place for checking progress.
5. The case manager will provide detailed information to participants about available non-1915(i) RISE Initiative services that may assist in reaching their goals and objectives.

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

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

6. The case manager is required to provide options counseling and education on available service options to meet a participant's person-centered goals and objectives, using required processed for educating the participant and other team members on service providers.

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

b. The case manager is responsible to ensure that the scope, frequency, amount and duration of services falls within the allowable utilization criteria and limitations set by the Department, and clearly document any planned changes in utilization anticipated over the course of the year.

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

7. Once signatures have been secured from all required person-centered team members, including the participant and the participant's legal guardian, if applicable, the case manager, and all 1915(i) RISE Initiative funded service providers delivering PCSP included services, services may be initiated. The signatures should not be obtained until the person-centered planning process and the PCSP are complete.

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

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

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

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

B. Annual Redetermination of the Person-Centered Service Plan

A participant's PCSP is recertified on an annual basis. Prior to the reviewing and modifying of the PCSP, the following activities must occur:

1. The case manager is encouraged to co-attend and must review the annual functional assessment, which is housed in department-approved system.
2. Should a case manager choose to attend the functional assessment, they are expected to support the participant in answering questions and not answer questions on his/her behalf or influence the participant's response or lack of response. The functional assessor is not to use information provided by a case manager that directly conflicts with assessment feedback provided by the participant.

The person-centered service planning can begin forty-five (45) calendar days prior to the end of the current period. The PCSP must be completed and uploaded to department-approved system seven (7) calendar days prior to the end of the current period. The period is defined as the period spanning 364 calendar days from the date a participant is enrolled in the 1915(i) RISE Initiative in department-approved system. Person-centered service planning and development of the PCSP should follow the steps described under "Process for Developing a Person-Centered Service Plan" in this section.

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

1. A participant and a participant's legal guardian, if applicable, may request a modification to their PCSP due to changes in their condition or service needs at any time.
    a. Additionally, throughout the course of plan monitoring, the case manager is responsible to address instances when a modification to the PCSP may be appropriate. The case manager may not initiate any modification to the PCSP without the consent of the participant and the participant's legal guardian if applicable. The services providers affected by an event-based modification to the PCSP must be involved in the process as well.
2. Certain modifications or event-based circumstances may require completion of updated assessments to assess changes in the participant's needs and make necessary adjustments to the participant's PCSP. The following are examples of circumstances that could merit completion of a functional assessment outside of the annual assessment cycle:
    a. Inpatient admission to an institutional care setting with changes at discharge in functional ability from previous assessment including:
        I. Decreased functional ability in one or more activities of daily living, or
        II. Decreased functional ability in three (3) or more instrumental activities of daily living.
    b. Change in care setting that increases the participant's level of care, including transitions between community-based settings such as moving from a participant's own home to a residential setting.
    c. Long-term change in access to or ability of an unpaid caregiver(s).
    d. Observed or reported changes that result in the inability of the participant to meet goals and objectives based on the current PCSP, and/or do not provide a level of service sufficient to address health, safety, or welfare concerns.
3. The case manager is responsible to initiate the event-based assessment in department-approved system.
4. The case manager will be responsible to review the updated assessment and share information about the assessment outcomes with the participant and the participant's legal guardian, if applicable. The case manager will work with the participant, and any members of the participant's person-centered team as requested by the participant, to modify the PCSP to address any requested or necessary modifications.

The updated PCSP must be signed by the participant and the participant's legal guardian, if applicable, the case

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

7. **Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):*

All 1915(i) RISE Initiative participants are informed of their choice of 1915(i) RISE Initiative programs and available services by their case manager. This information is provided at the initial person-centered planning meeting and at least annually thereafter. An electronic copy of this signed form is retained in department-approved system.

8. **Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency.** *(Describe the process by which the person-centered service plan is made subject to the approval of the Medicaid agency):*

Upon completion of the PCSP, it is the responsibility of the case manager to submit the PCSP through the State Medicaid Agency (SMA)-approved system for review and service authorization. A service authorization shall not be issued without appropriate review and approval.

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

9. **Maintenance of Person-Centered Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies)*:

●	Medicaid agency	☐	Operating agency	☐	Case manager
	Other *(specify):*				

Services

1. **State plan HCBS.** *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Supervised Residential Care
Service Definition (Scope):	

Supervised Residential Care provides supportive and health-related residential services provided to individuals in Medicaid-approved and certified settings. This service shall not have greater than three (3) participants in a home rented or owned by the service provider. Based on the individual needs of a participant per the PCSP this setting may include unsupervised time per day for a participant to work towards increased independence. If this option is utilized, a participant will work with their case manager to develop a PCSP for the participant to work towards increased independence. The plan shall include:

1. Necessary provisions to assure the participant's health, safety and welfare;
2. Documented approval by the participant's treatment team, including the participant being served; and
3. Periodic review and updates, based on changes in the participant's status.

Staff within Supervised Residential Care are expected to provide assistance and training to identify and complete Activities of Daily Living (ADLs)/Instrumental Activities of Daily Living (IADLs) including:

1. Personalized support to assist residents in cueing and prompting for execution ADLs.
2. Personalized support with meal preparation, shopping, laundry, cleaning, financial management and/or bill paying for resident's personal expenses and executing telephonic, e-mail and/or other communication with formal and informal supports, communicating needs and preferences during covered activities, and arranging for participant supports.
3. Assistance with medications education and adherence based upon the results of an RN assessment per the PCSP.
4. Social skills training including developing interpersonal effectiveness skills, and reduction or elimination of barriers to recovery.
5. Provide or arrange transportation and accompany participant to services and activities that enable participant involvement in community activities, medical appointments as needed, as well as accompanying and assisting a participant while utilizing transportation services.
6. Support a participant to arrange, attend, communicate, and manage their post-appointment follow up treatment and care activities, as recommended by the provider.

Participants will work with their Case Managers to develop PCSPs that include the utilization of Community Residential Supports specifically supporting the development of natural supports, as well as community integration and participation.

Residents shall be routinely engaged to identify their preparedness and/or desire to transition to a more community-integrated residential setting that is non-congregate, to promote timely and appropriate "step-down" to a participant's preferred residential arrangement. During the step-down phase from a supervised care setting, participant with SMI will receive evidence-based programming to promote the furtherance of the goals in their PCSP and establish community integration and participation foundations. Providers of supervised residential care services must collaborate with other members of the participant's person-centered team to promote successful preparation and transition when a move-out occurs.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Additional needs-based criteria for the provision of the Supervised Residential Care service include the following:

Homelessness Risk Factors (Limited to Housing Supports), to include one of the following criteria:

a. Homeless as defined per 24 CFR § 578.3.
b. At-risk of homelessness as defined per 24 CFR § 578.3.
c. History of frequent (more than 1/year) stays in nursing home/inpatient settings.
d. Was homeless in the prior 24 months, or formerly homeless, now residing in HUD assisted housing.

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

X	Categorically needy *(specify limits):*
	Limited to one (1) unit per participant per calendar day. Payments for Supervised Residential Care do not include reimbursement for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep, and improvement. Separate payments will not be made for medication management services, non-medical transportation services, or for any other service that is provided to a participant under the Supervised Residential Care but listed as a separate service in this 1915(i) RISE Initiative SPA. The state must ensure that duplication of services does not occur by prohibiting payment for services without authorization. Two entities may not be paid for providing the same service to the same participant during the same time period. These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with 1915(i) RISE Initiative objectives of avoiding institutionalization.
	Medically needy *(specify limits):*
	N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
1915(i) RISE Initiative Provider Agency that meets the minimum eligibility and standards for DMS provider enrollment.	N/A	Certified by DMS or its designee, the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities	The agency must meet certified 1915(i) RISE Initiative provider qualifications as defined in 907 KAR 16:015. If medication management is offered as part of this service, it shall be provided by a pharmacist, medical doctor, physician assistant, advanced practice registered nurse, a registered nurse as defined in KRS 314.011(5), a licensed practical nurse as defined in KRS 314.011(9) under the supervision of a registered nurse. Medication Management may also be provided by an Allied Health Care Professional when it is provided as a service within In-Home Independent Living Supports or Supervised Residential Care 1) "Allied health care professional" or "AHCP" means an individual who provides support in a residential setting, including a: a) Certified nursing assistant; b) Medication aide; c) Licensed practical nurse; or d) Registered nurse.

			Agency staff who come into direct contact with 1915(i) RISE Initiative service participants must meet the following qualifications: 1. Be at least eighteen (18) years of age. 2. Completes Department-approved, service-specific training and is monitored for competency on topics including, but not limited to: situational de-escalation, abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered principles. 3. Any additional trainings required by the state behavioral health authority and training on accreditation standards required by the state, which may include: a. Risk assessment, suicide prevention and suicide response; b. Roles of families and peers; and c. Other trainings required by the state or accrediting agency 4. Has the ability to: a. Communicate effectively with a participant in the participant's preferred manner of communication and with the participant's family; b. Read, understand, and implement written and oral instructions; c. Perform required documentation; d. Participate as a member of the participant's person-centered team if requested by the participant; and 5. Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant's PCSP. 6. Undergoes pre-employment screenings. 7. If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all

			applicable State laws while operating the vehicle.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
1915(i) RISE Initiative Provider Agency that meets the minimum eligibility and standards for DMS provider enrollment.	Certified by DMS or its designee	Initially and every two-years (or more frequently if necessary)

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	X	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: In-Home Independent Living Supports

Service Definition (Scope)*:*

In-Home Independent Living Supports are routine services provided to participants to support their ability to live independently and the development of the requisite skills to support independent living. Services are intended to support the participant to maximize his or her own independence in self-managing independent living, as defined below, and may be reduced over time as a participant becomes more self-sufficient. Services may be provided to participants in their own private housing unit or in a housing unit the participant shares with others, including a single-family home, duplex, or apartment building. No more than two (2) 1915(i) RISE Initiative service participants may be supported in one (1) home or apartment. All provided home, or apartment units must, at minimum, adhere to housing standards outlined by the Department of Housing and Urban Development (HUD).

In-home Independent Living Supports provides a range of assistance and training, based on assessed need to identify and complete Activities of Daily Living (ADLs)/Instrumental Activities of Daily Living (IADLs). Assistance may be in the form of hands-on assistance, supervision, and/or cueing with the goal of offering participant direction opportunities. ADLs/IADLs include the following:

1. Assistance with bathing, grooming, and dressing when detailed in a participants PCSP goals.
2. Assistance with financial management, meal preparation, shopping, preparing and storing food safely, cleaning, and telephonic communication.
3. Assistance with medications education and adherence based upon the PCSP goals.
4. Social skills training including developing interpersonal effectiveness skills, and reduction or elimination of barriers to recovery.
5. Provide or arrange transportation to services, activities, and behavioral health and medical appointments as needed as well as accompanying and assisting a participant while utilizing transportation services, including supporting the participant to independently navigate public transportation systems and other community transit options.
6. Participation in behavioral health and medical appointments and follow-up care as directed by the medical staff.

ADL and IADL support will vary based on the assessed need of the participant.

Services must be furnished in a way that fosters the independence of each participant to facilitate autonomy, self-sufficiency and/or recovery. Providers are expected to teach participants to learn coping skills to navigate their chosen independent living environment. Routines of service delivery must be person-centric and participant -driven, to the maximum extent possible and each participant must be treated with dignity and respect and have full freedom of choice and self-determination. The PCSP will document any planned intervention which could potentially impinge on participant autonomy. Documentation will include informed consent of the participant to the intervention; the specific need for the intervention in supporting the participant to achieve his/her goals; assurance that the intervention is the most inclusive and person-centered option; time limits for the intervention, periodic reviews of the intervention to determine if it is still needed, and assurance that the intervention will cause no harm to the participant.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Additional needs-based criteria include the following:

Homelessness Risk Factors (Limited to Housing Supports), to include one of the following criteria:

a. Homeless as defined per 24 CFR § 578.3.
b. At-risk of homelessness as defined per 24 CFR § 578.3.
c. History of frequent (more than 1/year) stays in nursing home/inpatient settings.
d. Was homeless in the prior 24 months, or formerly homeless, now residing in HUD assisted housing.

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

[X] Categorically needy *(specify limits):*

Limited to one (1) unit per participant per calendar day.

Payments for In-home Independent Living Supports are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep, and improvement.

Separate payments will not be made for medication management services, non-medical transportation services, financial management or for any other service that is provided to a participant under the In-home Independent Living Supports but listed as a separate service in this 1915(i) RISE Initiative SPA. The state must ensure that duplication of services does not occur by prohibiting payment for services without authorization. Two entities may not be paid for providing the same service to the same participant during the same time.

These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with 1915(i) RISE Initiative objectives of avoiding institutionalization.

[ ] Medically needy *(specify limits):*

N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
1915(i) RISE Initiative Provider Agency that meets the minimum eligibility and standards for DMS provider enrollment.	N/A	Certified by DMS or its designee	The agency must meet certified 1915(i) RISE Initiative service provider qualifications as defined in 907 KAR 16:015. If medication management is offered as part of this service, it shall be provided by a

			pharmacist, medical doctor, physician assistant, advanced practice registered nurse, a registered nurse as defined in KRS 314.011(5), a licensed practical nurse as defined in KRS 314.011(9) under the supervision of a registered nurse. Medication Management may also be provided by an Allied Health Care Professional when it is provided as a service within In-Home Independent Living Supports or Supervised Residential Care 2) "Allied health care professional" or "AHCP" means an individual who provides support in a residential setting, including a: a) Certified nursing assistant; b) Medication aide; c) Licensed practical nurse; or d) Registered nurse. Agency staff who come into direct contact with 1915(i) RISE Initiative service participants must meet the following qualifications: 1. Be at least eighteen (18) years of age. 2. Completes Department-approved, service-specific training and is monitored for competency on topics including, but not limited to: situational de-escalation, abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered principles. 3. Any additional trainings required by the state behavioral health authority and training on accreditation standards required by the state, which may include: a. Risk assessment, suicide prevention and suicide response; b. Roles of families and peers; and c. Other trainings required by the state or accrediting agency 4. Has the ability to: a. Communicate effectively with a participant in the participant's preferred manner of communication and with the participant's family;

			b. Read, understand, and implement written and oral instructions; c. Perform required documentation; d. Participate as a member of the participant's person-centered team if requested by the participant; and 5. Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant's PCCP. 6. Undergoes pre-employment screenings. 7. If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable State laws while operating the vehicle.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
1915(i) RISE Initiative Provider Agency that meets the minimum eligibility and standards for DMS provider enrollment.	Certified by DMS or its designee	Initially, and every two-years (or more frequently if necessary)

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	X	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Tenancy Supports

Service Definition (Scope):

Tenancy supports includes both pre-tenancy supports and tenancy-sustaining supports.

Pre-Tenancy Support Services are determined to be necessary for a participant to identify, select, and enter into a lease agreement resulting in the participant moving into an independent housing unit. Provision of pre-tenancy support should be tailored to person-centered goals, as stated in the participant's Person-Centered Service Plan (PCSP), and assist the participant in identifying and leasing a housing unit that is expected to promote the participant's personal health and welfare in a housing arrangement that is not provider-owned or controlled and is instead governed by a lease that is entered into with the owner or landlord of the housing unit.

Pre-tenancy supports, when otherwise not available, include the following components:

1. Conducting an assessment to identify the participant's needs and preferences related to housing (e.g., type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other preferences) as well as community integration.
2. Assisting in budgeting for housing / living expenses, including financial literacy education on budget basics based upon anticipated housing, utility and other known budget components.
3. Assisting participants with finding and applying for housing, including filling out housing, utility, and rental assistance applications, remitting necessary fees and/or obtaining and submitting appropriate documentation required for tenancy approval.
4. Reviewing, understanding the terms of and assisting the participant with consenting to and a rental agreement / lease.
5. Assisting participants with completing reasonable accommodation requests and obtaining disability verifications as needed to secure an appropriate housing arrangement. Assistance shall include identifying verbal requests for a reasonable accommodation and supporting written documentation of the request with the prospective landlord.
6. Coordinating with the 1915(i) RISE Initiative case manager to develop an individualized PCSP and housing supports plan which includes a community integration plan and identifies short and long-term measurable goals, how goals will be achieved, and how barriers to achieving goals will be addressed.
    a. Additionally, any housing supports plan should include plans for housing maintenance, lease adherence, facilitation of tenant-landlord communications.
7. Assisting with identifying and securing resources to obtain housing including community-based resources to assist with securing documentation, fees needed, and transportation needs.
8. Ensuring the living environment is safe (including the assessment of health risks to ensure the living environment is not adversely affecting the occupants' health) and accessible for move-in.
9. Assisting in arranging for and supporting the details and activities of the move-in. This includes assisting the participant with identifying the date and time that the move-in will take place as well as providing the participant with assistance to arrange necessary transportation for the move-in.

Participants enrolling in this service may currently be residing in any living environment, up to and including those exiting institutional settings.

Tenancy-sustaining Supports are made available to support participants to maintain tenancy once housing is secured. The availability of ongoing housing-related services in addition to other long-term services and supports promotes housing success, fosters community integration and inclusion, and develops natural support networks.

Tenancy-sustaining Supports include the following components:

1. Coordination with the participant to plan, participate in, review, update and modify their individualized housing support plan on a regular basis (at minimum every 90 days), including at redetermination

and/or revision plan meetings, to reflect current needs and preferences and address existing or recurring housing retention barriers.

2. Working collaboratively with 1915(i) RISE Initiative Case Manager to assist participants with maintaining entitlements and benefits (including rental assistance) necessary to maintain community integration and housing stability (e.g., assisting participants in obtaining documentation, assistance with completing documentation, navigating the process to secure and maintain benefits, and coordinating with the entitlement/benefit assistance agency).
3. Working collaboratively with 1915(i) RISE Initiative Case Manager to provide participants with assistance with securing supports to preserve maximize independent living.
4. Working collaboratively with the 1915(i) RISE Initiative case manager to ensure that referrals are made to services that are needed to promote housing stabilization, adaptation to surrounding neighborhood conditions, lease adherence and sustained landlord-tenant communications and problem-solving.
    a. Referrals may include but are not limited to substance use treatment providers, mental health providers, medical, vision, nutritional and dental providers, vocational, education, employment and volunteer supports, hospital and emergency rooms, probation and parole crisis services, end of life planning, and other support groups and natural supports.
5. Providing supports to assist the participant in the development of independent living skills to remain in the most integrated setting (e.g., skills coaching to maintain a healthy living environment, develop and manage a household budget, interact appropriately with neighbors or roommates, reduce social isolation, utilize local transportation).
6. Providing supports to assist the participant in communicating with the landlord and/or property manager. Educating and training the participant on the role, rights, and responsibilities of the tenant and landlord, and providing training and resources to assist the participant with complying with his/her lease.
7. Assisting in reducing the risk of eviction by providing services to prevent eviction (e.g., to improve conflict resolution skills; coaching; role-playing and communication strategies targeted towards resolving disputes with landlords and neighbors; communicating with landlords and neighbors to reduce the risk of eviction; addressing biopsychosocial behaviors that put housing at risk; providing ongoing support with activities related to household management; and linking the tenant to community resources to prevent eviction including expert resources to address legal issues).
8. Supporting the participant with unanticipated threats to housing stability including man-made and natural disasters and other imminent jeopardy to health and or safety, including planning and referral to temporary housing arrangements, as necessary.
9. Providing early identification, risk management and proactive intervention for actions or behaviors that may jeopardize housing.

Pre-Tenancy and Tenancy-Sustaining Supports Services will adhere to the Permanent Supportive Housing (PSH) principles:

1. Choice and Self-Determination–People should have choice in all aspects of their lives, including the planning and delivery of services, and housing and living support arrangements. Participants should be free to choose housing from the same living environments available to the general public.
2. Safety–People should have the opportunity to live in housing that is decent and safe, in neighborhoods free from problems of drugs and crime.
    a. A secure environment includes the development and implementation of clear administrative procedures for rent collection, building maintenance, monitoring visitors, enforcement of house rules, and opportunities for tenants to provide input on the safety and comfort of their living environment. Introduce risk mitigation language – General supportive housing principles.
3. Affordable–People should have the opportunity to live in housing that is affordable – where no more than thirty percent of their income pays for their housing costs (rent/ mortgage and utilities).
4. Integrated–People are entitled to have available to them housing options that are integrated into neighborhoods and are typical of the housing in the neighborhood.
5. Consumer and Family Involvement–People and their family members should play a role in the development of new housing and support opportunities and in promoting the availability of housing alternatives for people with disabilities.

6. Permanent–People should be provided needed support in obtaining housing where they lease, own, or otherwise control the housing. Decisions regarding housing tenure should be separate from decisions about needed supports and services.
7. Accessible–Participant should have access to housing with needed physical modifications or other reasonable accommodations to support them in daily living. Participants should receive necessary assistance in requesting and accessing such housing and supports.
8. Flexible and Individualized Services and Supports–Participant should have support services available to them regardless of where they choose to live. Services and supports should be person-centered and should enable participants to live in their own homes. Supports should include community supports (congregations, schools) and natural supports (family, friends, and neighbors).

Recipients of Pre-tenancy and Tenancy Sustaining Supports must be included in the search, choice, and any pertinent decisions regarding the establishment of their housing arrangement. Housing shall be guided by and support the goals for social inclusion and community integration as defined by the participant in their PCSP.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Additional needs-based criteria include the following:

a. Homeless as defined per 24 CFR § 578.3
b. At-risk of homelessness as defined per 24 CFR § 578.
c. History of frequent (more than 1/year) stays in nursing home/inpatient settings.
d. Was homeless in the prior 24 months, or formerly homeless, now residing in HUD assisted housing.

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

[X] Categorically needy *(specify limits):*

Tenancy Support Services are based on a daily rate with a benefit limitation of 30 days over a 180-day authorization period and must include direct contact with the member. Any additional time within that 180-day period must be authorized as an exception.

This benefit does not include:

1. Payment of rent or other room and board costs.
2. Payment of any costs and / or fees associated with tenancy application or lease-up.
3. Capital costs related to the development or modification of housing, including implementation of physical reasonable accommodations, which are the responsibility of the property owner
4. Expenses for utilities or other regularly occurring bills.
5. Goods or services intended for leisure or recreation.
6. Payment of emergency-based or temporary housing arrangements during emergencies or gaps in permanent housing arrangements.
7. Duplicative services from other state or federal programs.

[ ] Medically needy *(specify limits):*

N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
1915(i) RISE Initiative Provider Agency that meets the minimum eligibility and	N/A	Certified by DMS or its designee	The agency must meet certified 1915(i) RISE Initiative service provider qualifications as defined in 907 KAR 16:015.

standards for DMS provider enrollment.			Agency staff who come into direct contact with 1915(i) RISE Initiative service participants must meet the following qualifications: 1. Be at least eighteen (18) years of age. 2. Completes Department-approved, service-specific training and is monitored for competency on topics including, but not limited to: situational de-escalation, abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered principles. 3. Any additional trainings required by the state behavioral health authority and training on accreditation standards required by the state, which may include: a. Risk assessment, suicide prevention and suicide response; b. Roles of families and peers; and c. Other trainings required by the state or accrediting agency 4. Has the ability to: a. Communicate effectively with a participant in the participant's preferred manner of communication and with the participant's family; b. Read, understand, and implement written and oral instructions; c. Perform required documentation; d. Participate as a member of the participant's person-centered team if requested by the participant; and 5. Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant's PCSP. 6. Undergoes pre-employment screenings. 7. If the employee provides transportation, the employee must be legally licensed to operate the

			transporting vehicle and obeys all applicable State laws while operating the vehicle.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
1915(i) RISE Initiative Provider Agency that meets the minimum eligibility and standards for DMS provider enrollment.	Certified by DMS or its designee	Initially and every two-years (or more frequently if necessary)

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	X	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Supported Education (SEd)

Service Definition (Scope)*:*

Supported Education (SEd) services are individualized and promote engagement, sustain participation, and restore a participant's ability to function in the learning environment. Services must be specified in the Person-Centered Service Plan (PCSP) to enable the participant to integrate more fully into the community and/or educational setting and must ensure the health, welfare, and safety of the participant.

The goals of SEd are for participants to:

1. Engage and navigate the learning environment;
2. Support and enhance attitude and motivation;
3. Develop skills to improve educational competencies (social skills, social-emotional learning skills, literacy, study skills, time management);
4. Promote self-advocacy, self-efficacy, and empowerment (e.g., disclosure, reasonable accommodations, advancing educational opportunities); and
5. Build community connections and natural supports as needed to adapt to and thrive within the educational program and/or setting of the participant's choosing.

Supported Education providers are to exhaust all other available resources prior to utilizing the 1915(i) RISE Initiative services.
Supported Education providers are expected to provide individualized services that include any combination of the following:

<u>Engage, Bridge, and Transition</u>

1. Act as a liaison / support in the educational learning environment.
2. Facilitate outreach and coordination of learning opportunities.
3. Familiarize participant and caregiver (if applicable) to educational settings, to help navigate the school system and student services.
4. Assist with admission applications and registration.
5. Assist with transitions and/or withdrawals from programs such as those resulting from behavioral health challenges, medical conditions, and other co-occurring disorders.
6. Improve access by effectively linking consumers of mental health services to educational programs within the school, college, or university of their choice.

7. Coordinate with the 1915(i) RISE Initiative Case Manager who will oversee the needs of the participant and act as a liaison.
8. Assist with advancing education opportunities including applying for work experience, employment training programs, apprenticeships, and colleges.
9. Tend to other identified educational needs in accordance with the participant's care plan that support the participant with PCSP goal advancement and/or attainment.

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The educational environments include college, technical college, proprietary, distance learning and short-term learning.

Training facilities must be accredited or licensed by appropriate accrediting or licensing bodies and comply with all state and federal requirements applicable to their use by the Office of Vocational Rehabilitation and 1915(i) RISE Initiative approved provider types.

Support and enhance attitude and motivation

1. Develop an education/career plan and revise as needed in response to participant's needs and recovery process.
2. Assist in training to enhance interpersonal skills and social-emotional learning skills (effective problem solving, self-discipline, impulse control, increase social engagement, emotion management and coping skills).
3. Individualize behavioral supports in all educational environments including but not limited to classroom, dining facility, and test-taking environments.
4. Working collaboratively with 1915(i) RISE Initiative Case Manager to assist participants in conducting a needs assessment/educational assessment, based on goals to identify education/training requirements, personal strengths, and necessary support services.

Before utilizing this service, all resources available through the Office of Vocational Rehabilitation must first be exhausted. This service may support training required to achieve an agreed upon vocational goal. Informed choice, benefit in terms of employment outcome, and expenditure of time and resources of the participant should be considered when making training decisions. Prior to the provision of training:

- Thorough career exploration should occur, which may include interest inventories, visits to job sites and training institutions, job shadowing, or volunteer opportunities. Tools such as O*Net and the Occupation Outlook Handbook provide valuable occupational information. Counselors should explain labor market trends for the planned occupation;
- Counselor should assess transferable skills, interests, and capacities to determine if training is needed to obtain suitable employment;
- Documentation should support the ability, aptitude, and interest to complete the training, with or without reasonable accommodations. Documentation may include performance measures such as academic records, ACT or TABE scores; and
- Counselors should discuss all situations, obligations, history, and attendant factors, which may affect successful completion of training and explore comparable training options prior to finalizing a plan.

The goal of supported education is not education alone but employment.

Develop skills to improve educational competencies

1. Work with participants to develop the skills needed to remain in the learning environment (e.g., effective problem solving, self-discipline, impulse control, emotion management, coping skills, literacy, English-learning, study skills, note taking, time and stress management, and social skills).
2. Provide opportunities to explore individual interests related to career development and vocational choice.

Self-Advocacy, self-efficacy, and empowerment; To ensure duplication does not occur providers must coordinate efforts with the Department of Education and/ or local Vocational Rehabilitation Agency.

1. Act as a liaison to assist with attaining alternative outcomes (e.g., completing the process to request an incomplete rather than failing grades if the student needs a medical leave or withdrawal).
2. Have or promote individualized and ongoing discussions regarding the disclosure of disability.

3. Provide advocacy support to obtain accommodations (such as requesting extensions for assignments and different test-taking settings if needed for documented disability).
4. Advocacy and coaching on reasonable accommodations as defined by the Individuals with Disabilities Education Act (IDEA), Section 504 of the Rehabilitation Act of 1973, and Americans with Disabilities Act (ADA) (e.g., note-taking services, additional time to complete work in class and on tests, modifications in the learning environment, test reading, taking breaks during class when needed, changes in document/ assignment format, etc.).
5. Provide instruction on self-advocacy skills in relation to independent functioning in the educational environment.

Community connections and natural supports

1. Serve as a resource clearinghouse for educational opportunities, tutoring, financial aid and other relevant educational supports and resources.
2. Provide access to recovery supports including but not limited to cultural, recreational, and spiritual resources.
3. Provide linkages to education-related community resources including supports for learning and cognitive disabilities.
4. Identify financial aid resources and assist with applications for Financial Aid.
5. Assist in applying for student loan forgiveness on previous loans because of disability status.

Ongoing SEd service components may be conducted after a participant is successfully admitted to an educational program.

Services are designed to be delivered in and outside of the classroom setting and may be provided by schools and/or agencies enrolled as approved providers of 1915(i) RISE Initiative SEd services that specialize in providing educational support services.

The person-centered individualized care plan will be developed based on the participant's needs with respect to telehealth or in person services to ensure proper monitoring for the health and safety of the participant.

Telehealth includes real-time, two-way communication between the service provider and the participant. Telehealth is limited to check-ins (e.g., reminders, verbal cues, prompts) and consultations (e.g., counseling, problem solving) within the scope of services.

To respect the privacy of the participant, telehealth will be elected on behalf of the participant, and whenever feasible, on an agreed-upon schedule, ensuring protection of the participant's personal space and activities.

Utilizing telehealth will allow for more flexibility for the participant to participate, allows for less-disruption in the setting, therefore allowing for integration more fully into the community and/or educational setting.

The telehealth service may be rendered either in tandem with a caregiver, personal assistant, or other support person(s) when physical assistance is required or may be rendered in the absence of additional support person(s) when appropriate utilizing assistive technology tools to deliver services.

Participants that require assistance utilizing technology necessary for telehealth delivery of service will be considered for eligibility for assistive technology (AT). Education and training for the participant and family, guardian, and/or provider staff to aid the participant in the use of the AT is incorporated as a service of AT.

Telehealth options include:

1. Telephone
2. Secure Video Conferencing

Telehealth must:

1. Be elected by the participant receiving services;
2. Not block the member's access to the community;

3. Not prohibit needed in-person services for the member;
4. Utilize a HIPPA compliant platform; and
5. Prioritize the integration of the member into the community.

For each utilization, providers must document that the telehealth option:

1. Was elected by the member receiving services;
2. Did not block the member's access to the community;
3. Did not prohibit needed in-person services for the member;
4. Utilized a Health Insurance Portability and Accountability Act (HIPAA)-compliant platform; and
5. Prioritized the integration of the participant into the community.

The keys to providing better member care lies in making services available and ensuring members seek help when necessary. Telehealth options are for the benefit of the member, rather than the benefit of the provider. The member's election to utilize telehealth must enhance their integration into the community. Examples of the appropriate use of telehealth include:

1. Members with behavioral health conditions who are feeling stigmatized and, thus, avoiding seeking services in an effort to hide their conditions from others. Telehealth will allow these members to receive services from the comfort of their own surroundings, reducing the stigma and increasing the chances they will seek services and stay engaged. Telehealth alternatives will make ongoing care and follow-ups more convenient and easier to schedule for the member, likely increasing the number of appointments made, as well as the number of appointments kept.

Members in the midst of a crisis situation or addiction relapse will be able to more easily reach out to service providers, reducing risks associated with their conditions and the likelihood of needing a higher level of care.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

[X] Categorically needy *(specify limits):*

Supported education is limited to four hundred and eighty (480) fifteen (15) minute units per 180-day authorization period. Any additional time within that 180-day period must be authorized as an exception.

Supported education services are to be rendered consistent with frequency, duration, and scope recommended by the participant's PCSP.

This service cannot be provided to a participant at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. Participants eligible for multiple Medicaid funded authorities cannot access this service in more than one authority and are required to utilize the service through the alternate authority rather than the 1915(i) RISE Initiative.

Services furnished through the 1915(i) RISE Initiative must not be duplicated by services funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1400 et seq.). To ensure duplication does not occur providers must coordinate efforts with the Department of Instruction and/ or local Vocational Rehabilitation Agency. Justification that services are not otherwise available to the participant through these agencies under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1400 et seq.) must be documented in the participant's record and kept on file.

These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with 1915(i) RISE Initiative objectives of avoiding institutionalization.

☐ Medically needy *(specify limits):*

N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
1915(i) RISE Initiative Provider Agency that meets the minimum eligibility and standards for DMS provider enrollment.	N/A	Certified by DMS or its designee	To be a SEd qualified provider, the provider shall: 1. Be an approved vendor through Office of Vocational Rehabilitation 2. Provide the evidence-based practice of SEd through training and technical assistance provided by state Individual Placement and Support Trainers 3. Participate in fidelity reviews required by the developer of the practice 4. Complete Supported Employment core training offered through UK-Human Development Institute The agency must meet certified 1915(i) RISE Initiative service provider qualifications as defined in 907 KAR 16:015. Agency staff who come into direct contact with 1915(i) RISE Initiative service participants must meet the following qualifications: 1. Be at least eighteen (18) years of age. 2. Completes Department-approved, service-specific training and is monitored for competency on topics including, but not limited to: situational de-escalation, abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered principles. 3. Any additional trainings required by the state behavioral health authority and training on accreditation standards required by the state, which may include: a. Risk assessment, suicide prevention and suicide response; b. Roles of families and peers; and c. Other trainings required by the state or accrediting agency

			4. Has the ability to: a. Communicate effectively with a participant in the participant's preferred manner of communication and with the participant's family; b. Read, understand, and implement written and oral instructions; c. Perform required documentation; d. Participate as a member of the participant's person-centered team if requested by the participant; and 5. Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant's PCSP. 6. Undergoes pre-employment screenings. 7. If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable State laws while operating the vehicle.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
1915(i) RISE Initiative Provider Agency that meets the minimum eligibility and standards for DMS provider enrollment.	Certified by DMS or its designee	Initially and every two-years (or more frequently if necessary)

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	X	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Individual Placement and Support – Supported Employment (IPS-SE)

Service Definition (Scope)*:*

Individual Placement and Support – Supported Employment (IPS-SE) is an evidence-based practice designed to assist participants with Serious Mental Illness (SMI) or co-occurring SMI and Substance Use Disorders (SUD) to obtain and maintain employment in Competitive Integrated Employment (CIE) using the supports of their behavioral health treatment team, an employment specialist, and benefits counselor.

The IPS-SE principles are planned and implemented through a coordinated and integrated partnership with the participant and his or her person-centered team members, of which the Employment Specialist is a member, to assist the participant in achieving their specific employment goals as defined by the Person-Centered Service Plan (PCSP).

Practice Principles of IPS-SE:

1. Focus on Competitive Integrated Employment: Agencies providing IPS services are committed to competitive employment as an attainable goal for people with behavioral health conditions seeking employment. Mainstream education and specialized training may enhance career paths.
2. Eligibility Based on Client Choice: People are not excluded based on readiness, diagnoses, symptoms, substance use history, psychiatric hospitalizations, homelessness, level of disability, or legal system involvement.
3. Integration of Rehabilitation and Mental Health Services: IPS programs are closely integrated with mental health treatment teams.
4. Attention to Worker Preferences: Services are based on each person's preferences and choices, rather than providers' judgments.
5. Personalized Benefits Counseling: Employment specialists help people obtain personalized, understandable, and accurate information about their Social Security, Medicaid, and other government entitlements.
6. Rapid Job Search: IPS programs use a rapid job search approach to help job seekers obtain jobs directly, rather than providing lengthy pre-employment assessment, training, and counseling. If further education is part of their plan, IPS specialists assist in these activities as needed.
7. Systematic Job Development: Employment specialists systematically visit employers, who are selected based on job seeker preferences, to learn about their business needs and hiring preferences.
8. Time-Unlimited and Individualized Support: Job supports are individualized and continue for as long as each worker wants and needs the support.

Consistent with the purpose and intent of this service definition, IPS-SE includes the following employment activities:

1. Vocational Assessment or Career Profile;
2. Development of a Vocational Plan;
3. On-the-job Training and Skill Development;
4. Job-seeking Skills Training (JSST);
5. Job Development and Placement;
6. Job Coaching;
7. Individualized job supports, which may include regular contact with the employers, family members, guardians, advocates, treatment providers, and other community supports;
8. Benefits Planning;
9. General consultation, advocacy, building and maintaining relationships with employers;
10. Time unlimited individualized vocational support.

IPS-SE will follow all components of the definition of CIE, including:

1. Compensating at or above minimum wage and comparable to the customary rate paid by the employer to employees without disabilities performing similar duties and with similar training and experience;
2. Receiving the same level of benefits provided to other employees without disabilities in similar positions;
3. Located where the employee interacts with other individuals without disabilities; and
4. Presenting opportunities for advancement similar to other employees without disabilities in similar positions.

IPS-SE provides CIE job options with permanent status rather than temporary or time-unlimited status. Jobs that anyone can apply for and are not set aside for people with disabilities. Payment will be made only for the adaptations, supervision, and training required by participants receiving IPS-SE services and will not include

payment for the supervisory activities rendered as a normal part of the business setting.

IPS-SE services furnished under the 1915(i) RISE Initiative service are not available under a program funded by either the Rehabilitation Act of 1973 the IDEA (20 U.S.C. 1400 et seq). Documentation will be maintained in the file of each participant receiving this service that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1400 et seq).

FFP may not be claimed for incentive payments, subsidies, or unrelated vocational training expenses including the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for vocational training that is not directly related to a participant's supported employment program. All supported employment services must be prior authorized.

Extended services are available to a participant once they are employed and are provided periodically to address work-related issues as they arise (e.g., understanding employer leave policies, scheduling, time sheets, tax withholding, etc.). Ongoing follow-along support may also involve assistance to address issues in the work environment, including accessibility, career advancement, and employee – employer relations. Services are designed to identify any problems or concerns early and to provide the best opportunity for long lasting work opportunities.

Also included are supports to address any barriers that interfere with employment success/maintaining employment, including providing support to the employer.

The person-centered individualized care plan will be developed based on the participant’s needs with respect to telehealth or in person to ensure proper monitoring for the health and safety of the participant.

Telehealth includes real-time, two-way communication between the service provider and the participant. Telehealth is limited to check-ins (e.g., reminders, verbal cues, prompts) and consultations (e.g., counseling, problem solving) within the scope of services.

To respect the privacy of the participant, telehealth will be elected on behalf of the participant, and whenever feasible, on an agreed-upon schedule, that ensures protection of the participant’s personal space and activities.

Telehealth will allow for more flexibility for the participant to participate, allows for less-disruption in the setting, therefore allowing for integration more fully into the community and/or educational setting.

The telehealth service may be rendered either in tandem with a caregiver, personal assistant, or other support person(s) when physical assistance is required or may be rendered in the absence of additional support person(s) when appropriate utilizing assistive technology tools to deliver services.

Participants that require assistance utilizing the technology necessary for telehealth delivery of service will be considered for eligibility for assistive technology (AT). Education and training for the participant and family, guardian, and/or provider staff to aid the participant in the use of the AT is incorporated as a service of AT

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

[X] Categorically needy *(specify limits):*

IPS-SE is limited to four hundred and eighty (480) fifteen (15) minute units per 180-day authorization period. Any additional time within that 180-day period must be authorized as an exception.
IPS-SE services are to be rendered consistent with frequency, duration, and scope recommended by the participant's PCSP. IPS-SE may be a standalone service provided in conjunction with case management services.

Supported Employment Services may be provided to the participant in-person, telephonically, or through video communications (in-person service delivery preferred).
Supported Employment Services may not be provided in a group setting and may not be duplicated by any other services provided through the Home & Community Based Services 1915(i) RISE Initiative.

Services do not include payment for the supervisory activities rendered as a normal part of the business setting.

Services do not include payment for supervision, training, support, and adaptations typically available to other non-disabled workers filling similar positions in the business.

Services do not include adaptations, assistance, and training used to meet an employer's responsibility to fulfill requirements for reasonable accommodations under the Americans with Disabilities Act.

Transportation to and from the work site may be a component of - and the cost of this transportation may be included in - the rate paid to providers unless the participant can access public transportation or has other means of transportation available to them. If public transportation is available, then it should be utilized by the participant, if at all possible.

Documentation must be maintained for each participant receiving this service that the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973, relating to vocational rehabilitation services, or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.), relating to special education.

Services will not be reimbursed for job placements paying below minimum wage.

Services must be delivered in a manner that supports and respects the participant's communication needs including translation services, assistance with, and use of communication devices.

Services must be provided in regular integrated settings and do not include sheltered work or other types of vocational services in specialized facilities, or incentive payments, subsidies, or unrelated vocational training expenses, which includes the following:

1. Incentive payments made to an employer to encourage hiring the participant;
2. Payments that are passed through to the participant;
    a. Payments for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business; or
    b. Payments used to defray the expenses associated with starting up or operating a business.

[ ] Medically needy *(specify limits):*

N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
1915(i) RISE Initiative Provider Agency that meets the minimum eligibility and standards for DMS provider enrollment.	N/A	Certified by the DMS or its designee	The agency must meet certified 1915(i) RISE Initiative service provider qualifications as defined in 907 KAR 16:015. To be an IPS-SE 1915(i) RISE Initiative qualified provider, the provider must: 5. Be an approved vendor through Office of Vocational Rehabilitation 6. Provide the evidence-based practice of IPS-SE through training and technical assistance provided by state IPS SE Trainers 7. Participate in fidelity reviews required by the developer of the practice 8. Complete Supported Employment core training offered through UK-Human Development Institute Agency staff who come into direct contact with 1915(i) RISE Initiative service participants must meet the following qualifications: 1. Be at least eighteen (18) years of age. 2. Completes Department-approved, service-specific training and is monitored for competency on topics including, but not limited to: situational de-escalation, abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered principles. 3. Any additional trainings required by the state behavioral health authority and training on accreditation standards required by the state, which may include: a. Risk assessment, suicide prevention and suicide response; b. Roles of families and peers; and c. Other trainings required by the state or accrediting agency 4. Has the ability to: a. Communicate effectively with a participant in the

			participant's preferred manner of communication and with the participant's family; b. Read, understand, and implement written and oral instructions; c. Perform required documentation; d. Participate as a member of the participant's person-centered team if requested by the participant; and 5. Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant's PCSP. 6. Undergoes pre-employment screenings. 7. If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable State laws while operating the vehicle.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
1915(i) RISE Initiative Provider Agency that meets the minimum eligibility and standards for DMS provider enrollment.	Certified by DMS or its designee	Initially, and every two-years (or more frequently if necessary)

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	X	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Case Management

Service Definition (Scope)*:*

Case management is defined as services furnished to assist participants in gaining access to needed medical, social, educational, and other recovery support services that do not conflict or are not duplicative of case management services that a participant already receives. Kentucky Administrative Regulations (907 KAR 15:060) states that the department shall not pay for targeted case management services which duplicate services provided by another public agency or private entity.

Case management involves working with the participant, the participant's legal guardian, others who the

participant identifies, such as immediate family member(s), and service providers in developing and documenting a Person-centered Service Plan (PCSP). Using a person-centered planning process, case managers assist in identifying and implementing support strategies to enable the PCSP to advance the participant's identified goals while meeting assessed community-based needs. Support strategies incorporate the principles of empowerment, community inclusion, health and safety assurances, and the use of paid, unpaid, and community supports. Case managers adhere to person-centered principles during all planning, coordination, and monitoring activities.

Case managers work closely with the participant to assess the participant's needs, outcomes, services, available resources, and overall satisfaction with services and processes. Case managers ensure that participants have freedom of choice of providers.

Case management activities include face-to-face, telehealth, telephonic, and other methods of communication that provide coordination and oversight, which assure the following:

1. Ongoing access to conflict-free options counseling to select appropriate services to meet identified needs and goals, along with education about available service providers;
2. The desires and needs of the participant are determined through a person-centered planning process;
3. The development and/or review of the PCSP, including monitoring of the effectiveness of the PCSP to advance person-centered goals and objectives and respond to changes in participant goals and objectives;
4. The coordination of multiple services and/or among multiple providers, to include other service-specific plans (e.g., housing supports plan) where appropriate;
5. Linking 1915(i) RISE Initiative service participants to services that support their home and community-based needs;
6. Addressing problems in and barriers to service provision;
7. Implementing participant crisis mitigation plans and making appropriate referrals to address active or potential crisis;
8. Detecting, reporting, and mitigating suspected abuse, neglect, and exploitation of participants, including adherence to mandatory reporter laws, and monitoring the quality of the supports and services;
9. Assisting participant in developing and coordinating access to social networks to promote community inclusion as requested by the participant;
10. Assess the quality of services, safety of services, and cost effectiveness of services being provided to a participant in order to ensure that implementation of the participant's PCSP is successful and done so in a way that is efficient regarding the participant's financial assets and benefits; and
11. Routinely assess participant's progress towards achieving the goals identified in the PCSP as well as the participant's readiness to transition to a lower level of care or less restrictive residential setting.
12. Performing advocacy activities on behalf of the client.
13. Providing Social Security Income/Social Security Disability Income (SSI/SSDI) Outreach, Access, and Recovery (SOAR) to assist participants with accessing Social Security disability benefits, when applicable.

Activities are documented and plans for supports and services are reviewed by the case manager at least annually and more often as needed using the person-centered planning processes.

The provision of case management services will not restrict a participant's free choice of providers in violation of section 1902(a) (23) of the Social Security Act (Title XIX) Act.

1. Eligible participants will have free choice of the providers of case management services.
2. Eligible participants will have free choice of the providers of other behavioral health care and medical care under the plan.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

X	Categorically needy *(specify limits):*
	This service is limited to one unit per participant, per calendar month. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose, such as Targeted Case Management. The following activities are excluded from case management as a billable 1915(i) RISE Initiative service: 1. Travel time incurred by the Case Manager may not be billed as a discrete unit of service; 2. Representative payee functions; and 3. Other activities identified by DMS
	Medically needy *(specify limits):*
	N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
1915(i) RISE Initiative Provider Agency that meets the minimum eligibility and standards for DMS provider enrollment.	N/A	Certified by DMS or its designee.	The agency must meet certified 1915(i) RISE Initiative service provider qualifications as defined in 907 KAR 16:015. Providers responsible for developing the Person-Centered Service Plan shall be required to meet the following minimum requirements: ▪ Bachelor's degree in Behavioral Health/Human Services **OR** ▪ Bachelor's degree in any field not closely related **AND** one (1) year of human services related experience, **OR** ▪ An associate degree in a behavioral science, social science, or a closely related field **AND** two (2) years human services related experience, **OR** ▪ Three (3) years of human services related experience. Relevant fields of study may include: • Social Work • Psychology • Rehabilitation • Nursing • Counseling • Education

			• Gerontology • Human Services • Sociology **Human Services Related experience may include:** ▪ Experience as a case manager or in a related human services field. ▪ Certified Nursing Assistant experience ▪ Certified Medical Assistant experience ▪ Certified Home Health Aide experience ▪ Personal Care Assistant experience ▪ Paid professional experience with aging and/or disabled populations or programs as a Case Manager, a Rehabilitation Specialist or Health Specialist, and/or Social Services Coordinator. ▪ Assessment and care planning experience with clients ▪ Experience in working directly with persons with serious mental illness and/or substance use disorder. ▪ Work providing assistance to individuals and groups with issue such as economically disadvantaged, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural. • Is a registered nurse, OR • Is a licensed clinical social worker, licensed marriage and family therapist, licensed professional clinical counselor, licensed psychologist, or licensed psychological practitioner. Agency staff who come into direct contact with 1915(i) RISE Initiative service participants must meet the following qualifications: 1. Be at least eighteen (18) years of age. 2. Completes Department-approved, service-specific training and is monitored for competency on topics including, but not limited to: situational de-escalation, abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered principles. 3. Any additional trainings required by the state behavioral health authority and training on accreditation standards required by the state, which may include:

			a. Risk assessment, suicide prevention and suicide response; b. Roles of families and peers; and c. Other trainings required by the state or accrediting agency 4. Has the ability to: a. Communicate effectively with a participant in the participant's preferred manner of communication and with the participant's family; b. Read, understand, and implement written and oral instructions; c. Perform required documentation; d. Participate as a member of the participant's person-centered team if requested by the participant; and 5. Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant's PCSP. 6. Undergoes pre-employment screenings. 7. If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable State laws while operating the vehicle.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
1915(i) RISE Initiative Provider Agency that meets the minimum eligibility and standards for DMS provider enrollment.	Certified by DMS or its designee.	Initially and every two-years (or more frequently if necessary)

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	X	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Planned Respite for Caregivers

Service Definition (Scope):

Planned Respite for Caregivers (i.e., "Respite") is a service that provides temporary relief from care giving to the primary caregiver of a participant during times when the participant's primary caregiver would normally provide care.

Respite is considered an essential service to assist the participant and their family to prevent institutionalization. Respite services are intended to assist in maintaining a goal of living in a natural community home and are provided on a short-term, intermittent basis to relieve the participant's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work elsewhere full time.

Routine respite services include hourly, daily, and overnight support. Decisions about the methods and amounts of respite should be decided during the development of the Person-Centered Service Plan (PCSP) to ensure the health, welfare, and safety of the participant.

Kentucky will prior authorize respite services, and case managers shall be responsible for assisting participants in identifying and accessing other natural supports or supports available through other available funding streams if their needs exceed the service limit.

Respite services are available to participants who are residing in their family home (biological or kin) or legal guardian's home. Respite must be offered contingent upon the willingness of the participant to engage in the respite activity and may not be offered at a service against a participant's will or under duress that would impede the participant's autonomy in personal decision-making.

Respite may be provided in the following settings:

1. Participant's home or place of residence
2. Provider owned or controlled facility approved by the State that is not a private residence (e.g., supervised residential home or licensed respite care facility)
3. Home of a friend or relative chosen by the participant and members of the planning team
4. In community (social/recreational) settings

Respite services may not be provided by:

1. Participant's primary caregiver
2. Participant's legal guardian

Cost of room and board must not be included as part of the respite service unless provided as part of the respite care in a facility that is not a private residence.

Respite service activities include:

1. Assistance with daily living skills
2. Assistance with accessing/transporting to / from community activities
3. Assistance with grooming and personal hygiene
4. Assistance with meal preparation, serving, and cleanup
5. Administration of medications as needed
6. Supervision as needed to ensure the participant's health and safety
7. Recreational and leisure activities

This service includes activities that facilitate the participant's inclusion in community activities, use of natural supports and typical community services available to all people, social interaction, and participation in leisure activities, and development of socially valued behaviors and daily living and functional living skills.

Respite is provided for the planned or emergency short-term relief for natural, unpaid caregivers. Respite is provided intermittently when the natural caregiver is temporarily unavailable to provide supports based on

routine or typical patterns of caregiving timing, duration and scope of support, as recorded by the participant's case manager in his or her PCSP.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

[X] Categorically needy *(specify limits):*

Respite services shall not exceed 21 hours per month, or 200 hours annually without authorization. Respite is not a stand-alone service and must be provided in conjunction with other treatment services.

Respite services may only be provided in-person. Reimbursement for respite care shall not be available for services rendered via telehealth.

Transportation costs associated with the respite service are included in the respite rate. Providers may not bill for 1915(i) transportation to a respite service site.

[ ] Medically needy *(specify limits):*

N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
1915(i) RISE Initiative Provider Agency that meets the minimum eligibility and standards for DMS provider enrollment.	N/A	Certified by DMS or its designee	The agency must meet certified 1915(i) RISE Initiative service provider qualifications as defined in 907 KAR 16:015. Agency staff who come into direct contact with 1915(i) RISE Initiative service participants must meet the following qualifications: 1. Be at least eighteen (18) years of age. 2. Completes Department-approved, service-specific training and is monitored for competency on topics including, but not limited to: situational de-escalation, abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered principles. 3. Any additional trainings required by the state behavioral health authority and training on accreditation standards required by the state, which may include:

			a. Risk assessment, suicide prevention and suicide response; b. Roles of families and peers; and c. Other trainings required by the state or accrediting agency 4. Has the ability to: a. Communicate effectively with a participant in the participant's preferred manner of communication and with the participant's family; b. Read, understand, and implement written and oral instructions; c. Perform required documentation; d. Participate as a member of the participant's person-centered team if requested by the participant; and 5. Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant's PCSP. 6. Undergoes pre-employment screenings. 7. If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable State laws while operating the vehicle.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
1915(i) RISE Initiative Provider Agency that meets the minimum eligibility and standards for DMS provider enrollment.	Certified by DMS or its designee.	Initially and every two-years (or more frequently if necessary)

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	X	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Medication Management

Service Definition (Scope):

Medication Management is intended to support program participants adherence to, and implementation of medication regimens (e.g., the appropriateness of the medications that a person receives), with the participant in a person-centered manner. Medication Management is provided by licensed individuals and includes face-to-face contact with the participant, in an individual setting, for the purpose of monitoring a participant's medication adherence, providing education and training about medications, monitoring, and offering support to assist a participant experiencing medication side effects, and providing other nursing or behavioral health and medical assessments. The goal of this service in the 1915(i) RISE Initiative State Plan Amendment is to provide the information, training, and empowerment necessary for a participant to make an informed decision about their medication regimen.

Identified barriers and challenges to medication autonomy will be reflected in the participant's Person-Centered Service Plan (PCSP) by the case manager and may be amended as situations change. Changes to the PCSP should reflect the progression of a participant to less restrictive service delivery to promote progress towards self-identified goals. Medication Management services must be determined by a participant's PCSP, in which the participant had explicit input, and, at a minimum, include:

1. Medication Training and Support that demonstrate movement toward and/or achievement of participant-driven treatment goals identified in the PCSP.
2. Medication Training and Support goals that are habilitative in nature
3. Documentation must support how the service benefits the participant and / or addresses individualized risks for ongoing health and safety that are linked to the participants' medication

Medication Training and Support includes the following services:

1) Setting or filling medication boxes.
2) Consulting with the attending physician or AHCP regarding medication-related issues.
3) Ensuring linkage that lab and/or other prescribed clinical orders are sent.
4) Ensuring that the participant follows through and receives lab work and services pursuant to other clinical orders.
5) Follow up reporting of lab and clinical test results to the participant and physician.
6) Support for the participant, including:
   a) In-person contact with the participant, in an individual setting, for the purpose of monitoring a participant's medication adherence;
   b) Providing education and training about medications;
   c) Offering support to assist a participant experiencing medication side effects; or
   d) Providing other nursing or behavioral health and medical assessments

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

X	Categorically needy *(specify limits):*
	Medication Training and Support service including all subtypes (individual, group, family/couple, with and without participant present) may be provided for a maximum of 182 hours (728 15-minute units) per year. Additional entities, including CMHCs may offer this service after meeting the training and regulation criteria to provide Medication Training and Support.
	Exclusions:

If a participant receives medication management via In-Home Independent Living Supports or Supervised Residential Care, then Medication Management services may not be billed separately for the same visit by the same provider.

These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with 1915(i) RISE Initiative objectives of avoiding institutionalization.

☐ Medically needy *(specify limits):*

N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
1915(i) RISE Initiative Provider Agency that meets the minimum eligibility and standards for DMS provider enrollment.	N/A	Certified by DMS or its designee.	Medication management shall be provided by a pharmacist, medical doctor, physician assistant, advanced practice registered nurse, a registered nurse as defined in KRS 314.011(5), or a licensed practical nurse as defined in KRS 314.011(9) under the supervision of a registered nurse. Medication Management may be provided by an Allied Health Care Professional when it is provided as a service within In-Home Independent Living Supports or Supervised Residential Care 1) "Allied health care professional" or "AHCP" means an individual who provides support in a residential setting, including a: a) Certified nursing assistant; b) Medication aide; c) Licensed practical nurse; or d) Registered nurse. The agency must meet certified 1915(i) RISE Initiative service provider qualifications as defined in 907 KAR 16:015. Agency staff who come into direct contact with 1915(i) RISE Initiative service participants must meet the following qualifications: 1. Be at least eighteen (18) years of age. 2. Completes Department-approved, service-specific training and is monitored for competency on topics including, but not limited to: situational de-escalation, abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered principles. 3. Any additional trainings required by the state behavioral health authority

			and training on accreditation standards required by the state, which may include: a. Risk assessment, suicide prevention and suicide response; b. Roles of families and peers; and c. Other trainings required by the state or accrediting agency 4. Has the ability to: a. Communicate effectively with a participant in the participant's preferred manner of communication and with the participant's family; b. Read, understand, and implement written and oral instructions; c. Perform required documentation; d. Participate as a member of the participant's person-centered team if requested by the participant; and 5. Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant's PCSP. 6. Undergoes pre-employment screenings. 7. If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable State laws while operating the vehicle.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
1915(i) RISE Initiative Provider Agency that meets the minimum eligibility and standards for DMS provider enrollment.	Certified by DMS or its designee.	Initially, and every two-years (or more frequently if necessary)

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	X	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Assistive Technology (AT)

Service Definition (Scope)*:*

Assistive Technology (AT) is any item, piece of equipment, software program, or product system that is used to increase, maintain, or improve the independence and functional capabilities of persons with disabilities in education, employment, recreation, and daily living activities. By augmenting strengths and providing an alternative mode of performing tasks, AT enhances all aspects of life and can be used to ensure the health, welfare, and safety of the participant.

AT ranges from low tech to high tech devices or equipment. AT includes the services necessary to get and use the devices, including assessment, customization, repair, and training.

AT services and supports include the following:

1. The cost of the AT, including; purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants.
2. Consultation and assessment to identify and address the participant's needs as specified in the Person-Centered Service Plan (PCSP) and/or other supporting documentation.
3. Individual and small group demonstration and exploration of devices to increase awareness and knowledge of what is available.
4. Individual consultations to support device trials and assist in appropriate device selection.
5. Individual and small group training on a specific device to support proper use.
6. Education and training for the participant and family, guardian, and/or provider staff to aid the participant in the use of the AT.
7. Maintenance and repair of AT.
8. One-time implementation training per order if needed and not provided by the vendor as part of delivery and installation. Additional therapy-related training should be recommended by the doctor/ evaluator as appropriate.

All items must meet applicable standards of manufacture, design, and installation and must be of direct benefit to the participant.

This service is provided to participants aged 21 and over. All medically necessary AT services for children under age 21 are covered in the state plan pursuant to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit.

Funding for AT through service is available only after benefits available through Medicaid, Medicare, or other third-party resources have been confirmed and documented as exhausted.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Additional needs-based criteria include the following:

The need for AT must be identified in the participant's PCSP.

Recommendations of AT (both services and goods) that exceed $300.00 or more must be ordered by one of the following:

1. Licensed Physician, Physician's Assistant (PA), or Advanced Practice Registered Nurse (APRN)
2. Licensed Psychiatrist
3. Licensed Audiologist
4. Licensed Physical Therapist (PT), Occupational Therapist (OT), or Speech Therapist (ST)
5. Licensed Psychologist, Licensed Professional Counselor (LPC), Licensed Clinical Social Worker (LCSW), or Licensed Marriage and Family Therapist (LMFT)

6. RESNA ATP (Rehabilitation Engineering and Assistive Technology Society of North America Assistive Technology Professional)
7. Other qualified professionals whose signature indicates approval

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

[X] Categorically needy *(specify limits):*

The annual cap is $10,000 per participant, per year. Should a participant require AT after the cost limit has been reached, the participant's case manager should assist them with accessing other resources or alternate funding sources that may be available.

[ ] Medically needy *(specify limits):*

N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
1915(i) RISE Initiative Provider Agency that meets the minimum eligibility and standards for DMS provider enrollment.	N/A	Certified by DMS or its designee.	The agency must meet certified 1915(i) RISE Initiative service provider qualifications as defined in 907 KAR 16:015. Agency staff who come into direct contact with 1915(i) RISE Initiative service participants must meet the following qualifications: 1. Be at least eighteen (18) years of age. 2. Completes Department-approved, service-specific training and is monitored for competency on topics including, but not limited to: situational de-escalation, abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered principles. 3. Any additional trainings required by the state behavioral health authority and training on accreditation standards required by the state, which may include: a. Risk assessment, suicide prevention and suicide response; b. Roles of families and peers; and

			c. Other trainings required by the state or accrediting agency 4. Has the ability to: a. Communicate effectively with a participant in the participant's preferred manner of communication and with the participant's family; b. Read, understand, and implement written and oral instructions; c. Perform required documentation; d. Participate as a member of the participant's person-centered team if requested by the participant; and 5. Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant's PCSP. 6. Undergoes pre-employment screenings. If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable State laws while operating the vehicle.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
1915(i) RISE Initiative Provider Agency that meets the minimum eligibility and standards for DMS provider enrollment.	Certified by DMS or its designee.	Initially and every two-years (or more frequently if necessary)

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	X	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Non-Medical Transportation

Service Definition (Scope)*:*

Non-Medical Transportation is a service offered to aid participants in gaining access to 1915(i) RISE Initiative services and other community services, activities, and resources, as specified by their Person-Centered Service

Plan (PCSP). This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the state plan, defined at 42 CFR §440.170(a) (if applicable), and does not replace them.

Non-Medical Transportation services under the 1915(i) RISE Initiative are offered in accordance with the participant's care plan and must support the participant with PCSP goal advancement and/or attainment. Whenever possible, natural supports, which can provide this service without charge should be exhausted, with 1915(i) RISE Initiative funded transportation being accessible as a last resort.

Non-Medical Transportation Services are for non-medical transportation needs related to goals identified in the PCSP and are mutually exclusive of State Plan medical transportation services. Non-Medical Transportation services defined within this 1915(i) RISE Initiative refer to transportation needs not covered under the provision of other services listed in this 1915(i) RISE Initiative, and those not currently covered under Non-Emergency Medical Transportation (NEMT). Contracted providers are required to provide and document service provision in accordance with program policies and procedures and billing guidelines. Documentation requirements for Non-Medical transportation include date of contact; mileage log with start and stop time; printed name of service provider; location of origination and destination; and signature and credentials of service provider.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

[X] Categorically needy *(specify limits):*

Service limited to $2500 per year.

Documentation must support that claims for Non-Medical transportation are not duplicative or inclusive of transportation provided as part of another service, including other state plan transportation benefits.

1. System edits will be in place to prevent duplicative billing.
2. All Medicaid transportation services will be coordinated by the participant's case manager and the relevant full-risk broker or managed transportation organization in the client's area.
3. The state Medicaid authority has final authority over approval of claims.
4. The state will perform periodic review of claims data to check for duplicative claims.
5. Where duplicative claims are found, the State will recoup claims payment.

The participant's service limit of $2500 is not Medicaid reimbursable for ride sharing applications.

[ ] Medically needy *(specify limits):*

N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
1915(i) RISE Initiative Provider Agency that meets the minimum eligibility and standards for DMS provider enrollment.	N/A	Certified by DMS or its designee	The agency must meet certified 1915(i) RISE Initiative service provider qualifications as defined in 907 KAR 16:015. Agency staff who come into direct contact with 1915(i) RISE Initiative service participants must meet the following qualifications: 1. Be at least eighteen (18) years of age.

			2. Completes Department-approved, service-specific training and is monitored for competency on topics including, but not limited to: situational de-escalation, abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered principles. 3. Any additional trainings required by the state behavioral health authority and training on accreditation standards required by the state, which may include: a. Risk assessment, suicide prevention and suicide response; b. Roles of families and peers; and c. Other trainings required by the state or accrediting agency 4. Has the ability to: a. Communicate effectively with a participant in the participant's preferred manner of communication and with the participant's family; b. Read, understand, and implement written and oral instructions; c. Perform required documentation; d. Participate as a member of the participant's person-centered team if requested by the participant; and 5. Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant's PCSP. 6. Undergoes pre-employment screenings. 7. If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable State laws while operating the vehicle.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:		
Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
1915(i) RISE Initiative Provider Agency that meets the minimum eligibility and standards for DMS provider enrollment.	Certified by DMS or its designee	Initially, and every two-years (or more frequently if necessary)

Service Delivery Method. *(Check each that applies)*:			
	Participant-directed	X	Provider managed

2. ☐ **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the state assures that):* There are policies pertaining to payment the state makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the state makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the state ensures that the provision of services by such persons is in the best interest of the individual; (d) the state's strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

Election of Participant-Direction. (Select one):

☑	The state does not offer opportunity for participant-direction of State plan HCBS.
○	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. *(Specify criteria):*

1. **Description of Participant-Direction.** *(Provide an overview of the opportunities for participant-direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

2. **Limited Implementation of Participant-Direction.** *(Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to state wideness requirements. Select one):*

○	Participant direction is available in all geographic areas in which State plan HCBS are available.
○	

○	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the state. Individuals who reside in these areas may elect self-directed service delivery options offered by the state, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (*Specify the areas of the state affected by this option)*:

3. Participant-Directed Services. *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
	☐	☐
	☐	☐

4. Financial Management. (*Select one):*

○	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
○	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

5. ☐ **Participant–Directed Person-Centered Service Plan.** *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and: Specifies the State plan HCBS that the individual will be responsible for directing; Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget; Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual; Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and specifies the financial management supports to be provided.

6. Voluntary and Involuntary Termination of Participant-Direction. *(Describe how the state facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

7. Opportunities for Participant-Direction

a. Participant–Employer Authority *(individual can select, manage, and dismiss State plan HCBS providers). (Select one):*

○	The state does not offer opportunity for participant-employer authority.
○	Participants may elect participant-employer Authority *(Check each that applies):*

	☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
	☐	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. Participant–Budget Authority *(individual directs a budget that does not result in payment for medical assistance to the individual). (Select one):*

○	The state does not offer opportunity for participants to direct a budget.
○	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.):*
	Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards.*

Quality Improvement Strategy

Quality Measures

(Describe the state's quality improvement strategy. For each requirement, and lettered sub-requirement, complete the table below):

1. Service plans a) address assessed needs of 1915(i) participants; b) are updated annually; and (c document choice of services and providers.

2. Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.

3. Providers meet required qualifications.

4. Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).

5. The SMA retains authority and responsibility for program operations and oversight.

6. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.

7. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.

(Table repeats for each measure for each requirement and lettered sub-requirement above.)

Requirement #1	Person-centered service plans (PCSPs) a) address assessed needs of 1915(i) RISE Initiative participants; b) are updated annually; and c) document choice of services and providers.
Discovery	
Discovery Evidence *(Performance Measure)*	1. **Clinical and Support needs:** Percent of PCSPs that contain the clinical and support needs necessary to address assessed needs. N = Number of PCSPs that contain the clinical and support needs necessary to address assessed needs. D = Number of PCSPs. 2. **Strengths and Preferences:** Percent of PCSPs that address the person's strengths and preferences. N = Number of PCSPs that address the person's strengths and preferences. D = Number of PCSPs. 3. **Goals and Desired Outcomes:** Percent of PCSPs that reflect the person's goals and desired outcomes. N = Number of PCSPs that reflect the person's goals and desired outcomes. D = Number of PCSPs. 4. **Services and Supports:** Percent of PCSPs with services and supports that will assist to achieve the identified goals. N = Number of PCSPs with services and supports that will assist to achieve the identified goals. D = Number of PCSPs. 5. **Traditional Medicaid State Plan Services:** Percentage of PCSPs that document the exploration of state plan services. N = Number of PCSPs with state plan service exploration. D = Number of PCSPs. 6. **Annual Updates:** Percent of participants whose PCSPs were updated and submitted within one year of their initial or last assessment. N = Number of participants whose PCSPs were updated and submitted within one year of their initial or last assessment. D = Number of PCSPs.

	7. **Individual Choice:** Percent of participant records indicating participant has been given choice of 1915(i) RISE Initiative services and choice between eligible 1915(i) RISE Initiative providers. N = Number of PCSPs indicating participant has been given choice of and choice between eligible 1915(i) RISE Initiative providers. D = Number of current approved PCSPs.
Discovery Activity *(Source of Data & sample size)*	1. **Data Sources:** Records Review, Off-Site: Review of PCSPs and other documentation in the Medicaid Waiver Management Application and claims data from Medicaid Management Information System (MMIS). **Sampling Approach:** Representative sample with a confidence interval of 95 percent.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency / Other State Operating Agency
Requirement #1 (cont.)	PCSPs a) address assessed needs of 1915(i) RISE Initiative participants; b) are updated annually; and c) document choice of services and providers.
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	State Medicaid Agency / Other State Operating Agency
Frequency *(of Analysis and Aggregation)*	Annually

Requirement #2	Eligibility Requirements: (a) an evaluation for 1915(i) RISE Initiative eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) RISE Initiative services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) RISE Initiative eligibility are applied appropriately; and (c) the 1915(i) RISE Initiative benefit eligibility of enrolled participants is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) RISE Initiative HCBS.
Discovery	
Discovery Evidence *(Performance Measure)*	1. **Evaluation of Eligibility**: Number and percent of new applicants who had a face-to-face evaluation for eligibility prior to enrollment. N = Number of new applicants who had a face-to-face evaluation for eligibility prior to enrollment. D = Total number of new applicants who had an evaluation prior to enrollment.

	2. **Correct Application:** Number and percent of InterRAI Community Mental Health assessments completed according to policy. N = Number of applicants who had a face-to-face InterRAI Community Mental Health assessment completed (within 30 days of application submission) for eligibility prior to enrollment. D = Total number of new applicants who had an InterRAI Community Mental Health assessment completed prior to enrollment. 3. **Re-evaluation of Eligibility:** Number and percent of enrolled participants re-evaluated at least annually or more frequently, as specified in the approved 1915(i) RISE Initiative benefit. N = Number of re-evaluations completed for enrolled participants during the review period. D = Total number of enrolled participants due for re-evaluation during the review period.
Discovery Activity *(Source of Data & sample size)*	1. **Data Sources:** Records Review, Off-Site: Medicaid Waiver Management Application. **Sampling Approach:** Representative sample with a confidence interval of 95 percent.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency / Other State Operating Agency
Requirement #2 (cont.)	Eligibility Requirements: (a) an evaluation for 1915(i) RISE Initiative HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) RISE Initiative services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) RISE Initiative eligibility are applied appropriately; and (c) the 1915(i) RISE Initiative benefit eligibility of enrolled participants is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) RISE Initiative HCBS.
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	State Medicaid Agency / Other State Operating Agency
Frequency *(of Analysis and Aggregation)*	Annually

Requirement #3	Providers meet required qualifications.
Discovery	
Discovery Evidence *(Performance Measure)*	1. **New Providers:** Percent of new provider agencies that meet initial certification and licensure requirements and adhere to other standards prior to the furnishing of 1915(i) RISE Initiative services.

	N = Number of new provider agencies who meet initial certification and licensure requirements and adhere to other standards prior to furnishing services. D = Number of new providers. 2. **Ongoing Review:** Percent of enrolled provider agencies who continue to meet certification and licensure requirements and adhere to other standards following initial enrollment as required to continue to render 1915(i) RISE Initiative services. N = Number of enrolled provider agencies who continue to meet certification and licensure requirements and adhere to other standards following initial enrollment as required to continue to render 1915(i) RISE Initiative services. D = Number of enrolled providers. 3. **Mandatory Training:** Percent of providers agencies in which 85% of staff have successfully completed mandatory training in accordance with state requirements and the approved 1915(i) RISE Initiative. N = Number of provider agencies in which 85% of staff have successfully completed mandatory training in accordance with state requirements and the approved 1915(i) RISE Initiative. D = Total number of providers.
Discovery Activity *(Source of Data & sample size)*	1. **Data Sources:** Other – Provider Quality Monitoring. **Sampling Approach:** 100% Review. 2. **Data Sources:** Other – Provider Records; **Sampling Approach:** 100% Review. 3. **Data Sources:** Other – Combination of Onsite interviews, observations, monitoring, Desk review of records depending on the type of service and whether services are provided onsite or at the participant's place of residence. **Sampling Approach:** Representative sample with a confidence interval of 95 percent.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency / Other State Operating Agency

Requirement #3 (cont.)	Providers meet required qualifications.
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	State Medicaid Agency / Other State Operating Agency
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	Settings meet the home and community-based setting requirements as specified in this SPA and

#4	in accordance with 42 CFR 441.710(a)(1) and (2).
Discovery	
Discovery Evidence *(Performance Measure)*	1. **Settings Requirements:** Number and percent of HCBS settings meeting appropriate licensure or certification and Federal HCBS requirements. N= the number of participants who are residing in settings that meet the HCBS settings requirements initially and ongoing. D= Total number of participants reviewed.
Discovery Activity *(Source of Data & sample size)*	Representative sample, with a confidence level of 95 percent, of provider agencies, on- site reviews, and report of case manager.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency / Other State Operating Agency
Requirement #4 (cont.)	Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	State Medicaid Agency / Other State Operating Agency
Frequency *(of Analysis and Aggregation)*	Annually

Requirement #5	The SMA retains authority and responsibility for program operations and oversight.
Discovery	
Discovery Evidence *(Performance Measure)*	1. **Provider Agreement:** Percent of providers with a current approved provider agreement on file. N=The number of providers with a current approved provider agreement on file. D=The number of enrolled providers.
Discovery Activity *(Source of Data & sample size)*	1. **Data Sources:** Records Review, Off-Site: Medicaid Partner Portal System **Sampling Approach:** 100% Review

Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency / Other State Operating Agency
Requirement #5 (cont.)	The SMA retains authority and responsibility for program operations and oversight.
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	State Medicaid Agency / Other State Operating Agency
Frequency *(of Analysis and Aggregation)*	Annually

Requirement #6	The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) RISE Initiative participants by qualified providers.
Discovery	
Discovery Evidence *(Performance Measure)*	1. **Claims Coded and Claimed:** Number and percent of claims coded and paid for in accordance with the established reimbursement methodology specified in the approved 1915(i) RISE Initiative. N = Number of claims coded and paid in accordance with the established reimbursement methodology in the approved 1915(i) RISE Initiative. D = Number of claims coded and paid. 2. **Claims Submitted and Paid for Service Rendered:** Percent of 1915(i) RISE Initiative service claims submitted and paid for services rendered on the participants plan of care and only for services rendered. N = Number of 1915(i) RISE Initiative service claims that were submitted and paid for services rendered on the participant's plan of care and only for services rendered. D = Number of 1915(i) RISE Initiative service claims submitted and paid.
Discovery Activity *(Source of Data & sample size)*	1. **Data Sources:** Financial Records (including expenditures), Records Review, Offsite. **Sampling Approach**: Representative sample, with a confidence level of 95 percent
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMS and DBHDID
Requirement #6 (cont.)	The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) RISE Initiative participants by qualified providers.

Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	State Medicaid Agency / Other State Operating Agency
Frequency *(of Analysis and Aggregation)*	Annually

Requirement #7	The state identifies, addresses, and seeks to prevent suspected incidents of abuse, neglect, and exploitation, including the use of restraints.
Discovery	
Discovery Evidence *(Performance Measure)*	1. **Reporting and Identifying Abuse:** % of participants (or families/legal guardians) who received info regarding how to identify and report suspected abuse/neglect/exploitation/unexpected death. N = Number participants of (or families/legal guardians) who received info regarding how to identify and report suspected abuse/neglect/exploitation/unexpected death. D = Number of participants. 2. **Abused, Neglect, Exploitations (ANE), and Unexpected Death:** Percent of suspected abuse, neglect, exploitation & unexpected death incident reports submitted in required timeframe. N= Number incident reports of suspected abuse, neglect, exploitation &unexpected death submitted in timeframe. D= Number incident reports of suspected abuse, neglect, exploitation & unexpected death. 3. **Abused, Neglect, Exploitations, and Unexpected Death:** Percent of suspected abuse, neglect, exploitation & unexpected death incidents reviewed/investigated in required timeframe. N= Number of suspected abuse, neglect, exploitation & unexpected death incidents reviewed/investigated in required timeframe. D= Number of suspected abuse, neglect, exploitation & unexpected death incidents received. 4. **Correction Action:** Percent of suspected abuse, neglect, exploitation & unexpected death incidents that impelled the Department to require follow up action by provider (CAP, provider sanctions, etc.) where required action was completed by provider & correction submitted to the Dept. N = Number abuse, neglect, exploitation & unexpected death incidents that impelled the Department to request follow up action by providers, where required action was completed by provider & correction submitted to the Department. D = Number abuse, neglect, exploitation & unexpected death incidents that impelled the Department to request follow up action by providers.

	5. **Investigative Entities:** Percent of suspected abuse/neglect/exploitation/unexpected death incidents referred to appropriate investigative entities (ex: Law Enforcement/APS/CPS) for follow-up. N = Number of suspected abuse/neglect/exploitation/unexpected death incidents referred to appropriate investigative entities (ex: Law Enforce/APS/CPS) for follow-up. D = Number suspected ANE/unexpected death incidents. 6. **Mandatory Training:** Percent of employees who received training on suspected abuse, neglect, exploitation, and preventable deaths. N= Number of employees who received training on suspected A/N/E and preventable deaths. D = Number of employee records. 7. **Root Cause Analysis:** Percent of critical incidents where investigation included root cause analysis. N = Number of critical incidents where investigation included root cause analysis. D = Number of critical incidents received. 8. **Restrictive Policies:** Percent of reported critical incidents where use of restrictive interventions followed policies and procedures. N = Number of reported critical incident reports where use of restrictive interventions followed policies and procedures. D = Number of reported critical incidents listing the use of restrictive interventions.
Discovery Activity *(Source of Data & sample size)*	1. **Data Sources:** Records Review, Off-Site: Medicaid Waiver Management Application acknowledgement page. **Sampling Approach:** Less than 100% Review and Representative Sample with Confidence interval= 95% +/- 5%. 2. **Data Sources:** Records Review, Off-Site: Medicaid Waiver Management Application critical incident reporting module. **Sampling Approach:** 100% Review. 3. **Data Sources:** Records Review, Off-Site: Medicaid Waiver Management Application critical incident reporting module. **Sampling Approach:** 100% Review. Representative Sample - Confidence interval= 95% +/- 5%. 4. **Data Sources:** Records Review, Off-Site: Medicaid Waiver Management Application critical incident reporting module. **Sampling Approach:** 100% Review. Representative Sample - Confidence interval= 95% +/- 5%. 5. **Data Sources:** Records Review, Off-Site: Medicaid Waiver Management Application critical incident reporting module. **Sampling Approach:** 100% Review. Representative Sample - Confidence interval= 95% +/- 5%. 6. **Data Source:** Records Review, Off-Site: Employee Records. **Sampling Approach:** *Less than 100% Review. Representative Sample – Confidence interval=* 95% +/- 5%. 7. **Data Source:** Records Review, Off-Site: Medicaid Waiver Management Application critical incident reporting module. **Sampling Approach:** Less than 100% Review. Representative Sample – Confidence interval=95% +/- 5%. 8. **Data Source:** Records Review, Off-Site: Medicaid Waiver Management Application critical incident reporting module.

	Sampling Approach: Less than 100% Review. Representative Sample – Confidence interval= 95% +/- 5%. 9. **Data Source:** Records Reviews, Off-Site: Medicaid Waiver Management Application and participant surveys. **Sampling Approach:** Less than 100% Review. Representative Sample – Confidence interval= 95% +/- 5%.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency / Other State Operating Agency
Requirement #7 (Cont.)	The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	State Medicaid Agency / Other State Operating Agency
Frequency *(of Analysis and Aggregation)*	Annually

System Improvement

(Describe the process for systems improvement as a result of aggregated discovery and remediation activities.)

1. Methods for Analyzing Data and Prioritizing Need for System Improvement

The data collected provides meaningful insights and informs decisions related to process and systems improvement. The Department has defined its quality-related operational elements including data aggregation, measurement, and reporting activities which promotes consistent, rigorous quality management approaches that are institutionalized within Cabinet operations and culture. The Department determined what data should be collected based on several factors including: relevance to participant health and welfare, reliability of data, importance to the Department operational goals, ease and feasibility of data collection, among other factors. The information collected includes data from: Eligibility determinations; service authorization, service and expenditure reports; individual plans and outcomes; incident reports; consumer surveys; monitoring visits; progress toward achieving corrective action plan goals; and recertification reviews. The Department analyzes the aggregate data based on established performance targets related to each data point. The Department evaluates data collected against these performance targets to identify performance gaps. As gaps are identified, the Department evaluates program-wide data in a manner that enables the Department staff to observe overarching trends and to “drill down” to observe differences among various geographies, subpopulations, etc. so that the Department can begin to understand potential root causes of performance patterns and variation. Subsequently, the Department identifies opportunities to improve operational processes based on performance gaps and trends.

2. Roles and Responsibilities

State Medicaid Agency / Other State Operating Agency

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

3. Frequency

Annually

4. Method for Evaluating Effectiveness of System Changes

The Department continually monitors system design changes by evaluating the performance data pre- and post-implementation of system changes. The Department establishes performance goals when implementing systems redesign and regularly tracks the progress towards meeting these goals. The Department will monitor the implementation of system improvements through regularly schedule meetings, progress towards key milestone, and continuous monitoring of performance measures. The Department reserves the right to increase the frequency or number of measures collected during system change implementation to identify unforeseen impacts of the system change plan. The Department can modify its design changes based on outcomes indicated by its performance data. As new performance gaps arise, the Department prioritizes additional systems changes to address these gaps. The Department or its designee creates reports to track progress of these systems improvements and discusses progress and with the appropriate parties. This process continues as the Department improves its operations to meet its program-wide goals.

The Cabinet is shifting its approach to re-orient its quality management activities from the current compliance focus to one that recognizes the importance of both regulatory compliance and quality improvement to promote improved participant outcomes and other performance improvements. The Department is creating a quality strategy that mirrors this shift in approach. The Department has selected performance measures that allows the Department the ability to understand the effectiveness and quality of its current 1915(i) RISE Initiative operations. The data collected provides meaningful insights and informs decisions related to process and systems improvement. The Department regularly reviews each of its 1915(i) RISE Initiative operations and identifies opportunities to modify existing measures or add measures to appropriately monitor its operational effectiveness. In addition, the Department performs a formal annual review of its quality strategy and revises, as needed.

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Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates*):

☑	HCBS Case Management
	Rate is derived from the Kentucky the 1915(c) HCBS 2024 rate study. KY DMS: The 1915i State Plan HCBS fee schedule is published at: https://www.chfs.ky.gov/agencies/dms/Pages/feesrates.aspx. Room and board is not included in this rate.
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☐	HCBS Adult Day Health
☐	HCBS Habilitation
☐	HCBS Respite Care
☑	For Individuals with Chronic Mental Illness, the following services:
☐	HCBS Day Treatment or Other Partial Hospitalization Services
☐	HCBS Psychosocial Rehabilitation
☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)
☑	Other Services (specify below)
	Supervised Residential Care, In-Home Independent Living Support, Supported Employment, Planned Respite for Caregivers, and Medication Management: In 2024, DMS completed a rate study for the majority of services in the existing 1915(c) waivers. DMS developed cost-based rates that align with federal requirements of "efficiency, economy, and quality of care" (1902(a)30(A) of the Social Security Act). DMS used an independent model approach that relied on provider-reported survey materials as well as public national and state level data including wages from the Bureau of Labor Statistics and health insurance data from the Medical Expenditure Panel Survey to determine direct and indirect costs of providing services. Resulting benchmark rates are currently under Legislative review. For this 1915(i) State Plan Amendment, DMS derived rates from 70% of the identified 1915(c) benchmark rates, as proposed by the Governor and under review by the Legislature, to promote rate parity across populations (i.e., between 1915(c) waivers and the proposed 1915(i) SPA). For cases where the proposed

1915(i) service is exactly the same as a current 1915(c) service, DMS used 70% of the benchmark rate for that 1915(c) service for this 1915(i) SPA. In cases where the services were similar but not exactly the same, DMS used 70% of the benchmark rate for a similar service from the 1915(c) waivers. The table below describes which services from the 1915(c) waivers the Cabinet used to determine rates for the 1915(i).

Service in 1915(i) State Plan Amendment	Corresponding 1915(c) Waiver Service
Supervised Residential Care	Supervised Residential Care, Level I
In-Home Independent Living Support	Supervised Residential Care, Level III
Supported Employment	Supported Employment
Planned Respite for Caregivers	Respite
Medication Management	Nursing Supports

Tenancy Supports, Supported Education, Transportation, and Assistive Technology:
For services not included in the 1915(c) waiver rate study, DMS based rates on similar services in peer states. Given that these are newly offered services in Kentucky with no prior utilization in other populations, DMS relied on peer states that offer similar programs to identify payment rates. DMS will reevaluate rates after utilization data for this program becomes available.

KY DMS: The 1915i State Plan HCBS fee schedule is published at https://www.chfs.ky.gov/agencies/dms/Pages/feesrates.aspx.

Room and board is not included in these rates.

Groups Covered

Optional Groups other than the Medically Needy

In addition to providing State plan HCBS to individuals described in 1915(i)(1), the state may **also** cover the optional categorically needy eligibility group of individuals described in 1902(a)(10)(A)(ii)(XXII) who are eligible for HCBS under the needs-based criteria established under 1915(i)(1)(A) and have income that does not exceed 150% of the FPL, or who are eligible for HCBS under a waiver approved for the state under Section 1915(c), (d) or (e) or Section 1115 (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate. See 42 CFR § 435.219. (*Select one*):

☑ No. Does not apply. State does not cover optional categorically needy groups.

☐ Yes. State covers the following optional categorically needy groups.
(Select all that apply):

(a) ☐ Individuals not otherwise eligible for Medicaid who meet the needs-based criteria of the 1915(i) benefit, have income that does not exceed 150% of the federal poverty level, and will receive 1915(i) services. There is no resource test for this group. Methodology used:
(Select one):

☐ SSI. The state uses the following less restrictive 1902(r)(2) income disregards for this group. (*Describe, if any*):

☐ OTHER (*describe*):

(b) ☐ Individuals who are eligible for home and community-based services under a waiver approved for the State under section 1915(c), (d) or (e) (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate.
Income limit: (*Select one):*

☐ 300% of the SSI/FBR

☐ Less than 300% of the SSI/FBR (*Specify):* _____%

Specify the applicable 1915(c), (d), or (e) waiver or waivers for which these individuals would be eligible: *(Specify waiver name(s) and number(s)):*

(c) ☐ Individuals eligible for 1915(c), (d) or (e) -like services under an approved 1115 waiver. The income and resource standards and methodologies are the same as the applicable approved 1115 waiver.

Specify the 1115 waiver demonstration or demonstrations for which these individuals would be eligible. *(Specify demonstration name(s) and number(s)):*