Andy Beshear
GOVERNOR

CABINET FOR HEALTH AND FAMILY SERVICES

Eric Friedlander
SECRETARY

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June 5, 2025

Senator Stephen West, Co-Chair
Representative Derek Lewis, Co-Chair
c/o Emily Caudill
Administrative Regulation Review Subcommittee
Legislative Research Commission
083, Capitol Annex
Frankfort KY 40601

907 KAR 1:039. Hearing Program reimbursement provisions and requirements.

Dear Co-Chairs West and Lewis:

After discussions with Administrative Regulation Review Subcommittee staff of the issues raised by 907 KAR 1:039, the Department for Medicaid Services proposes the attached suggested substitutes to 907 KAR 1:039.

If you have any questions, please feel free to contact Jonathan Scott, Regulatory and Legislative Advisor with the Department for Medicaid Services at (502) 564-4321 ext. 2015.

Sincerely,

Stacy Carey

Stacy Carey
Executive Staff Advisor
Office of Legislative and Regulatory Affairs

Final, 6-4-2025

SUGGESTED SUBSTITUTE

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Health Care Policy

907 KAR 1:039. Hearing Program reimbursement provisions and requirements.

RELATES TO: KRS 205.520, ***205.8451,*** 334.010, 334.040, 334.200, 334A.020***(2)[(5)]***, 42 C.F.R. ***400.203, Part 414, 438.2,*** 440.110, 447.200, ***447.204, 42 U.S.C. 1395m, 1395w-4[204]***
STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3)
NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed, or opportunity presented, by federal law to qualify for federal Medicaid funds. This administrative regulation establishes the reimbursement provisions and requirements for covered audiology services, hearing instruments, and related items provided to a Medicaid recipient who is not enrolled with a managed care organization.

Section 1. Definitions.
(1) "Audiologist" is defined by KRS 334A.020(2)[(5)].
(2) "CPT code" means a code used for reporting procedures and services performed by medical practitioners and published annually by the American Medical Association in Current Procedural Terminology.
(3) "Department" means the Department for Medicaid Services or its designee.
(4) "Federal financial participation" is defined by 42 C.F.R. 400.203.
(5) "Healthcare Common Procedure Coding System" or "HCPCS" means a collection of codes acknowledged by the Centers for Medicare and Medicaid Services (CMS) that represents procedures or time.
(6) "Kentucky Medicaid Audiology Fee Schedule" means a list, located at https://chfs.ky.gov/agencies/dms/Pages/feesrates.aspx, that:
(a) Contains the current reimbursement rates for audiology services established by the department in accordance with 907 KAR 1:038 and this administrative regulation; and
(b) Is updated at least annually to coincide with the quarterly updates made by the Centers for Medicare and Medicaid Services as required by 42 U.S.C. 1395m and 1395w-4 and 42 C.F.R. Part 414["Hearing instrument" is defined by KRS 334.010(4)].
(7) "Managed care organization" means an entity for which the Department for Medicaid Services has contracted to serve as a managed care organization as defined in 42 C.F.R. 438.2.
(8) "Medically necessary" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.
(9) "Participating audiologist" means an audiologist who:
(a) Is enrolled in the Medicaid Program pursuant to 907 KAR 1:672;
(b) Is currently participating in the Medicaid Program pursuant to 907 KAR 1:671; and
(c) Meets the audiologist requirements established in 907 KAR 1:038.
(10) "Participating specialist in hearing instruments" means a specialist in hearing instruments who:
(a) Is enrolled in the Medicaid Program pursuant to 907 KAR 1:672;
(b) Is currently participating in the Medicaid Program pursuant to 907 KAR 1:671; and
(c) Meets the specialist in hearing instruments requirements established in 907 KAR 1:038.
(11) "Recipient" is defined by KRS 205.8451(9).
(12) "Specialist in hearing instruments" is defined by KRS 334.010(11)[(9)].

(13) "Usual and customary charge" means the uniform amount that a provider bills to the general public for a specific covered benefit.

Section 2. General Reimbursement Requirements.

(1) For the department to reimburse for a service or item, the requirements of 907 KAR 1:038, Section 2, ***including that the service be medically necessary,*** shall be met.

(2) The department shall not reimburse for:

(a) A service with a CPT code that is not listed on the Kentucky Medicaid Audiology[~~Department for Medicaid Services Hearing Program~~] Fee Schedule as available at: https://www.chfs.ky.gov/agencies/dms/Pages/feesrates.aspx; or

(b) An item with an HCPCS code that is not listed on the Kentucky Medicaid Audiology[~~Department for Medicaid Services Hearing Program~~] Fee Schedule as available at: https://www.chfs.ky.gov/agencies/dms/Pages/feesrates.aspx.

Section 3. Audiology Service Reimbursement. The department shall reimburse a participating audiologist for an audiology service at the lesser of the:

(1) Audiologist's usual and customary charge for the service; or

(2) Reimbursement established on the Kentucky Medicaid Audiology[~~Department for Medicaid Services Hearing Program~~] Fee Schedule as available at: https://www.chfs.ky.gov/agencies/dms/Pages/feesrates.aspx for the service.

Section 4. Hearing Instrument Reimbursement.

(1) The department shall reimburse a participating specialist in hearing instruments or participating audiologist for a hearing instrument at the lesser of the:

(a) Provider's usual and customary charge for the hearing instrument; or

(b) Reimbursement established on the Kentucky Medicaid Audiology[~~Department for Medicaid Services Hearing Program~~] Fee Schedule as available at: https://www.chfs.ky.gov/agencies/dms/Pages/feesrates.aspx for the hearing instrument.

(2) A hearing examination of a recipient by a physician and a recommendation for a hearing instrument for the recipient by an audiologist shall:

(a) Be required for the department to cover a hearing instrument; and

(b) Occur prior to the fitting of a hearing instrument.

(3)

(a) Except for an ear mold, an invoice for a hearing instrument, related supply, or accessory shall be submitted with the corresponding claim:

1. To the department; and
2. By the participating audiologist or participating specialist in hearing instruments who supplied the hearing instrument, related supply, or accessory.

(b) The department shall not require a participating audiologist or participating specialist in hearing instruments to submit an invoice for an ear mold.

Section 5. Ear Mold Reimbursement.

(1) The department shall reimburse a participating audiologist or participating specialist in hearing instruments for an ear mold at the lesser of the:

(a) Provider's usual and customary charge for the ear mold; or

(b) Reimbursement established on the Kentucky Medicaid Audiology[~~Department for Medicaid Services Hearing Program~~] Fee Schedule as available at: https://www.chfs.ky.gov/agencies/dms/Pages/feesrates.aspx for the ear mold.

(2) The department shall limit reimbursement for an ear mold as consistent with the Kentucky Medicaid Audiology Fee Schedule[~~, in conjunction with an ear examination, to:~~]

[~~(a)~~] [~~One (1) ear mold per six (6) month period for a child aged three (3) years or under; or~~]

[~~(b)~~] [~~One (1) ear mold per twelve (12) month period for a child who is at least four (4) years of age~~].

Section 6. Reimbursement for Hearing Instrument Batteries.

(1) The department shall reimburse a participating audiologist or participating specialist in hearing instruments for a hearing instrument battery at the lesser of the:

(a) Provider's usual and customary charge for the hearing instrument battery; or

(b) Reimbursement established on the Kentucky Medicaid Audiology[~~Department for Medicaid Services Hearing Program~~] Fee Schedule as available at: https://www.chfs.ky.gov/agencies/dms/Pages/feesrates.aspx for the hearing instrument battery.

(2)

(a) The department shall reimburse[~~'s reimbursement~~] for hearing instrument batteries [~~shall be limited to fifty-two (52) batteries per hearing instrument~~][~~when dispensed with a:~~]

[~~(a)~~] [~~New hearing instrument; or~~]

[~~(b)~~] [~~Replacement hearing instrument~~].

(b) The department's reimbursement for hearing instrument batteries shall be consistent with manufacturer's recommendations and at regular intervals as necessary to ensure optimal functioning of the hearing instrument.

Section 7. Replacement Cord Reimbursement. The department shall reimburse a participating audiologist or participating specialist in hearing instruments for a replacement cord at the lesser of the:

(1) Provider's usual and customary charge for the replacement cord; or

(2) Reimbursement established on the Kentucky Medicaid Audiology[~~Department for Medicaid Services Hearing Program~~] Fee Schedule as available at: https://www.chfs.ky.gov/agencies/dms/Pages/feesrates.aspx for the replacement cord.

Section 8. Hearing Instrument Repair Reimbursement. The department shall reimburse a participating audiologist or participating specialist in hearing instruments for hearing instrument repair at the lesser of the:

(1) Provider's usual and customary charge for the hearing instrument repair; or

(2) Reimbursement established on the Kentucky Medicaid Audiology[~~Department for Medicaid Services Hearing Program~~] Fee Schedule as available at: https://www.chfs.ky.gov/agencies/dms/Pages/feesrates.aspx for the hearing instrument repair.

Section 9. Not Applicable to Managed Care Organizations. A managed care organization shall not be required to reimburse the same amount as established in this administrative regulation for a service or item covered pursuant to 907 KAR 1:038 and this administrative regulation.

Section 10. Federal Approval and Federal Financial Participation. The department's reimbursement for services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the reimbursement; and

(2) Centers for Medicare and Medicaid Services' approval for the reimbursement.

Section 11. Appeals. A provider may appeal a department decision as to the application of this administrative regulation in accordance with 907 KAR 1:671.

[~~Section 12.~~] [~~Incorporation by Reference.~~]

[~~(1)~~] [~~The "Department for Medicaid Services Hearing Program Fee Schedule", December 2013, is incorporated by reference.~~]

[~~(2)~~] [~~This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky, Monday through Friday, 8 a.m. to 4:30 p.m. or online at the department's Web site at http://www.chfs.ky.gov/dms/incorporated.htm.~~]

Andy Beshear
GOVERNOR

CABINET FOR HEALTH AND FAMILY SERVICES

Eric Friedlander
SECRETARY

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June 9, 2025

Senator Stephen West, Co-Chair
Representative Derek Lewis, Co-Chair
c/o Emily Caudill
Administrative Regulation Review Subcommittee
Legislative Research Commission
083, Capitol Annex
Frankfort KY 40601

907 KAR 3:100. Reimbursement for acquired brain injury waiver services.

Dear Co-Chairs West and Lewis:

After discussions with Administrative Regulation Review Subcommittee staff of the issues raised by 907 KAR 3:100, the Department for Medicaid Services proposes the attached suggested substitutes to 907 KAR 3:100.

If you have any questions, please feel free to contact Jonathan Scott, Regulatory and Legislative Advisor with the Department for Medicaid Services at (502) 564-4321 ext. 2015.

Sincerely,

Lucie Estill
Staff Assistant
Office of Legislative and Regulatory Affairs

SUGGESTED SUBSTITUTE
Final Version: 6/4/2025 3:00 PM

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
(Amendment)

907 KAR 3:100. Reimbursement for acquired brain injury waiver services.

RELATES TO: KRS 205.5605(2), ***205.5606,*** 34 C.F.R. Subtitle B, Chapter III, 42 C.F.R. 441.300 - 310, 29 U.S.C. Chapter 16, 42 U.S.C. 1396a, b, d, n
STATUTORY AUTHORITY: KRS 194A.010(1), 194A.030***(2)[(3)]***, 194A.050(1), 205.520(3)
NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health Services, Department for Medicaid Services, has ***the*** responsibility to administer the Medicaid program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed, or opportunity presented, by federal law for the provision of medical assistance to Kentucky's indigent citizenry. This administrative regulation establishes the payment provisions relating to home - and community -based waiver services provided to an individual with an acquired brain injury as an alternative to nursing facility services for the purpose of rehabilitation and retraining for reentry into the community with existing resources.

Section 1. Definitions.
(1) "ABI" means an acquired brain injury.
(2) "ABI provider" means an entity that meets the provider criteria established in 907 KAR 3:090, Section 2.
(3) "ABI recipient" means an individual who meets the ABI recipient criteria established in 907 KAR 3:090, Section 3.
(4) "Acquired brain injury waiver service" or "ABI waiver service" means a home and community based waiver service provided to a Medicaid eligible individual who has acquired a brain injury.
(5) "Consumer" is defined by KRS 205.5605(2).
(6) "Consumer directed option" or "CDO" means an option established by KRS 205.5606 within the home and community based services waiver that allows recipients to:
(a) Assist with the design of their programs;
(b) Choose their providers of services; and
(c) Direct the delivery of services to meet their needs.
(7) "Department" means the Department for Medicaid Services or its designated agent.
(8) "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

Section 2. Coverage. The department shall reimburse a participating provider for an ABI waiver service if the service is:
(1) Provided to an ABI recipient;
(2) Prior authorized;
(3) Included in the recipient's plan of care;
(4) Medically necessary; and
(5) Essential for the rehabilitation and retraining of the recipient.

Section 3. Exclusions to Acquired Brain Injury Waiver Program. Under the ABI waiver program, the department shall not reimburse a provider for a service provided:

(1) To an individual who has a condition identified in 907 KAR 3:090, Section 5; or

(2) ***That[~~Which~~]*** has not been prior authorized as a part of the recipient's plan of care.

Section 4. Payment Amounts.

(1) A participating ABI waiver service provider shall be reimbursed a fixed rate for reasonable and medically necessary services for a prior-authorized unit of service provided to a recipient.

(2) A participating ABI waiver service provider certified in accordance with 907 KAR 3:090 shall be reimbursed at the lesser of:

(a) The provider's usual and customary charge; or

(b) The Medicaid [~~fixed upper payment limit~~] per unit of service as established in Section 5 of this administrative regulation.

Section 5. Base Payment Rate Table and Reimbursement Requirements. [~~Fixed Upper Payment Limits.~~]

(1) The rates established in the following table shall establish the base payment rate for ABI waiver services:

[~~(1)~~] [~~Except as provided by subsection (2) of this section, the following respective rates shall be the fixed upper payment limits for the corresponding respective ABI waiver services in conjunction with the corresponding units of service and unit of service limits:~~]

Service	Unit	Base Rate Effective January 1, 2025
Adult Day Training	15-minute	$4.88
Assessment & Reassessment	Per assessment	$121.00
Behavior Programming	15-minute	$40.67
Case Management	Per month	$525.14
Companion	15-minute	$6.73
Companion - PDS	15-minute	$6.73
Counseling, Individual	15-minute	$28.85
Counseling, Group	15-minute	$6.96
Environmental ***and[~~or~~]*** Minor Home Adaptation	Per year	Up to $2,420.00
Financial Management Services	Per month	$121.00
Occupational Therapy	15-minute	$31.34
Personal Care	15-minute	$6.73
Personal Care - PDS	15-minute	$6.73
Respite	15-minute	$5.92
Respite - PDS	15-minute	$5.92
Speech Therapy	15-minute	$34.38
Supervised Residential Care - Level I	Per day	$300.00

Supervised Residential Care - Level II	Per day	$225.00
Supervised Residential Care - Level III	Per day	$112.50
Supported Employment	15-minute	$10.54
Supported Employment - PDS	15-minute	$10.54

(2) Specialized medical equipment and supplies shall be reimbursed on a per-item basis based on a reasonable cost as negotiated by the department if the equipment or supply is:

(a) Not covered through the Medicaid durable medical equipment program established in 907 KAR 1:479; and

(b) Provided to an individual participating in the ABI waiver program.

(3) Respite care may exceed 336 hours in a twelve (12) month period if an individual's normal caregiver[~~care giver~~] is unable to provide care due to a death in the family, serious illness, or hospitalization.

(4) If an ABI recipient is placed in a nursing facility to receive respite care, the department shall pay the nursing facility its per diem rate for that individual.

(5) If supported employment services are provided at a work site in which persons without disabilities are employed, payment shall:

(a) Be made only for the supervision and training required as the result of the ABI recipient's disabilities; and

(b) Not include payment for supervisory activities normally rendered.

(6)

(a) The department shall only pay for supported employment services for an individual if supported employment services are unavailable under a program funded by either the Rehabilitation Act of 1973 (29 U.S.C. Chapter 16) or Pub.L. 94-142 (34 C.F.R. Subtitle B, Chapter III).

(b) For an individual receiving supported employment services, documentation shall be maintained in his or her record demonstrating that the services are not otherwise available under a program funded by either the Rehabilitation Act of 1973 (29 U.S.C. Chapter 16) or Pub.L. 94-142 (34 C.F.R. Subtitle B, Chapter III).

Section 6. Payment Exclusions. Payment shall not include:

(1) The cost of room and board, unless provided as part of respite care in a Medicaid certified nursing facility;

(2) The cost of maintenance, upkeep, an improvement, or an environmental modification to a group home or other licensed facility;

(3) Excluding an environmental modification, the cost of maintenance, upkeep, or an improvement to a recipient's place of residence;

(4) The cost of a service that is not listed in the recipient's approved plan of care; or

(5) A service provided by a family member.

Section 7. Records Maintenance. A participating provider shall:

(1) Maintain fiscal and service records for at least six (6) years;

(2) Provide, as requested by the department, a copy of, and access to, each record of the ABI waiver program retained by the provider pursuant to:

(a) Subsection (1) of this section; or

(b) 907 KAR 1:672; and

(3) Upon request, make available service and financial records to a representative or designee of:

(a) The Commonwealth of Kentucky, Cabinet for Health and Family Services;
(b) The United States Department for Health and Human Services, Comptroller General;
(c) The United States Department for Health and Human Services, the Centers for Medicare and Medicaid Services (CMS);
(d) The General Accounting Office;
(e) The Commonwealth of Kentucky, Office of the Auditor of Public Accounts; or
(f) The Commonwealth of Kentucky, Office of the Attorney General.

Section 8. Appeal Rights. An ABI waiver[~~wavier~~] provider may appeal department decisions as to the application of this administrative regulation as it impacts the provider's reimbursement in accordance with 907 KAR 1:671, Sections 8 and 9.

Section 9. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:
(1) Receipt of federal financial participation for the coverage; and
(2) Centers for Medicare and Medicaid Services' approval for the coverage.

CONTACT PERSON: Krista Quarles, Policy Analyst, Office of Legislative and Regulatory Affairs, 275 East Main Street 5 W-A, Frankfort, Kentucky 40621; phone 502-564-7476; fax 502-564-7091; email CHFSregs@ky.gov.

Andy Beshear
GOVERNOR

CABINET FOR HEALTH AND FAMILY SERVICES

Eric Friedlander
SECRETARY

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June 9, 2025

Senator Stephen West, Co-Chair
Representative Derek Lewis, Co-Chair
c/o Emily Caudill
Administrative Regulation Review Subcommittee
Legislative Research Commission
083, Capitol Annex
Frankfort KY 40601

907 KAR 3:210. Acquired brain injury long-term care waiver services and reimbursement.

Dear Co-Chairs West and Lewis:

After discussions with Administrative Regulation Review Subcommittee staff of the issues raised by 907 KAR 3:210, the Department for Medicaid Services proposes the attached suggested substitutes to 907 KAR 3:210.

If you have any questions, please feel free to contact Jonathan Scott, Regulatory and Legislative Advisor with the Department for Medicaid Services at (502) 564-4321 ext. 2015.

Sincerely,

Office of Legislative and Regulatory Affairs
Cabinet for Health and Family Services

SUGGESTED SUBSTITUTE
Final Version: 6/4/2025 3:00 PM

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
(Amendment)

907 KAR 3:210. Acquired brain injury long-term care waiver services and reimbursement.

RELATES TO: KRS 17.165, 202A.011, 205.5605, 205.5607, 205.8451, 205.8477, ***209.030,*** 314.011, 319.010***(9)[(8)]***, 319A.010, 319.056, 327.010, 334A.020, 335.300(2), 335.500(3), ***Chapter 369,*** 620.030, 42 C.F.R. ***431.17, 435.905(b),*** 441 Subpart G, 455 Subpart B, ***45 C.F.R. Parts 160, 161, 164,*** 42 U.S.C. 1396a, 1396b, 1396d, 1396n***, 1320d-2***
STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.5606(1)
NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has ***the*** responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed, or opportunity presented, by federal law to qualify for federal Medicaid funds. KRS 205.5606(1) requires the cabinet to promulgate administrative regulations to establish a participant-directed services program to provide an option for the home and community-based services waivers. This administrative regulation establishes the coverage provisions relating to home- and community- based waiver services provided to an individual with an acquired brain injury as an alternative to nursing facility services and including a participant-directed services program pursuant to KRS 205.5606. The purpose of acquired brain injury long term care waiver services is to provide an alternative to institutional care to individuals with an acquired brain injury who require maintenance services.

Section 1. Definitions.

(1) "1915(c) home and community based services waiver program" means a Kentucky Medicaid program established pursuant to and in accordance with 42 U.S.C. 1396n(c).

(2) "ABI" means an acquired brain injury.

(3) "ABI provider" means an entity that meets the criteria established in Section 2 of this administrative regulation.

(4) "ABIB" means the Acquired Brain Injury Branch in the Division of Community Alternatives, in the Cabinet for Health and Family Services.

(5) "Acquired brain injury long term care waiver service" means a home and community based waiver service for an individual who requires long term maintenance and has acquired a brain injury involving the central nervous system that resulted from:

(a) An injury from a physical trauma;

(b) Anoxia or a hypoxic episode; or

(c) Allergic condition, toxic substance, or another acute medical incident.

(6) "ADHC services" means adult day health care services provided on a regularly scheduled basis that ensure optimal functioning of a participant who does not require twenty-four (24) hour care in an institutional setting.

(7) "Assessment" or "reassessment" means a comprehensive evaluation of abilities, needs, and services that:

(a) Serves as the basis for a level of care determination;

(b) Is completed on a MAP 351, Medicaid Waiver Assessment that is uploaded into the MWMA; and

(c) Occurs at least once every twelve (12) months thereafter.

(8) "Axis I diagnosis" means a clinical disorder or other condition ***that[~~which~~]*** may be a focus of clinical attention.

(9) "Behavior intervention committee" or "BIC" means a group of individuals established to evaluate the technical adequacy of a proposed behavior intervention for a participant.

(10) "Blended services" means a nonduplicative combination of ABI waiver services identified in Section 6 of this administrative regulation and participant-directed services identified in Section 10 of this administrative regulation provided in accordance with the participant's approved person-centered service plan.

(11) "Board certified behavior analyst" means an independent practitioner who is certified by the Behavior Analyst Certification Board, Inc.

(12) "Case manager" means an individual who manages the overall development and monitoring of a participant's person-centered service plan.

(13) "Covered services and supports" is defined by KRS 205.5605(3).

(14) "Crisis prevention and response plan" means a plan developed to identify any potential risk to a participant and to detail a strategy to minimize the risk.

(15) "DCBS" means the Department for Community Based Services.

(16) "Department" means the Department for Medicaid Services or its designee.

(17) "Family training" means providing to the family or other responsible person:

(a) Interpretation or explanation of medical examinations and procedures;

(b) Treatment regimens;

(c) Use of equipment specified in the person-centered service plan; or

(d) ***Advice in[~~Advising the family~~]*** how to assist the participant.

(18) "Good cause" means a circumstance beyond the control of an individual ***that[~~which~~]*** affects the individual's ability to access funding or services, including:

(a) Illness or hospitalization of the individual ***that[~~which~~]*** is expected to last sixty (60) days or less;

(b) Death or incapacitation of the primary caregiver;

(c) Required paperwork and documentation for processing in accordance with Section 3 of this administrative regulation that has not been completed but is expected to be completed in two (2) weeks or less; or

(d) The individual not having been accepted for services or placement by a potential provider despite the individual or individual's legal representative having made diligent contact with the potential provider to secure placement or access services within sixty (60) days.

(19) "Human rights committee" means a group of individuals established to protect the rights and welfare of a participant.

(20) "Human rights restriction" means the denial of a basic right or freedom to which all humans are entitled, including the right to life and physical safety, civil and political rights, freedom of expression, equality before the law, social and cultural justice, the right to participate in culture, the right to food and water, the right to work, and the right to education.

(21) "Licensed marriage and family therapist" or "LMFT" is defined by KRS 335.300(2).

(22) "Licensed medical professional" means:

(a) A physician;

(b) An advanced practice registered nurse;

(c) A physician assistant;

(d) A registered nurse;

(e) A licensed practical nurse; or

(f) A pharmacist.

(23) "Licensed practical nurse" or "LPN" means a person who:

(a) Meets the definition of KRS 314.011(9); and

(b) Works under the supervision of a registered nurse.

(24) "Licensed professional clinical counselor" or "LPCC" is defined by KRS 335.500(3).

(25) "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(26) "MWMA" means the Kentucky Medicaid Waiver Management Application internet portal located at https://www.chfs.ky.gov/agencies/dms/dca/Pages/mwma.aspx[~~http://chfs.ky.gov/dms/mwma.htm~~].

(27) "Nursing supports" means training and monitoring of services by a registered nurse or a licensed practical nurse.

(28) "Occupational therapist" is defined by KRS 319A.010(3).

(29) "Occupational therapy assistant" is defined by KRS 319A.010(4).

(30) "Participant" means an individual who meets the criteria established in Section 3 of this administrative regulation.

(31) "Participant-directed services" or "PDS" means an option established by KRS 205.5606 within the 1915(c) home and community based service waiver programs ***that[~~which~~]*** allows participants to receive non-medical services in which the individual:

(a) Assists with the design of the program;

(b) Chooses the providers of services; and

(c) Directs the delivery of services to meet their needs.

(32) "Person-centered service plan" means a written individualized plan of services for a participant that meets the requirements established in Section 4 of this administrative regulation.

(33) "Person-centered team" means the participant, the participant's guardian or representative, and other individuals who are natural or paid supports, and who:

(a) Recognize that evidenced based decisions are determined within the basic framework of what is important for the participant and within the context of what is important to the participant based on informed choice;

(b) Work together to identify what roles they will assume to assist the participant in becoming as independent as possible in meeting the participant's needs; and

(c) Include providers who receive payment for services who shall:

1. Be active contributing members of the person centered team meetings;
2. Base their input upon evidence-based information; and
3. Not request reimbursement for person centered team meetings.

(34) "Physical therapist" is defined by KRS 327.010(2).

(35) "Physical therapist assistant" means a skilled health care worker who:

(a) Is certified by the Kentucky Board of Physical Therapy; and

(b) Performs physical therapy and related duties as assigned by the supervising physical therapist

(36) "Pro re nata" or "PRN" means as needed.

(37) "Psychologist" is defined by KRS 319.010(9)[~~(8)~~].

(38) "Psychologist with autonomous functioning" means an individual who is licensed in accordance with KRS 319.056.

(39) "Qualified mental health professional" is defined by KRS 202A.011(13)[~~(12)~~].

(40) "Registered nurse" or "RN" means a person who:

(a) Meets the definition established in KRS 314.011(5); and

(b) Has one (1) year or more experience as a professional nurse.

(41) "Representative" is defined by KRS 205.5605(6).

(42) "Speech-language pathologist" is defined by KRS 334A.020(9)[~~(3)~~].

(43) "Support broker" means an individual designated by the department to:

(a) Provide training, technical assistance, and support to a participant; and

(b) Assist a participant in any other aspects of participant-directed services.

Section 2. Non-PDS Provider Participation Requirements.

(1) In order to provide an ABI waiver service in accordance with Section 4 of this administrative regulation, excluding a participant-directed service, an ABI provider shall:

(a) Be enrolled as a Medicaid provider in accordance with 907 KAR 1:671;

(b) Be located within an office in the Commonwealth of Kentucky; and

(c)

1. Be a licensed provider in accordance with:

a. 902 KAR 20:066, if an adult day health care provider;

b. 902 KAR 20:081, if a home health service provider; or

c. 902 KAR 20:091, if a community mental health center; or

2. Be certified by the department in accordance with 907 KAR 12:010, Section 3, or 907 KAR 3:090, Section 2, if a provider type is not listed in subparagraph 1. of this paragraph; and

(d) Complete and submit a MAP-4100a to the department.

(2) An ABI provider shall comply with:

(a) 907 KAR 1:671;

(b) 907 KAR 1:672;

(c) 907 KAR 1:673;

(d) 907 KAR 7:005;

(e) The Health Insurance Portability and Accountability Act, 42 U.S.C. 1320d-2, and 45 C.F.R. Parts 160, 162, and 164; and

(f) 42 U.S.C. 1320d to 1320d-8.

(3) An ABI provider shall have a governing body that shall be:

(a) A legally-constituted entity within the Commonwealth of Kentucky; and

(b) Responsible for the overall operation of the organization including establishing policy that complies with this administrative regulation concerning the operation of the agency and the health, safety, and welfare of a participant served by the agency.

(4) An ABI provider shall:

(a) Unless providing participant-directed services, ensure that an ABI waiver service is not provided to a participant by a staff member of the ABI provider who has one (1) of the following blood relationships to the participant:

1. Child;

2. Parent;

3. Sibling; or

4. Spouse;

(b) Not enroll a participant for whom the ABI provider cannot meet the service needs; and

(c) Have and follow written criteria in accordance with this administrative regulation for determining the eligibility of an individual for admission to services.

(5) An ABI provider shall meet the following requirements if responsible for the management of a participant's funds:

(a) Separate accounting shall be maintained for each participant or for the participant's interest in a common trust or special account;

(b) Account balance and records of transactions shall be provided to the participant or legal representative on a quarterly basis; and

(c) The participant or legal representative shall be notified if a large balance is accrued that may affect Medicaid eligibility.

(6) An ABI provider shall have a written statement of its mission and values.

(7) An ABI provider shall have written policies and procedures for communication and interaction with a family and legal representative of a participant ***that[~~which~~]*** shall:

(a) Require a timely response to an inquiry;

(b) Require the opportunity for interaction with direct care staff;

(c) Require prompt notification of any unusual incident;

(d) Permit visitation with the participant at a reasonable time and with due regard for the participant's right of privacy;

(e) Require involvement of the legal representative in decision-making regarding the selection and direction of the service provided; and

(f) Consider the cultural, educational, language, and socioeconomic characteristics of the participant.

(8)

(a) An ABI provider shall have written policies and procedures for all settings that assure the participant has:

1. Rights of privacy, dignity, respect, and freedom from coercion and restraint; and
2. Freedom of choice:

a. As defined by the experience of independence, individual initiative, or autonomy in making life choices, both in small everyday matters (what to eat or what to wear), and in large, life-defining matters (where and with whom to live and work); and

b. Including the freedom to choose:

(i) Services;

(ii) Providers;

(iii) Settings from among setting options including non-disability specific settings; and

(iv) Where to live with as much independence as possible and in the most community-integrated environment.

(b) The setting options and choices shall be:

1. Identified and documented in the person-centered service plan; and
2. Based on the participant's needs and preferences.

(c) For a residential setting, the resources available for room and board shall be documented in the person-centered service plan.

(9) An ABI provider shall have written policies and procedures for residential settings that assure the participant has:

(a) Privacy in the sleeping unit and living unit in a residential setting;

(b) An option for a private unit in a residential setting;

(c) A unit with lockable entrance doors and with only the participant and appropriate staff having keys to those doors;

(d) A choice of roommate or housemate;

(e) The freedom to furnish or decorate the sleeping or living units within the lease or other agreement;

(f) Visitors of the participant's choosing at any time and access to a private area for visitors; and

(g) Physical accessibility, defined as being easy to approach, enter, operate, or participate in a safe manner and with dignity by a person with or without a disability.

1. Settings considered to be physically accessible shall also meet the Americans with Disabilities Act standards of accessibility for all participants served in the setting.

2. All communal areas shall be accessible to all participants as well as have a means to enter the building (i.e. keys, security codes, etc.).

3. Bedrooms shall be accessible to the appropriate persons.

4.

a. Any modification of an additional residential condition except for the setting being physically accessible requirement shall be supported by a specific assessed need and justified in the participant's person-centered service plan.

b. Regarding a modification, the following shall be documented in a participant's person-centered service plan:

(i) That the modification is the result of an identified specific and individualized assessed need;

(ii) Any positive intervention or support used prior to the modification;

(iii) Any less intrusive method of meeting the participant's need that was tried but failed;

(iv) A clear description of the condition that is directly proportionate to the specific assessed need;

(v) Regular collection and review of data used to measure the ongoing effectiveness of the modification;

(vi) Time limits established for periodic reviews to determine if the modification remains necessary or should be terminated;

(vii) Informed consent by the participant or participant's representative for the modification; and

(viii) An assurance that interventions and supports will cause no harm to the participant.

(10) An ABI provider shall cooperate with monitoring visits from monitoring agents.

(11) An ABI provider shall maintain a record for each participant served that shall:

(a) Be recorded in permanent ink;

(b) Be free from correction fluid;

(c) Have a strike through for each error ***that~~[which]~~*** is initialed and dated; and

(d) Contain no blank lines between each entry.

(12) A record of each participant who is served shall:

(a) Be cumulative;

(b) Be readily available;

(c) Contain a legend that identifies any symbol or abbreviation used in making a record entry;

(d) Contain the following specific information:

1. The participant's name and Medical Assistance Identification Number (MAID);

2. An assessment summary relevant to the service area;

3. The person-centered service plan;

4. The crisis prevention and response plan that shall include:

a. A list containing emergency contact telephone numbers; and

b. The participant's history of any allergies with appropriate allergy alerts for severe allergies;

5. The training objective for any service ***that~~[which]~~*** provides skills training to the participant;

6. The participant's medication record, including a copy of the prescription or the signed physician's order and the medication log if medication is administered at the service site;

7. Legally-adequate consent for the provision of services or other treatment including consent for emergency attention ***that~~[which]~~*** shall be located at each service site;

8. The MAP-350, Long Term Care Facilities and Home and Community Based Program Certification Form updated at recertification; and

9. Current level of care certification;

(e) Be maintained by the provider in a manner to ensure the confidentiality of the participant's record and other personal information and to allow the participant or legal representative to determine when to share the information;

(f) Be secured against loss, destruction, or use by an unauthorized person ensured by the provider; and

(g) Be available to the participant or legal guardian according to the provider's written policy and procedures ***that[~~which~~]*** shall address the availability of the record.

(13) An ABI provider:

(a) Shall ensure that each new staff person or volunteer performing direct care or a supervisory function has had a tuberculosis (TB) risk assessment performed by a licensed medical professional and, if indicated, a TB skin test with a negative result within the past twelve (12) months as documented on test results received by the provider;

(b) Shall maintain documentation of the annual TB risk assessment or negative TB test result described in paragraph (a) of this subsection for:

1. Existing staff; or

2. A volunteer, if the volunteer performs direct care or a supervisory function;

(c) Shall ensure that an employee or volunteer who tests positive for TB, or has a history of a positive TB skin test, shall be assessed annually by a licensed medical professional for signs or symptoms of active disease;

(d) Shall if it is determined that signs and symptoms of active TB are present, ensure that the employee or volunteer has follow-up testing administered by the employee's or volunteer's physician and that the follow-up test results indicate the employee or volunteer does not have active TB disease;

(e) Shall not permit an individual to work for or volunteer for the provider if the individual has TB or symptoms of active TB;

(f) Shall maintain documentation for an employee or volunteer with a positive TB test to ensure that active disease or symptoms of active disease are not present;

(g)

1. Shall:

a. Prior to the employee's date of hire or the volunteer's date of service, obtain the results of:

(i) A criminal record check from the Administrative Office of the Courts or the equivalent out-of-state agency if the individual resided, worked, or volunteered outside Kentucky during the year prior to employment or volunteer service in Kentucky;

(ii) A Nurse Aide Abuse Registry check as ***established[~~described~~]*** in 906 KAR 1:100; and

(iii) A ***Vulnerable Adult Maltreatment[~~Caregiver Misconduct~~]*** Registry check as ***established[~~described~~]*** in 922 KAR 5:120; and

b. Within thirty (30) days of the date of hire or service as a volunteer, obtain the results of a Central Registry check as established[described] in 922 KAR 1:470; or

2. May use Kentucky's national background check program established by 906 KAR 1:190 to satisfy the background check requirements of subparagraph 1 of this paragraph;

(h) Shall annually, for twenty-five (25) percent of employees randomly selected, obtain the results of a criminal record check from:

1. The Kentucky Administrative Office of the Courts; or

2. The equivalent out-of-state agency, if the individual resided or worked outside of Kentucky during the year prior to employment;

(i) Shall evaluate and document the performance of each employee upon completion of the agency's designated probationary period, and at a minimum, annually thereafter;

(j) Conduct and document periodic and regularly scheduled supervisory visits of all professional and paraprofessional direct service staff at the service site in order to ensure that high quality, appropriate services are provided to the participant;

(k) Not employ or permit an individual to serve as a volunteer performing direct care or a supervisory function, if the individual has a prior conviction of an offense ***established[~~delineated~~]*** in KRS 17.165(1) through (3) or prior felony conviction;

(l) Not permit an employee or volunteer to transport a participant, if the employee or volunteer has a conviction of Driving under the Influence (DUI) during the past year;

(m) Not employ or permit an individual to serve as a volunteer performing direct care or a supervisory function, if the individual has a conviction of abuse or sale of illegal drugs during the past five (5) years;

(n) Not employ or permit an individual to serve as a volunteer performing direct care or a supervisory function, if the individual has a conviction of abuse, neglect, or exploitation;

(o) Not employ or permit an individual to serve as a volunteer performing direct care or a supervisory function, if the individual has a Cabinet for Health and Family Services finding of:

1. Child abuse or neglect pursuant to the Central Registry; or

2. Adult abuse, neglect, or exploitation pursuant to the ***Vulnerable Adult Maltreatment[~~Caregiver Misconduct~~]*** Registry; and

(p) Not employ or permit an individual to serve as a volunteer performing direct care or a supervisory function, if the individual is listed on the:

1. Nurse Aide Abuse Registry pursuant to 906 KAR 1:100; or

2. ***Vulnerable Adult Maltreatment[~~Kentucky Caregiver Misconduct~~]*** Registry pursuant to 922 KAR 5:120.

(14) An ABI provider shall:

(a) Have an executive director who:

1. Is qualified with a bachelor's degree from an accredited institution in administration or a human services field; and

2. Has a minimum of one (1) year of administrative responsibility in an organization ***that[~~which~~]*** served an individual with a disability; and

(b) Have adequate direct contact staff who:

1. Is eighteen (18) years of age or older and has a high school diploma or GED; and

2. Has a minimum of two (2) years of experience in providing a service to an individual with a disability or has successfully completed a formalized training program approved by the department.

(15) An ABI provider shall establish written guidelines ***that[~~which~~]***:

(a) Ensure the health, safety, and welfare of the participant;

(b) Address maintenance of sanitary conditions;

(c) Ensure each site operated by the provider is equipped with:

1. Operational smoke detectors placed in strategic locations; and

2. A minimum of two (2) correctly charged fire extinguishers placed in strategic locations, one (1) of which shall be capable of extinguishing a grease fire and with a rating of 1A10BC;

(d) Ensure the availability of a supply of hot and cold running water with the water temperature at a tap, for water used by the participant, not exceeding 120 degrees Fahrenheit, for a Supervised Residential Care, Adult Day Training, or Adult Day Health provider;

(e) Ensure that the nutritional needs of the participant are met in accordance with the current recommended dietary allowance of the Food and Nutrition Board of the National Research Council or as specified by a physician;

(f) Ensure that staff who supervise waiver participants in medication administration:

1. Unless the employee is a licensed or registered nurse, have been provided specific training by a licensed medical professional and competency has been documented on cause and effect and proper administration and storage of medication; and

2. Document on a medication log all medication administered, including:

a. Self-administered and over-the-counter drugs; and

b. The date, time, and initials of the person who administered the medication;

(g) Ensure that the medication shall be:

1. Kept in a locked container;

2. Kept under double lock if it is a controlled substance;

3. Carried in a proper container labeled with medication, dosage, and time of administration, if administered to the participant or self-administered at a program site other than the participant's residence;

4. Documented on a medication administration form; and

5. Properly disposed of if it is discontinued; and

(h) Establish policy and procedures for monitoring of medication administration, which shall be approved by the department before services begin to ensure that medication administration will be properly monitored under the policies and procedures as approved by the department.

(16) An ABI provider shall establish and follow written guidelines for handling an emergency or a disaster ***that[~~which~~]*** shall:

(a) Be readily accessible on site;

(b) Include an evacuation drill:

1. To be conducted and documented at least quarterly; and

2. For a residential setting, scheduled to include a time when a participant is asleep;

(c) Mandate:

1. That the result of an evacuation drill be evaluated and modified as needed; and

2. That results of the prior years' evacuation drills be maintained on site.

(17) An ABI provider shall:

(a) Provide orientation for each new employee ***that[~~which~~]*** shall include the agency's:

1. Mission;

2. Goals;

3. Organization; and

4. Policies and procedures;

(b) Require documentation of all training provided, which shall include the:

1. Type of training;

2. Name and title of the trainer;

3. Length of the training;

4. Date of completion; and

5. Signature of the trainee verifying completion;

(c) Ensure that each employee completes ABI training consistent with the curriculum that has been approved by the department, prior to working independently with a participant, which shall include:

1. Required orientation in brain injury;

2. Identifying and reporting:

a. Abuse;
b. Neglect; and
c. Exploitation;

3. Unless the employee is a licensed or registered nurse, first aid provided by an individual certified as a trainer by:
a. The American Red Cross; or
b. Other nationally accredited organization; and

4. Coronary pulmonary resuscitation provided by an individual certified as a trainer by:
a. The American Red Cross; or
b. Other nationally accredited organization;

(d) Ensure that each employee completes six (6) hours of continuing education in brain injury annually, following the first year of service;

(e) Not be required to receive the training specified in paragraph (c)1 of this subsection if the provider is a professional who has, within the prior five (5) years, attained 2,000 hours of experience providing services to a person with a primary diagnosis of a brain injury including:
1. An occupational therapist or occupational therapy assistant providing occupational therapy;
2. A psychologist or psychologist with autonomous functioning providing psychological services;
3. A speech-language pathologist providing speech therapy;
4. A board certified behavior analyst; or
5. A physical therapist or physical therapist assistant providing physical therapy; and

(f) Ensure that prior to the date of service as a volunteer, an individual receives training ***that***~~***[which]***~~ shall include:
1. Required orientation in brain injury as specified in paragraph (c)1, 2, 3, and 4 of this subsection;
2. Orientation to the agency;
3. A confidentiality statement; and
4. Individualized instruction on the needs of the participant to whom the volunteer shall provide services.

(18) An ABI provider shall provide information to a case manager necessary for completion of a Mayo-Portland Adaptability Inventory-4 for each participant served by the provider.

Section 3. Participant Eligibility, Enrollment, and Termination.

(1)

(a) To be eligible to receive a service in the ABI long term care waiver program, an individual shall:
1. Be at least eighteen (18) years of age;
2. Have an ABI ***that***~~***[which]***~~ necessitates:
a. Supervision;
b. Rehabilitative services; and
c. Long term supports;
3. Have an ABI that involves:
a. Cognition;
b. Behavior; or
c. Physical function; and
4. Be screened by the department for the purpose of making a preliminary determination of whether the individual might qualify for ABI waiver services.

(b) In addition to the individual meeting the requirements established in paragraph (a) of this subsection, the individual or a representative on behalf of the individual shall:

1. Apply for 1915(c) home and community based waiver services via the MWMA; and

2. Complete and upload into the MWMA a MAP - 115 Application Intake - Participant Authorization.

(2) The department shall utilize a first come, first serve priority basis to enroll an individual who meets the eligibility criteria established in this section.

(3) If funding is not available, an individual shall be placed on the ABI long term care waiver waiting list in accordance with Section 9 of this administrative regulation.

(4)

(a) A certification packet shall be entered into the MWMA by a case manager or support broker on behalf of the applicant.

(b) The packet shall contain:

1. A copy of the allocation letter sent to the applicant at the time funding was allocated for the applicant's participation in the ABI Long Term Care Waiver program;

2. A MAP-351, Medicaid Waiver Assessment;

3. A statement of the need for ABI long term care waiver services ***that*** ~~***[which]***~~ shall be signed and dated by a physician on a MAP 10, Waiver Services Physician's Recommendation form;

4. A MAP-350, Long Term Care Facilities and Home and Community Based Program Certification Form; and

5. A person-centered service plan.

(5) An individual shall receive notification of potential funding allocated for the ABI long term care waiver services for the individual in accordance with this section.

(6) An individual shall meet the patient status criteria for nursing facility services established in 907 KAR 1:022, including nursing facility services for a brain injury.

(7) An individual shall:

(a) Have a primary diagnosis that indicates an ABI with structural, non-degenerative brain injury;

(b) Be medically stable;

(c) Meet Medicaid eligibility requirements established in 907 KAR 20:010;

(d) Exhibit:

1. Cognitive damage;

2. Behavioral damage;

3. Motor damage; or

4. Sensory damage;

(e) Have a rating of at least four (4) or above on the Family Guide to the Rancho Levels of Cognitive Functioning; and

(f) Receive notification of approval from the department.

(8) The basis of an eligibility determination for participation in the ABI long term care waiver program shall be the:

(a) Presenting problem;

(b) Person-centered service plan;

(c) Expected benefit of the admission;

(d) Expected outcome;

(e) Service required; and

(f) Cost effectiveness of service delivery as an alternative to nursing facility and nursing facility brain injury services.

(9) An ABI long term care waiver service shall not be furnished to an individual if the individual is:

(a) An inpatient of a hospital, nursing facility, or an intermediate care facility for individuals with an intellectual disability; or

(b) Receiving a service in another 1915(c) home and community based services waiver program.

(10) The department shall make:

(a) An initial evaluation to determine if an individual meets the nursing facility level of care criteria established in 907 KAR 1:022; and

(b) A determination of whether to admit an individual into the ABI long term care waiver program.

(11) To maintain eligibility as a participant:

(a) An individual shall maintain Medicaid eligibility requirements established in 907 KAR 20:010;

(b) A reevaluation shall be conducted at least once every twelve (12) months to determine if the individual continues to meet the patient status criteria for nursing facility services established in 907 KAR 1:022; and

(c) Progress toward outcomes identified in the approved person-centered service plan shall not be required.

(12) The department shall exclude an individual from receiving an ABI long term care waiver service for whom the average cost of ABI waiver service is reasonably expected to exceed the cost of a nursing facility service.

(13) Involuntary termination and loss of an ABI long term care waiver program placement shall be in accordance with 907 KAR 1:563 and shall be initiated if:

(a) An individual fails to initiate an ABI long term care waiver service within sixty (60) days of notification of potential funding without good cause shown. The individual or legal representative shall have the burden of providing documentation of good cause, including:

1. A statement signed by the participant or legal representative;
2. Copies of letters to providers; and
3. Copies of letters from providers;

(b) A participant or legal representative fails to access the required service as outlined in the person-centered service plan for a period greater than sixty (60) consecutive days without good cause shown.

1. The participant or legal representative shall have the burden of providing documentation of good cause including:
   a. A statement signed by the participant or legal representative;
   b. Copies of letters to providers; and
   c. Copies of letters from providers.
2. Upon receipt of documentation of good cause, the department shall grant one (1) extension period, which shall not exceed sixty (60) days, to the participant during which time period the participant shall initiate the ABI long term care waiver services or access the required services as outlined in the person-centered service plan. The extension shall be in writing;

(c) A participant changes residence outside the Commonwealth of Kentucky;

(d) A participant does not meet the patient status criteria for nursing facility services established in 907 KAR 1:022;

(e) A participant is no longer able to be safely served in the community; or

(f) A participant is no longer actively participating in services within the approved person-centered service plan as determined by the person-centered team.

(14) Involuntary termination of a service to a participant by an ABI provider shall require:

(a) Simultaneous notice, which shall:

1. Be sent at least thirty (30) days prior to the effective date of the action, to the:
   a. Department;
   b. Participant or legal representative; and
   c. Case manager; and

2. Include:

a. A statement of the intended action;

b. The basis for the intended action;

c. The authority by which the action is taken; and

d. The participant's right to appeal the intended action through the provider's appeal or grievance process; and

(b) The case manager in conjunction with the provider to:

1. Provide the participant with the name, address, and telephone number of each current ABI provider in the state;

2. Provide assistance to the participant in making contact with another ABI provider;

3. Arrange transportation for a requested visit to an ABI provider site;

4. Provide a copy of pertinent information to the participant or legal representative;

5. Ensure the health, safety, and welfare of the participant until an appropriate placement is secured;

6. Continue to provide supports until alternative services or another placement is secured; and

7. Provide assistance to ensure a safe and effective service transition.

(15) Voluntary termination and loss of an ABI long term care waiver program placement shall be initiated if a participant or legal representative submits a written notice of intent to discontinue services to the service provider and to the department.

(a) An action to terminate services shall not be initiated until thirty (30) calendar days from the date of the notice.

(b) The participant or legal representative may reconsider and revoke the notice in writing during the thirty (30) calendar day period.

Section 4. Person-centered Service Plan Requirements.

(1) A person-centered service plan shall be established:

(a) For each participant; and

(b) By the participant's person-centered service plan team.

(2) A participant's person-centered service plan shall:

(a) Be developed by:

1. The participant, the participant's guardian, or the participant's representative;

2. The participant's case manager;

3. The participant's person-centered team; and

4. Any other individual chosen by the participant if the participant chooses any other individual to participate in developing the person-centered service plan;

(b) Use a process that:

1. Provides the necessary information and support to empower the participant, the participant's guardian, or participant's legal representative to direct the planning process in a way that empowers the participant to have the freedom and support to control the participant's schedules and activities without coercion or restraint;

2. Is timely and occurs at times and locations convenient for the participant;

3. Reflects cultural considerations of the participant;

4. Provides information:

a. Using plain language in accordance with 42 C.F.R. 435.905(b); and

b. In a way that is accessible to an individual with a disability or who has limited English proficiency;

5. Offers an informed choice defined as a choice from options based on accurate and thorough knowledge and understanding to the participant regarding the services and supports to be received and from whom;
6. Includes a method for the participant to request updates to the person-centered service plan as needed;
7. Enables all parties to understand how the participant:
a. Learns;
b. Makes decisions; and
c. Chooses to live and work in the participant's community;
8. Discovers the participant's needs, likes, and dislikes;
9. Empowers the participant's person-centered team to create a person-centered service plan that:
a. Is based on the participant's:
(i) Assessed clinical and support needs;
(ii) Strengths;
(iii) Preferences; and
(iv) Ideas;
b. Encourages and supports the participant's:
(i) Rehabilitative needs;
(ii) Habilitative needs; and
(iii) Long term satisfaction;
c. Is based on reasonable costs given the participant's support needs;
d. Includes:
(i) The participant's goals;
(ii) The participant's desired outcomes; and
(iii) Matters important to the participant;
e. Includes a range of supports including funded, community, and natural supports that shall assist the participant in achieving identified goals;
f. Includes:
(i) Information necessary to support the participant during times of crisis; and
(ii) Risk factors and measures in place to prevent crises from occurring;
g. Assists the participant in making informed choices by facilitating knowledge of and access to services and supports;
h. Records the alternative home and community-based settings that were considered by the participant;
i. Reflects that the setting in which the participant resides was chosen by the participant;
j. Is understandable to the participant and to the individuals who are important in supporting the participant;
k. Identifies the individual or entity responsible for monitoring the person-centered service plan;
l. Is finalized and agreed to with the informed consent of the participant or participant's legal representative in writing with signatures by each individual who will be involved in implementing the person-centered service plan;
m. Shall be distributed to the individual and other people involved in implementing the person-centered service plan;
n. Includes those services ***that*** ~~***[which]***~~ the individual elects to self-direct; and
o. Prevents the provision of unnecessary or inappropriate services and supports; and
(c) Includes in all settings the ability for the participant to:

1. Have access to make private phone calls, texts, or emails at the participant's preference or convenience; and

2.

a. Choose when and what to eat;

b. Have access to food at any time;

c. Choose with whom to eat or whether to eat alone; and

d. Choose appropriating clothing according to the:

(i) Participant's preference;

(ii) Weather; and

(iii) Activities to be performed.

(3) If a participant's person-centered service plan includes ADHC services, the ADHC services plan of treatment shall be addressed in the person-centered service plan.

(4)

(a) A participant's person-centered service plan shall be:

1. Entered into the MWMA by the participant's case manager; and

2. Updated in the MWMA by the participant's case manager.

(b) A participant or participant's authorized representative shall complete and upload into the MWMA a MAP - 116 Service Plan – Participant Authorization prior to or at the time the person-centered service plan is uploaded into the MWMA.

Section 5. Case Management Requirements.

(1) A case manager shall:

(a)

1. Be a registered nurse;

2. Be a licensed practical nurse; or

3. Be an individual with a bachelor's degree or master's degree in a human services field who meets all applicable requirements of his or her particular field including a degree in:

a. Psychology;

b. Sociology;

c. Social work;

d. Rehabilitation counseling; or

e. Occupational therapy;

(b)

1. Be independent as defined as not being employed by an agency that is providing ABI waiver services to the participant; or

2. Be employed by or work under contract with a free-standing case management agency; and

(c) Have completed case management training that is consistent with the curriculum that has been approved by the department prior to providing case management services.

(2) A case manager shall:

(a) Communicate in a way that ensures the best interest of the participant;

(b) Be able to identify and meet the needs of the participant;

(c)

1. Be competent in the participant's language either through personal knowledge of the language or through interpretation; and

2. Demonstrate a heightened awareness of the unique way in which the participant interacts with the world around the participant;

(d) Ensure that:

1. The participant is educated in a way that addresses the participant's:
   a. Need for knowledge of the case management process;
   b. Personal rights; and
   c. Risks and responsibilities as well as awareness of available services; and
2. All individuals involved in implementing the participant's person-centered service plan are informed of changes in the scope of work related to the person-centered service plan as applicable;

(e) Have a code of ethics to guide the case manager in providing case management ***that~~[which]~~*** shall address:

1. Advocating for standards that promote outcomes of quality;
2. Ensuring that no harm is done;
3. Respecting the rights of others to make their own decisions;
4. Treating others fairly; and
5. Being faithful and following through on promises and commitments;

(f)

1. Lead the person-centered service planning team; and
2. Take charge of coordinating services through team meetings with representatives of all agencies involved in implementing a participant's person-centered service plan;

(g)

1. Include the participant's participation or legal representative's participation in the case management process; and
2. Make the participant's preferences and participation in decision making a priority;

(h) Document:

1. A participant's interactions and communications with other agencies involved in implementing the participant's person-centered service plan; and
2. Personal observations;

(i) Advocate for a participant with service providers to ensure that services are delivered as established in the participant's person-centered service plan;

(j) Be accountable to:

1. A participant to whom the case manager providers case management in ensuring that the participant's needs are met;
2. A participant's person-centered service plan team and provide leadership to the team and follow through on commitments made; and
3. The case manager's employer by following the employer's policies and procedures;

(k) Stay current regarding the practice of case management and case management research;

(l) 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 person-centered service plan is successful and done so in a way that is efficient regarding the participant's financial assets and benefits;

(m) Document services provided to a participant by entering the following into the MWMA:

1. A monthly department-approved person centered monitoring tool; and
2. A monthly entry ***that~~[which]~~*** shall include:
   a. The month and year for the time period the note covers;
   b. An analysis of progress toward the participant's outcome or outcomes;
   c. Identification of barriers to achievement of outcomes;
   d. A projected plan to achieve the next step in achievement of outcomes;

e. The signature and title of the case manager completing the note; and

f. The date the note was generated;

(n) Document via an entry into the MWMA if a participant is:

1. Admitted to the ABI long term care waiver program;
2. Terminated from the ABI long-term care waiver program;
3. Temporarily discharged from the ABI long term care waiver program;
4. Admitted to a hospital;
5. Admitted to a nursing facility;
6. Changing the primary ABI provider;
7. Changing the case management agency;
8. Transferred to another Medicaid 1915(c) home and community based waiver service program; or
9. Relocated to a different address; and

(o) Provide information about participant-directed services to the participant or the participant's guardian:

1. At the time the initial person-centered service plan is developed; and
2. At least annually thereafter and upon inquiry from the participant or participant's guardian.

(3) A case management provider shall:

(a) Establish a human rights committee ***that[~~which~~]*** shall:

1. Include an:
   a. Individual with a brain injury or a family member of an individual with a brain injury;
   b. Individual not affiliated with the ABI provider; and
   c. Individual who has knowledge and experience in human rights issues;
2. Review and approve each person-centered service plan with human rights restrictions at a minimum of every six (6) months;
3. Review and approve, in conjunction with the participant's team, behavior intervention plans that contain human rights restrictions; and
4. Review the use of a psychotropic medication by a participant without an Axis I diagnosis; and

(b) Establish a behavior intervention committee ***that[~~which~~]*** shall:

1. Include one (1) individual who has expertise in behavior intervention and is not the behavior specialist who wrote the behavior intervention plan;
2. Be separate from the human rights committee; and
3. Review and approve, prior to implementation and at a minimum of every six (6) months in conjunction with the participant's team, an intervention plan that includes highly restrictive procedures or contain human rights restrictions; and

(c) Complete and submit a Mayo-Portland Adaptability Inventory-4 to the department for each participant:

1. Within thirty (30) days of the participant's admission into the ABI program;
2. Annually thereafter; and
3. Upon discharge from the ABI waiver program.

(4)

(a) Case management for any participant who begins receiving ABI waiver services after the effective date of this administrative regulation shall be conflict free.

(b)

1. Conflict free case management shall be a scenario in which a provider including any subsidiary, partnership, not-for-profit, or for-profit business entity that has a business interest in the provider who renders case management to a participant shall not also provide another 1915(c) home and

community based waiver service to that same participant unless the provider is the only willing and qualified ABI waiver services provider within thirty (30) miles of the participant's residence.

2. An exemption to the conflict free case management requirement shall be granted if:

a. A participant requests the exemption;

b. The participant's case manager provides documentation of evidence to the department, that there is a lack of a qualified case manager within thirty (30) miles of the participant's residence;

c. The participant or participant's representative and case manager signs a completed MAP - 531 Conflict-Free Case Management Exemption; and

d. The participant, participant's representative, or case manager uploads the completed MAP - 531 Conflict-Free Case Management Exemption into the MWMA.

3. If a case management service is approved to be provided despite not being conflict free, the case management provider shall document conflict of interest protections, separating case management and service provision functions within the provider entity and demonstrate that the participant is provided with a clear and accessible alternative dispute resolution process.

4. An exemption to the conflict free case management requirement shall be requested upon reassessment or at least annually.

(c) A participant who receives ABI waiver services prior to the effective date of this administrative regulation shall transition to conflict free case management when the participant's next level of care determination occurs.

(d) During the transition to conflict free case management, any case manager providing case management to a participant shall educate the participant and members of the participant's person-centered team of the conflict free case management requirement in order to prepare the participant to decide, if necessary, to change the participant's:

1. Case manager; or

2. Provider of non-case management ABI waiver services.

(5) Case management shall:

(a) Include initiation, coordination, implementation, and monitoring of the assessment or reassessment, evaluation, intake, and eligibility process;

(b) Assist a participant in the identification, coordination, and facilitation of the person centered team and person centered team meetings;

(c) Assist a participant and the person centered team to develop an individualized person-centered service plan and update it as necessary based on changes in the participant's medical condition and supports;

(d) Include monitoring of the delivery of services and the effectiveness of the person-centered service plan, which shall:

1. Be initially developed with the participant and legal representative if appointed prior to the level of care determination;

2. Be updated within the first thirty (30) days of service and as changes or recertification occurs; and

3. Include the person-centered service plan being sent to the department or its designee prior to the implementation of the effective date the change occurs with the participant;

(e) Include a transition plan that shall:

1. Be:

a. Developed within the first thirty (30) days of service;

b. Updated as changes or recertification occurs; and

c. Updated thirty (30) days prior to discharge; and

2. Include:

a. The skills or service obtained from the ABI waiver program upon transition into the community; and

b. A listing of the community supports available upon the transition;

(f) Assist a participant in obtaining a needed service outside those available by the ABI waiver;

(g) Be provided by a case manager who:

1. Meets the requirements of subsection (1) of this section;

2. Shall provide a participant and legal representative with a listing of each available ABI provider in the service area;

3. Shall maintain documentation signed by a participant or legal representative of informed choice of an ABI provider and of any change to the selection of an ABI provider and the reason for the change;

4. Shall provide a distribution of the crisis prevention and response plan, transition plan, person-centered service plan, and other documents within the first thirty (30) days of the service to the chosen ABI service provider and as information is updated;

5. Shall provide twenty-four (24) hour telephone access to a participant and chosen ABI provider;

6. Shall work in conjunction with an ABI provider selected by a participant to develop a crisis prevention and response plan ***that[~~which~~]*** shall be:

a. Individual-specific; and

b. Updated as a change occurs and at each recertification;

7. Shall assist a participant in planning resource use and assuring protection of resources;

8. Shall conduct one (1) face-to-face meeting with a participant within a calendar month occurring at a covered service site with one (1) visit quarterly at the participant's residence;

9. Shall ensure twenty-four (24) hour availability of services; and

10. Shall ensure that the participant's health, welfare, and safety needs are met; and

(h) Be documented by a detailed staff note in the MWMA ***that[~~which~~]*** shall include:

1. The participant's health, safety and welfare;

2. Progress toward outcomes identified in the approved person-centered service plan;

3. The date of the service;

4. Beginning and ending time;

5. The signature and title of the individual providing the service; and

6. A quarterly summary ***that[~~which~~]*** shall include:

a. Documentation of monthly contact with each chosen ABI provider; and

b. Evidence of monitoring of the delivery of services approved in the participant's person-centered service plan and of the effectiveness of the person-centered service plan.

(6) Case management shall involve:

(a) A constant recognition of what is and is not working regarding a participant; and

(b) Changing what is not working.

Section 6. Covered Services.

(1) An ABI waiver service shall:

(a) Not be covered unless it has been prior-authorized by the department; and

(b) Be provided pursuant to the participant's person-centered service plan.

(2) An ABI waiver provider shall provide the following services to a participant:

(a) Case management services in accordance with Section 4 of this administrative regulation;

(b) Behavioral services, which shall:

1. Be a systematic application of techniques and methods to influence or change a behavior in a desired way;
2. Include a functional analysis of the participant's behavior including:
   a. An evaluation of the impact of an ABI on:
      (i) Cognition; and
      (ii) Behavior;
   b. An analysis of potential communicative intent of the behavior;
   c. The history of reinforcement for the behavior;
   d. Critical variables that precede the behavior;
   e. Effects of different situations on the behavior; and
   f. A hypothesis regarding the:
      (i) Motivation behind the behavior;
      (ii) Purpose of the behavior; and
      (iii) Factors that maintain the behavior;
3. Include the development of a behavioral support plan, which shall:
   a. Be developed by the behavioral specialist;
   b. Not be implemented by the behavior specialist who wrote the plan;
   c. Be revised as necessary;
   d. Define the techniques and procedures used;
   e. Include the hierarchy of behavior interventions ranging from the least to the most restrictive;
   f. Reflect the use of positive approaches; and
   g. Prohibit the use of:
      (i) Prone or supine restraint;
      (ii) Corporal punishment;
      (iii) Seclusion;
      (iv) Verbal abuse; and
      (v) Any procedure ***that*** ***~~which~~*** denies private communication, requisite sleep, shelter, bedding, food, drink, or use of a bathroom facility;
4. Include the provision of training to other ABI providers concerning implementation of the behavioral intervention plan;
5. Include the monitoring of a participant's progress, which shall be accomplished through:
   a. The analysis of data concerning the behavior's:
      (i) Frequency;
      (ii) Intensity; and
      (iii) Duration; and
   b. Reports involved in implementing the behavioral service plan;
6. Be provided by a behavior specialist who shall:
   a. Be:
      (i) A psychologist;
      (ii) A psychologist with autonomous functioning;
      (iii) A licensed psychological associate;
      (iv) A psychiatrist;
      (v) A licensed clinical social worker;
      (vi) A clinical nurse specialist with a master's degree in psychiatric nursing or rehabilitation nursing;
      (vii) An advanced practice registered nurse;
      (viii) A board certified behavior analyst; or

(ix) A licensed professional clinical counselor; and

b. Have at least one (1) year of behavior specialist experience or provide documentation of completed coursework regarding learning and behavior principles and techniques; and

7. Be documented by a detailed staff note in the MWMA ***that[~~which~~]*** shall include:

a. The date of the service;

b. The beginning and ending time;

c. The signature and title of the behavioral specialist; and

d. A summary of data analysis and progress of the individual related to the approved person-centered service plan;

(c) Community living supports, which shall:

1. Be provided in accordance with the participant's person-centered service plan, including:

a. A nonmedical service;

b. Supervision; or

c. Socialization;

2. Include assistance, prompting, observing, or training in activities of daily living;

3. Include activities of daily living, which shall include:

a. Bathing;

b. Eating;

c. Dressing;

d. Personal hygiene;

e. Shopping; and

f. Money management;

4. Include prompting, observing, and monitoring of medications and nonmedical care not requiring a nurse or physician intervention;

5. Include socialization, relationship building, and participation in community activities according to the approved person-centered service plan ***that[~~which~~]*** are therapeutic and not diversional in nature;

6. Accompany and assist a participant while utilizing transportation services;

7. Include documentation in a detailed staff note in the MWMA ***that[~~which~~]*** shall include the:

a. Progress toward goals and objectives identified in the approved person-centered service plan;

b. Date of the service;

c. Beginning and ending time; and

d. Signature and title of the individual providing the service;

8. Not be provided to a participant who receives community residential services; and

9. Be provided by a:

a. Home health agency licensed and operating in accordance with 902 KAR 20:081;

b. Community mental health center licensed and operating in accordance with 902 KAR 20:091;

c. Community habilitation program certified at least annually by the department; or

d. Supervised residential care setting certified at least annually by the department;

(d) Supervised residential care level I, which:

1. Shall be provided by:

a. A community mental health center licensed and operating in accordance with 902 KAR 20:091 and certified at least annually by the department; or

b. An approved waiver provider certified at least annually by the department;

2. Shall not be provided to a participant unless the participant has been authorized to receive residential care by the department's residential review committee, which shall:

a. Consider applications for residential care in the order in which the applications are received;
b. Base residential care decisions on the following factors:
(i) Whether the applicant resides with a caregiver or not;
(ii) Whether the applicant resides with a caregiver but demonstrates maladaptive behavior ***that[~~which~~]*** places the applicant at significant risk of injury or jeopardy if the caregiver is unable to effectively manage the applicant's behavior or the risk it poses, resulting in the need for removal from the home to a more structured setting; or
(iii) Whether the applicant demonstrates behavior ***that[~~which~~]*** may result in potential legal problems if not ameliorated;
c. Be comprised of three (3) Cabinet for Health and Family Services employees:
(i) With professional or personal experience with brain injury or other cognitive disabilities; and
(ii) Two (2) of whom shall not be supervised by the manager of the acquired brain injury branch; and
d. Only consider applications for a monthly committee meeting ***that[~~which~~]*** were received no later than the close of business the day before the committee convenes;

3. Shall not have more than three (3) participants simultaneously in a home rented or owned by the ABI provider;

4. Shall provide twenty-four (24) hours of supervision daily unless the provider implements, pursuant to subparagraph 5. of this paragraph, an individualized plan allowing for up to five (5) unsupervised hours per day;

5. May include the provision of up to five (5) unsupervised hours per day per participant if the provider develops an individualized plan for the participant to promote increased independence ***that[~~which~~]*** shall:
a. Contain provisions necessary to ensure the participant's health, safety, and welfare;
b. Be approved by the participant's treatment team, with the approval documented by the provider; and
c. Contain periodic reviews and updates based on changes, if any, in the participant's status;

6. Shall include assistance and training with daily living skills including:
a. Ambulating;
b. Dressing;
c. Grooming;
d. Eating;
e. Toileting;
f. Bathing;
g. Meal planning;
h. Grocery shopping;
i. Meal preparation;
j. Laundry;
k. Budgeting and financial matters;
l. Home care and cleaning;
m. Leisure skill instruction; or
n. Self-medication instruction;

7. Shall include social skills training including the reduction or elimination of maladaptive behaviors in accordance with the individual's person-centered service plan;

8. Shall include provision or arrangement of transportation to services, activities, or medical appointments as needed;

9. Shall include accompanying or assisting a participant while the participant utilizes transportation services as specified in the participant's person-centered service plan;
10. Shall include participation in medical appointments or follow-up care as directed by the medical staff;
11. Shall be documented by a detailed staff note in the MWMA, which shall document:
a. Progress toward goals and objectives identified in the approved person-centered service plan;
b. The date of the service;
c. The beginning and ending time of the service; and
d. The signature and title of the individual providing the service;
12. Shall not include the cost of room and board;
13. Shall be provided to a participant who:
a. Does not reside with a caregiver;
b. Is residing with a caregiver but demonstrates maladaptive behavior that places him or her at significant risk of injury or jeopardy if the caregiver is unable to effectively manage the behavior or the risk it presents, resulting in the need for removal from the home to a more structured setting; or
c. Demonstrates behavior that may result in potential legal problems if not ameliorated;
14. May utilize a modular home only if the:
a. Wheels are removed;
b. Home is anchored to a permanent foundation; and
c. Windows are of adequate size for an adult to use as an exit in an emergency;
15. Shall not utilize a motor home;
16. Shall provide a sleeping room ***that[~~which~~]*** ensures that a participant:
a. Does not share a room with an individual of the opposite gender who is not the participant's spouse;
b. Does not share a room with an individual who presents a potential threat; and
c. Has a separate bed equipped with substantial springs, a clean and comfortable mattress, and clean bed linens as required for the participant's health and comfort; and
17. Shall provide service and training to obtain the outcomes for the participant as identified in the approved person-centered service plan;
(e) Supervised residential care level II, which shall:
1. Meet the requirements established in paragraph (d) of this subsection except for the requirements established in paragraph (d)4 and 5;
2. Provide twelve (12) to eighteen (18) hours of daily supervision, the amount of which shall:
a. Be based on the participant's needs;
b. Be approved by the participant's treatment team; and
c. Be documented in the participant's person-centered service plan ***that[~~which~~]*** shall also contain periodic reviews and updates based on changes, if any, in the participant's status; and
3. Include provision of twenty-four (24) hour on-call support;
(f) Supervised residential care level III, which shall:
1. Meet the requirements established in paragraph (d) of this subsection except for the requirements established in paragraph (d)4 and 5;
2. Be provided in a single family home, duplex, or apartment building to a participant who lives alone or with an unrelated roommate;
3. Not be provided to more than two (2) participants simultaneously in one (1) apartment or home;
4. Not be provided in more than two (2) apartments in one (1) building;

5. If provided in an apartment building, have staff:

a. Available twenty-four (24) hours per day and seven (7) days per week; and

b. Who do not reside in a dwelling occupied by a participant; and

6. Provide less than twelve (12) hours of supervision or support in the home based on an individualized plan developed by the provider to promote increased independence ***that*** ~~***[which]***~~ shall:

a. Contain provisions necessary to ensure the participant's health, safety, and welfare;

b. Be approved by the participant's treatment team, with the approval documented by the provider; and

c. Contain periodic reviews and updates based on changes, if any, in the participant's status;

(g) Counseling services, which:

1. Shall be designed to help a participant resolve personal issues or interpersonal problems resulting from the participant's ABI;

2. Shall assist a family member in implementing a participant's approved person-centered service plan;

3. In a severe case, shall be provided as an adjunct to behavioral programming;

4. Shall include substance use or chemical dependency treatment, if needed;

5. Shall include building and maintaining healthy relationships;

6. Shall develop social skills or the skills to cope with and adjust to the brain injury;

7. Shall increase knowledge and awareness of the effects of an ABI;

8. May include group counseling if the service is:

a. Provided to a maximum of twelve (12) participants; and

b. Included in the participant's approved person-centered service plan for:

(i) Substance use or chemical dependency treatment;

(ii) Building and maintaining healthy relationships;

(iii) Developing social skills;

(iv) Developing skills to cope with and adjust to a brain injury, including the use of cognitive remediation strategies consisting of the development of compensatory memory and problem solving strategies, and the management of impulsivity; and

(v) Increasing knowledge and awareness of the effects of the acquired brain injury upon the participant's functioning and social interactions;

9. Shall be provided by:

a. A psychiatrist;

b. A psychologist;

c. A psychologist with autonomous functioning;

d. A licensed psychological associate;

e. A licensed clinical social worker;

f. A clinical nurse specialist with a master's degree in psychiatric nursing;

g. An advanced practice registered nurse;

h. A certified alcohol and drug counselor;

i. A licensed marriage and family therapist;

j. A licensed professional clinical counselor;

k. A licensed clinical alcohol and drug counselor associate effective and contingent upon approval by the Centers for Medicare and Medicaid Services; or

l. A licensed clinical alcohol and drug counselor effective and contingent upon approval by the Centers for Medicare and Medicaid Services; and

10. Shall be documented by a detailed staff note in the MWMA ***that[~~which~~]*** shall include:
a. Progress toward the goals and objectives established in the person-centered service plan;
b. The date of the service;
c. The beginning and ending time; and
d. The signature and title of the individual providing the service;

(h) Family training, which shall:

1. Provide training and counseling services for the families of individuals served in the ABI long term care waiver. Training to family or other responsible persons shall include:
a. Interpretation or explanation of medical examinations and procedures;
b. Treatment regimens;
c. Use of equipment specified in the person-centered service plan; or
d. Advising how to assist the participant;
2. Include updates as needed to safely maintain the participant at home;
3. Include specified goals in the participant's person-centered service plan;
4. Be training provided to family that may include a person who:
a. Lives with, or provides care to, a participant; and
b. Is a:
(i) Parent;
(ii) Spouse;
(iii) Child;
(iv) Relative;
(v) Foster family; or
(vi) In-law;
5. Not include an individual who is employed to care for the participant;
6. Be provided by an approved ABI waiver provider that is certified at least annually and ***that[~~which~~]*** may include:
a. An occupational therapist;
b. A certified occupational therapy assistant;
c. A licensed practical nurse;
d. A physical therapist;
e. A physical therapist assistant;
f. A registered nurse;
g. A speech-language pathologist;
h. A psychiatrist;
i. A psychologist;
j. A psychologist with autonomous functioning;
k. A licensed psychological associate;
l. A clinical nurse specialist with a master's degree in:
(i) Psychiatric nursing; or
(ii) Rehabilitative nursing;
m. An advanced practice registered nurse;
n. A certified alcohol and drug counselor;
o. A licensed professional clinical counselor;
p. A board certified behavior analyst;
q. A licensed clinical social worker;
r. A licensed marriage and family therapist;

s. A licensed clinical alcohol and drug counselor associate effective and contingent upon approval by the Centers for Medicare and Medicaid Services; or

t. A licensed clinical alcohol and drug counselor effective and contingent upon approval by the Centers for Medicare and Medicaid Services; and

7. Be documented by a detailed staff note in the MWMA, which shall include:

a. Progress toward the goals and objectives established in the person-centered service plan;

b. The date of the service;

c. The beginning and ending time; and

d. The signature and title of the individual providing the service;

(i) Nursing supports, which shall include:

1.

a. A physician order to monitor medical conditions; or

b. A physician order for training and oversight of medical procedures;

2. The monitoring of specific medical conditions;

3. Services that shall be provided by:

a. A registered nurse who meets the definition established in KRS 314.011(5); or

b. A licensed practical nurse as defined by KRS 314.011(9) who works under the supervision of a registered nurse; and

4. Documentation by a detailed staff note in the MWMA, which shall include:

a. Progress toward the goals and objectives established in the person-centered service plan;

b. The date of the service;

c. The beginning and ending time; and

d. The signature and title of the individual providing the service;

(j) Occupational therapy, which shall be:

1. A physician-ordered evaluation of a participant's level of functioning by applying diagnostic and prognostic tests;

2. Physician-ordered services in a specified amount and duration to guide a participant in the use of therapeutic, creative, and self-care activities to assist the participant in obtaining the highest possible level of functioning;

3. Provided by an occupational therapist or an occupational therapy assistant if supervised by an occupational therapist in accordance with 201 KAR 28:130; and

4. Documented by a detailed staff note in the MWMA, which shall include:

a. Progress toward goals and objectives identified in the approved person-centered service plan;

b. The date of the service;

c. The beginning and ending time; and

d. The signature and title of the individual providing the service;

(k) A physical therapy service, which shall be:

1. A physician-ordered evaluation of a participant by applying muscle, joint, and functional ability tests;

2. Physician-ordered treatment in a specified amount and duration to assist a participant in obtaining the highest possible level of functioning;

3. Training of another ABI provider to improve the level of functioning of the participant in that provider's service setting;

4. Provided by a physical therapist or a physical therapist assistant supervised by a physical therapist in accordance with 201 KAR 22:001 and 201 KAR 22:020; and

5. Documented by a detailed staff note in the MWMA, which shall include:

a. Progress made toward outcomes identified in the person-centered service plan;
b. The date of the service;
c. The beginning and ending time of the service; and
d. The signature and title of the individual providing the service;

(l) A respite service, which shall:

1. Be provided only to a participant unable to administer self-care;
2. Be provided by a:
   a. Nursing facility;
   b. Community mental health center;
   c. Home health agency;
   d. Supervised residential care provider;
   e. Adult day training provider; or
   f. Adult day health care provider;
3. Be provided on a short-term basis due to the absence or need for relief of a non-paid primary caregiver;
4. Be limited to 5,760 fifteen (15) minute units per one (1) year authorized person-centered service plan period unless an individual's non-paid primary caregiver is unable to provide care due to a:
   a. Death in the family;
   b. Serious illness; or
   c. Hospitalization;
5. Not be provided to a participant who receives supervised residential care;
6. Not include the cost of room and board if provided in a nursing facility; and
7. Be documented by a detailed staff note in the MWMA, which shall include:
   a. Progress toward goals and objectives identified in the approved person-centered service plan;
   b. The date of the service;
   c. The beginning and ending time; and
   d. The signature and title of the individual providing the service;

(m) Speech-language pathology services, which shall be:

1. A physician-ordered evaluation of a participant with a speech, hearing, or language disorder;
2. A physician-ordered habilitative service in a specified amount and duration to assist a participant with a speech and language disability in obtaining the highest possible level of functioning;
3. Provided by a speech-language pathologist; and
4. Documented by a detailed staff note in the MWMA, which shall include:
   a. Progress toward goals and objectives identified in the approved person-centered service plan;
   b. The date of the service;
   c. The beginning and ending time; and
   d. The signature and title of the individual providing the service;

(n) Adult day training services, which shall:

1. Be provided by:
   a. An adult day training center that is certified at least annually by the department;
   b. An outpatient rehabilitation facility that is licensed and operating in accordance with 902 KAR 20:190; or
   c. A community mental health center licensed and operating in accordance with 902 KAR 20:091;
2. Focus on enabling the participant to attain or maintain the participant's maximum functional level and reintegrate the participant into the community;
3. Not exceed a staffing ratio of five (5) participants per one (1) staff person;

4. Include the following services:

a. Social skills training related to problematic behaviors identified in the participant's person-centered service plan;

b. Sensory or motor development;

c. Reduction or elimination of a maladaptive behavior;

d. Prevocational; or

e. Teaching concepts and skills to promote independence including:

(i) Following instructions;

(ii) Attendance and punctuality;

(iii) Task completion;

(iv) Budgeting and money management;

(v) Problem solving; or

(vi) Safety;

5. Be provided in a nonresidential setting;

6. Be developed in accordance with a participant's overall approved person-centered service plan;

7. Reflect the recommendations of a participant's person-centered team;

8. Be appropriate:

a. Given a participant's:

(i) Age;

(ii) Level of cognitive and behavioral function; and

(iii) Interest;

b. Given a participant's ability prior to and after the participant's injury; and

c. According to the approved person-centered service plan and be therapeutic in nature and not diversional;

9. Be coordinated with the occupational, speech, or other rehabilitation therapy included in a participant's person-centered service plan;

10. Provide a participant with an organized framework within which to function in the participant's daily activities;

11. Entail frequent assessments of a participant's progress and be appropriately revised as necessary; and

12. Be documented by a detailed staff note in the MWMA, which shall include:

a. Progress toward goals and objectives identified in the approved person-centered service plan;

b. The date of the service;

c. The beginning and ending time; and

d. The signature and title of the individual providing the service;

(o) Adult day health care services, which shall:

1. Be provided by an adult day health care center that is licensed and operating in accordance with 902 KAR 20:066; and

2. Include the following basic services and necessities provided to a participant during the posted hours of operation:

a. Skilled nursing services provided by a registered nurse or licensed practical nurse, including:

(i) Ostomy care;

(ii) Urinary catheter care;

(iii) Decubitus care;

(iv) Tube feeding;

(v) Venipuncture;

(vi) Insulin injections;
(vii) Tracheotomy care; or
(viii) Medical monitoring;

b. Meal service corresponding with hours of operation with a minimum of one (1) meal per day and therapeutic diets as required;

c. Snacks;

d. Supervision by a registered nurse;

e. Daily activities that are appropriate, given a participant's:
(i) Age;
(ii) Level of cognitive and behavioral function; and
(iii) Interest; and

f. Routine services that meet the daily personal and health care needs of a participant, including:
(i) Monitoring of vital signs;
(ii) Assistance with activities of daily living; and
(iii) Monitoring and supervision of self-administered medications, therapeutic programs, and incidental supplies and equipment needed for use by a participant;

3. Include developing, implementing, and maintaining nursing policies for nursing or medical procedures performed in the adult day health care center;

4. Focus on enabling the participant to attain or maintain the participant's maximum functional level and reintegrate a participant into the community by providing the following training:

a. Social skills training related to problematic behaviors identified in the participant's person-centered service plan;

b. Sensory or motor development;

c. Reduction or elimination of a maladaptive behavior per the participant's person-centered service plan;

d. Prevocational services; or

e. Teaching concepts and skills to promote independence including:
(i) Following instructions;
(ii) Attendance and punctuality;
(iii) Task completion;
(iv) Budgeting and money management;
(v) Problem solving; or
(vi) Safety;

5. Be provided in a nonresidential setting;

6. Be developed in accordance with a participant's overall approved person-centered service plan, therapeutic in nature, and not diversional;

7. Reflect the recommendations of a participant's person-centered team;

8. Include ancillary services in accordance with 907 KAR 1:023 if ordered by a physician, physician assistant, or advanced practice registered nurse in a participant's adult day health care plan of treatment. Ancillary services shall:

a. Consist of evaluations or reevaluations for the purpose of developing a plan that shall be carried out by the participant or adult day health care center staff;

b. Be reasonable and necessary for the participant's condition;

c. Be rehabilitative in nature;

d. Include:
(i) Physical therapy provided by a physical therapist or physical therapist assistant;

(ii) Occupational therapy provided by an occupational therapist or occupational therapy assistant; or

(iii) Speech-language pathology services provided by a speech-language pathologist; and

e. Comply with the physical, occupational, and speech-language pathology service requirements established in 907 KAR 1:030, Section 3;

9. Be provided to a participant by the health team in an adult day health care center, which may include:

a. A physician;

b. A physician assistant;

c. An advanced practice registered nurse;

d. A registered nurse;

e. A licensed practical nurse;

f. An activities director;

g. A physical therapist;

h. A physical therapist assistant;

i. An occupational therapist;

j. An occupational therapy assistant;

k. A speech-language pathologist;

l. A social worker;

m. A nutritionist;

n. A health aide;

o. An LPCC;

p. A licensed marriage and family therapist;

q. A certified psychologist with autonomous functioning; or

r. A licensed psychological associate;

10. Be provided pursuant to a plan of treatment and developed annually in accordance with 902 KAR 20:066 and from information in the MAP 351, Medicaid Waiver Assessment and revised as needed; and

11. Be documented by a detailed staff note in the MWMA, which shall include:

a. Progress toward goals and objectives identified in the approved person-centered service plan;

b. The date of the service;

c. The beginning and ending time;

d. The signature and title of the individual providing the service; and

e. A monthly summary that assesses the participant's status related to the approved person-centered service plan;

(p) Supported employment, which shall be:

1. Intensive, ongoing services for a participant to maintain paid employment in an environment in which an individual without a disability is employed;

2. Provided by a:

a. Supported employment provider;

b. Sheltered employment provider; or

c. Structured day program provider;

3. Provided one-on-one;

4. Unavailable under a program funded by either the Rehabilitation Act of 1973 (29 U.S.C. Chapter 16) or Pub.L. 99-457 (34 C.F.R. Parts 300 to 399), proof of which shall be documented in the participant's file;

5. Limited to forty (40) hours per week alone or in combination with adult day training or adult day health services;

6. An activity needed to sustain paid work by a participant receiving waiver services, including:

a. Supervision; and

b. Training;

7. Exclusive of work performed directly for the supported employment provider; and

8. Documented by a time and attendance record, which shall include:

a. Progress toward the goals and objectives identified in the person-centered service plan;

b. The date of service;

c. The beginning and ending time; and

d. The signature and title of the individual providing the service;

(q) Specialized medical equipment and supplies, which shall:

1. Include durable and nondurable medical equipment, devices, controls, appliances, or ancillary supplies;

2. Enable a participant to increase his or her ability to perform daily living activities or to perceive, control, or communicate with the environment;

3. Be ordered by a physician, documented in a participant's person-centered service plan, entered into the MWMA by the participant's case manager or support broker, and include three (3) estimates if the equipment is needed for vision or hearing;

4. Include equipment necessary for the proper functioning of specialized items;

5. Not be available through the department's durable medical equipment, vision, or hearing programs;

6. Not be necessary for life support;

7. Meet applicable standards of manufacture, design, and installation; and

8. Exclude those items ***that*** ~~***[which]***~~ are not of direct medical or remedial benefit to a participant;

(r) Environmental and minor home adaptations, which shall:

1. Be provided in accordance with applicable state and local building codes;

2. Be provided to a participant if:

a. Ordered by a physician;

b. Prior-authorized by the ABIB;

c. Specified in the participant's approved person-centered service plan and entered into the MWMA, by the participant's case manager or support broker;

d. Necessary to enable the participant to function with greater independence within the participant's home; and

e. Without the modification, the participant requires institutionalization;

3. Not include a vehicle modification;

4. Be limited to no more than $2,000 for a participant in a twelve (12) month period; and

5. If entailing:

a. Electrical work, be provided by a licensed electrician; or

b. Plumbing work, be provided by a licensed plumber;

(s) Assessment services, which shall:

1. Be a comprehensive assessment that shall identify a participant's needs and the services that the participant's family cannot manage or arrange for the participant;

2. Evaluate a participant's physical health, mental health, social supports, and environment;

3. Be requested by an individual requesting ABI services or a family or legal representative of the individual;

4. Be conducted by an ABI case manager or support broker;
5. Be conducted within seven (7) calendar days of receipt of the request for assessment;
6. Include at least one (1) face-to-face contact with the participant and, if appropriate, the participant's family by the assessor in the participant's home; and
7. Not be reimbursable if the individual does not receive a level of care certification; or

(t) Reassessment services, which shall:
1. Be performed at least every twelve (12) months;
2. Be conducted using the same procedures as for an assessment service;
3. Be conducted by an ABI case manager or support broker and submitted to the department no more than three (3) weeks prior to the expiration of the current level of care certification to ensure that certification is consecutive;
4. Not be reimbursable if conducted during a period that the participant is not covered by a valid level of care certification; and
5. Not be retroactive.

Section 7. Exclusions of the Acquired Brain Injury Waiver Program. A condition included in the following list shall not be considered an acquired brain injury requiring specialized rehabilitation:
(1) A stroke treatable in a nursing facility providing routine rehabilitation services;
(2) A spinal cord injury for which there is no known or obvious injury to the intracranial central nervous system;
(3) Progressive dementia or another condition related to mental impairment that is of a chronic degenerative nature, including:
(a) Senile dementia;
(b) Organic brain disorder;
(c) Alzheimer's disease;
(d) Alcoholism; or
(e) Another addiction;
(4) A depression or a psychiatric disorder in which there is no known or obvious central nervous system damage;
(5) A birth defect;
(6) An intellectual disability without an etiology to an acquired brain injury; or
(7) A condition ***that*** ~~***[which]***~~ causes an individual to pose a level of danger or an aggression that is unable to be managed and treated in a community.

Section 8. Incident Reporting Process.
(1)
(a) There shall be two (2) classes of incidents.
(b) The following shall be the two (2) classes of incidents:
1. An incident; or
2. A critical incident.
(2) An incident shall be any occurrence that impacts the health, safety, welfare, or lifestyle choice of a participant and includes:
(a) A minor injury;
(b) A medication error without a serious outcome; or
(c) A behavior or situation that is not a critical incident.
(3) A critical incident shall be an alleged, suspected, or actual occurrence of an incident that:
(a) Can reasonably be expected to result in harm to a participant; and

(b) Shall include:

1. Abuse, neglect, or exploitation;
2. A serious medication error;
3. Death;
4. A homicidal or suicidal ideation;
5. A missing person; or
6. Other action or event that the provider determines may result in harm to the participant.

(4)

(a) If an incident occurs, the ABI provider shall:

1. Report the incident by making an entry into the MWMA that includes details regarding the incident; and
2. Be immediately assessed for potential abuse, neglect, or exploitation.

(b) If an assessment of an incident indicates that the potential for abuse, neglect, or exploitation exists:

1. The incident shall immediately be considered a critical incident;
2. The critical incident procedures established in subsection (5) of this section shall be followed; and
3. The ABI provider shall report the incident to the participant's case manager and participant's guardian, if the participant has a guardian, within twenty-four (24) hours of discovery of the incident.

(5)

(a) If a critical incident occurs, the individual who witnessed the critical incident or discovered the critical incident shall immediately act to ensure the health, safety, and welfare of the at-risk participant.

(b) If the critical incident:

1. Requires reporting of abuse, neglect, or exploitation, the critical incident shall be immediately reported via the MWMA by the individual who witnessed or discovered the critical incident; or
2. Does not require reporting of abuse, neglect, or exploitation, the critical incident shall be reported via the MWMA by the individual who witnessed or discovered the critical incident within eight (8) hours of discovery.

(c) The ABI provider shall:

1. Conduct an immediate investigation and involve the participant's case manager in the investigation; and
2. Prepare a report of the investigation, which shall be recorded in the MWMA and shall include:
   a. Identifying information of the participant involved in the critical incident and the person reporting the critical incident;
   b. Details of the critical incident; and
   c. Relevant participant information including:
      (i) Axis I diagnosis or diagnoses;
      (ii) Axis II diagnosis or diagnoses;
      (iii) Axis III diagnosis or diagnoses;
      (iv) A listing of recent medical concerns;
      (v) An analysis of causal factors; and
      (vi) Recommendations for preventing future occurrences.

(6)

(a) Following a death of a participant receiving ABI services from an ABI provider, the ABI provider shall enter mortality data documentation into the MWMA within fourteen (14) days of the death.

(b) Mortality data documentation shall include:

1. The participant's person-centered service plan at the time of death;
2. Any current assessment forms regarding the participant;

3. The participant's medication administration records from all service sites for the past three (3) months along with a copy of each prescription;
4. Progress notes regarding the participant from all service elements for the past thirty (30) days;
5. The results of the participant's most recent physical exam;
6. All incident reports, if any exist, regarding the participant for the past six (6) months;
7. Any medication error report, if any exists, related to the participant for the past six (6) months;
8. The most recent psychological evaluation of the participant;
9. A full life history of the participant including any update from the last version of the life history;
10. Names and contact information for all staff members who provided direct care to the participant during the last thirty (30) days of the participant's life;
11. Emergency medical services notes regarding the participant if available;
12. The police report if available;
13. A copy of:
a. The participant's advance directive, medical order for scope of treatment, living will, or health care directive if applicable;
b. Any functional assessment of behavior or positive behavior support plan regarding the participant that has been in place over any part of the past twelve (12) months; and
c. The cardiopulmonary resuscitation and first aid card for any ABI provider's staff member who was present at the time of the incident that resulted in the participant's death;
14. A record of all medical appointments or emergency room visits by the participant within the past twelve (12) months; and
15. A record of any crisis training for any staff member present at the time of the incident ***that*** ~~***[which]***~~ resulted in the participant's death.

(7)
(a) An ABI provider shall report a medication error to the MWMA.
(b) An ABI provider shall document all medication error details on a medication error log retained on file at the ABI provider site.

Section 9. ABI Long Term Care Waiver Waiting List.
(1) An individual eighteen (18) years of age or older applying for an ABI long term care waiver service shall be placed on a statewide ABI long term care waiver waiting list that shall be maintained by the department.
(2) In order to be placed on the ABI long term care waiver waiting list, an individual or the individual's representative shall:
(a) Apply for 1915(c) home and community based waiver services via the MWMA;
(b) Complete and upload into the MWMA a MAP – 115 Application Intake – Participant Authorization; and
(c) Upload into the MWMA a completed MAP 10, Waiver Services Physician's Recommendation form that has been signed by a physician.
(3) The order of placement on the ABI long term care waiver waiting list shall be determined by the:
(a) Chronological date of complete application information regarding the individual being entered into the MWMA;
(b) Category of need of the individual as follows:
1. Emergency. An emergency shall exist if an immediate service is indicated as determined by:
a. The individual currently is demonstrating behavior related to the individual's acquired brain injury that places the participant, caregiver, or others at risk of significant harm; or

b. The individual is demonstrating behavior related to the individual's acquired brain injury ***that[~~which~~]*** has resulted in the individual's arrest; or

2. Nonemergency; and

(c) Emergency Committee, which shall consider applications for the Acquired Brain Injury long term care waiver program for emergency placement.

1. The Emergency Committee meetings shall regularly occur during the fourth week of each month. To be considered at the monthly committee meeting, an application shall be received by the department no later than three (3) business days before the scheduled committee meeting.

2. The Emergency Review Committee shall be comprised of three (3) program staff of the cabinet.

a. Each member shall have professional or personal experience with brain injuries or other cognitive disabilities.

b. At least two (2) members shall not be supervised by the branch manager of the Acquired Brain Injury Branch.

(4) In determining chronological status, the original date of the individual's complete application information being entered into the MWMA shall:

(a) Be maintained; and

(b) Not change if an individual is moved from one (1) category of need to another.

(5) A written statement by a physician or other qualified mental health professional shall be required to support the validation of risk of significant harm to an individual or caregiver, or the nature of the individual's medical need.

(6) Written documentation by law enforcement or court personnel shall be required to support the validation of a history of arrest.

(7) A written notification of placement on the waiting list shall be mailed to the individual or the individual's legal representative and case management provider if identified.

(8) Maintenance of the ABI long term care waiver waiting list shall occur as follows:

(a) The department shall, at a minimum, update the waiting list annually; and

(b) If an individual is removed from the ABI long term care waiver waiting list, written notification shall be mailed by the department to the:

1. Individual;

2. Individual's legal representative; and

3. ABI case manager.

(9) Reassignment of category of need shall be completed based on the updated information and validation process.

(10) An individual or legal representative may submit a request for consideration of movement from one (1) category of need to another at any time an individual's status changes.

(11) An individual shall be removed from the ABI long term care waiver waiting list if:

(a) After a documented attempt, the department is unable to locate the individual or the individual's legal representative;

(b) The individual is deceased;

(c) The individual or individual's legal representative refuses the offer of ABI long term care waiver services and does not request to be maintained on the ABI long term care waiver waiting list; or

(d) The individual does not access services without demonstration of good cause within sixty (60) days of the placement allocation date.

1. The individual or individual's legal representative shall have the burden of providing documentation of good cause including:

a. A signed statement by the individual or the legal representative;

b. Copies of letters to providers; and

c. Copies of letters from providers.

2. Upon receipt of documentation of good cause, the department shall grant one (1) sixty (60) day extension in writing.

(12) The removal of an individual from the ABI long term care waiver waiting list shall not prevent the submittal of a new application at a later date.

(13) Potential funding allocated for services for an individual shall be based upon:

(a) The individual's category of need; and

(b) The individual's chronological date of placement on the ABI long term care waiver waiting list.

Section 10. Participant-Directed Services.

(1) Covered services and supports provided to a participant receiving PDS shall include:

(a) A home and community support service, which shall:

1. Be available only as a participant-directed service;

2. Be provided in the participant's home or in the community;

3. Be based upon therapeutic goals and not be diversional in nature;

4. Not be provided to an individual if the same or similar service is being provided to the individual by a non-PDS acquired brain injury service; and

5.

a. Be respite for the primary caregiver; or

b. Be supports and assistance related to chosen outcomes to facilitate independence and promote integration into the community for an individual residing in the individual's own home or the home of a family member and may include:

(i) Routine household tasks and maintenance;

(ii) Activities of daily living;

(iii) Personal hygiene;

(iv) Shopping;

(v) Money management;

(vi) Medication management;

(vii) Socialization;

(viii) Relationship building;

(ix) Meal planning;

(x) Meal preparation;

(xi) Grocery shopping; or

(xii) Participation in community activities;

(b) Goods and services, which shall:

1. Be individualized;

2. Be utilized to reduce the need for personal care or to enhance independence within the home or community of the participant;

3. Not include experimental goods or services; and

4. Not include chemical or physical restraints; and

(c) A community day support service, which shall:

1. Be available only as a participant-directed service;

2. Be provided in a community setting;

3. Be tailored to the participant's specific personal outcomes related to the acquisition, improvement, and retention of skills and abilities to prepare and support the participant for:

a. Work or community activities;
b. Socialization; and
c. Leisure or retirement activities;

4. Be based upon therapeutic goals and not be diversional in nature; and

5. Not be provided to an individual if the same or similar service is being provided to the individual by a non-PDS acquired brain injury service.

(2) To be covered, a PDS shall be specified in a participant's person-centered service plan.

(3) Reimbursement for a PDS shall not exceed the department's allowed reimbursement for the same or a similar service provided in a non-PDS ABI setting.

(4) A participant, including a married participant, shall choose a provider and the choice of PDS provider shall be documented in the participant's person-centered service plan.

(5)

(a) A participant may designate a representative to act on the participant's behalf.

(b) The PDS representative shall:

1. Be twenty-one (21) years of age or older;

2. Not be monetarily compensated for acting as the PDS representative or providing a PDS; and

3. Be appointed by the participant on a MAP-2000, Initiation/Termination of Participant-Directed Services.

(6) A participant may voluntarily terminate PDS by completing a MAP-2000, Initiation/Termination of Participant-Directed Services and submitting it to the support broker.

(7) The department shall immediately terminate a participant from receiving PDS if:

(a) Imminent danger to the participant's health, safety, or welfare exists;

(b) The participant fails to pay patient liability;

(c) The participant's person-centered service plan indicates the participant requires more hours of service than the program can provide, jeopardizing the participant's safety and welfare due to being left alone without a caregiver present; or

(d) The participant, caregiver, family, or guardian threatens or intimidates a support broker or other PDS staff.

(8) The department may terminate a participant from receiving PDS if the department determines that the participant's PDS provider has not adhered to the person-centered service plan.

(9) Except as provided in subsection (7) of this section, prior to a participant's termination from receiving PDS, the support broker shall:

(a) Notify the assessment or reassessment service provider of potential termination;

(b) Assist the participant in developing a resolution and prevention plan;

(c) Allow at least thirty (30), but no more than ninety (90), days for the participant to resolve the issue, develop and implement a prevention plan, or designate a PDS representative;

(d) Complete and submit to the department a MAP-2000, Initiation/Termination of Participant-Directed Services terminating the participant from receiving PDS if the participant fails to meet the requirements in paragraph (c) of this subsection; and

(e) Assist the participant in transitioning back to traditional ABI services.

(10) Upon an involuntary termination of PDS, the department shall:

(a) Notify a participant in writing of its decision to terminate the participant's PDS participation; and

(b) Except if the participant failed to pay patient liability, inform the participant of the right to appeal the department's decision in accordance with Section 13 of this administrative regulation.

(11) A PDS provider shall:

(a) Be selected by the participant;

(b) Submit a completed Kentucky Participant-Directed Services Employee Provider Contract to the support broker;

(c) Be eighteen (18) years of age or older;

(d) Be a citizen of the United States with a valid Social Security number or possess a valid work permit if not a U.S. citizen;

(e) Be able to communicate effectively with the participant, participant representative, or family;

(f) Be able to understand and carry out instructions;

(g) Be able to keep records as required by the participant;

(h) Submit to a criminal background check conducted by:

1. The Administrative Office of the Courts if the individual is a Kentucky resident; or

2. An equivalent out-of-state agency if the individual resided or worked outside Kentucky during the year prior to selection as a provider of PDS;

(i) Submit to a check of the Central Registry maintained in accordance with 922 KAR 1:470 and not be found on the registry.

1. A participant may employ a provider prior to a Central Registry check result being obtained for up to thirty (30) days.

2. If a participant does not obtain a Central Registry check result within thirty (30) days of employing a provider, the participant shall cease employment of the provider until a favorable result is obtained;

(j) Submit to a check of the:

1. Nurse Aide Abuse Registry maintained in accordance with 906 KAR 1:100 and not be found on the registry; and

2. ***Vulnerable Adult Maltreatment[~~Caregiver Misconduct~~]*** Registry in accordance with 922 KAR 5:120 and not be found on the registry;

(k) Not have pled guilty or been convicted of committing a sex crime or violent crime as defined in KRS 17.165(1) through (3);

(l) Complete training on the reporting of abuse, neglect, or exploitation in accordance with KRS 209.030 or 620.030 and on the needs of the participant;

(m) Be approved by the department;

(n) Maintain and submit timesheets documenting hours worked; and

(o) Be a friend, spouse, parent, family member, other relative, employee of a provider agency, or other person hired by the participant.

(12) A parent, parents combined, or a spouse shall not provide more than forty (40) hours of services in a calendar week (Sunday through Saturday) regardless of the number of family members who receive waiver services.

(13)

(a) The department shall establish a budget for a participant based on the individual's historical costs in any Medicaid waiver program minus five (5) percent to cover costs associated with administering participant-directed services.

(b) If no historical cost exists for the participant, the participant's budget shall equal the average per capita historical costs of a participant participating in the ABI waiver program established by 907 KAR 3:090 minus five (5) percent.

(c) Cost of services authorized by the department for the participant's prior year person-centered service plan but not utilized may be added to the budget if necessary to meet the individual's needs.

(d) The department may adjust a participant's budget based on the participant's needs and in accordance with paragraphs (e) and (f) of this subsection.

(e) A participant's budget shall not be adjusted to a level higher than established in paragraph (a) of this subsection unless:

1. The participant's support broker requests an adjustment to a level higher than established in paragraph (a) of this subsection; and
2. The department approves the adjustment.

(f) The department shall consider the following factors in determining whether to allow for a budget adjustment:

1. If the proposed services are necessary to prevent imminent institutionalization;
2. The cost effectiveness of the proposed services;
3. Protection of the participant's health, safety, and welfare; or
4. If a significant change has occurred in the participant's:
   a. Physical condition resulting in additional loss of function or limitations to activities of daily living and instrumental activities of daily living;
   b. Natural support system; or
   c. Environmental living arrangement resulting in the participant's relocation.

(g) A participant's budget shall not exceed the average per capita cost of services provided to individuals with a brain injury in a nursing facility.

(14) Unless approved by the department pursuant to subsection (13)(c) through (f) of this section, if a PDS is expanded to a point in which expansion necessitates a budget allowance increase, the entire service shall only be covered via a traditional (non-PDS) waiver service provider.

(15) A support broker shall:

(a) Provide needed assistance to a participant with any aspect of PDS or blended services;

(b) Be available by phone or in person to a participant twenty-four (24) hours per day, seven (7) days per week to assist the participant in obtaining community resources as needed;

(c) Comply with applicable federal and state laws and requirements;

(d) Continually monitor a participant's health, safety, and welfare; and

(e) Complete or revise a person-centered service plan using person-centered planning principles.

(16) For a participant receiving PDS, a support broker may conduct an assessment or reassessment.

(17) Services provided by a support broker shall meet the conflict free requirements established for case management in Section 5(4) of this administrative regulation.

(18) Financial management services shall:

(a) Include managing, directing, or dispersing a participant's funds identified in the participant's approved PDS budget;

(b) Include payroll processing associated with an individual hired by a participant or the participant's representative;

(c) Include withholding local, state, and federal taxes and making payments to appropriate tax authorities on behalf of a participant;

(d) Be performed by an entity:

1. Enrolled as a Medicaid provider in accordance with 907 KAR 1:672; and
2. With at least two (2) years of experience working with acquired brain injury; and

(e) Include preparing fiscal accounting and expenditure reports for:

1. A participant or participant's representative; and
2. The department.

Section 11. Reimbursement and Coverage.

(1) The department shall reimburse a participating provider for a service provided to a Medicaid eligible person who meets the ABI long term care waiver program requirements as established in this administrative regulation.

(2) The department shall reimburse an ABI participating long term waiver provider for a prior-authorized ABI long term waiver service if the service is:

(a) Included in the person-centered service plan;

(b) Medically necessary; and

(c) Essential to provide an alternative to institutional care to an individual with an acquired brain injury who requires maintenance services.

(3) Under the ABI long term care waiver program, the department shall not reimburse a provider for a service provided:

(a) To an individual who does not meet the criteria established in Section 3 of this administrative regulation; or

(b) ***That*** ~~***[Which]***~~ has not been prior authorized as a part of the person-centered service plan.

(4)

(a) A participating ABI long term care waiver service provider shall be reimbursed a fixed rate for reasonable and medically necessary services for a prior-authorized unit of service provided to a participant.

(b) A participating ABI long term care waiver service provider certified in accordance with this administrative regulation shall be reimbursed at the lesser of:

1. The provider's usual and customary charge; or
2. The Medicaid fixed upper payment limit per unit of service as established in subsection (5) of this section.

(5)

(a) The unit amounts and base rate payment shall be ***reimbursed as*** ~~[, fixed upper payment limits, and other limits]~~ established in the following table ~~[shall apply]~~:

Service	Unit	Base Rate Effective January 1, 2025
Adult Day Health Care	15-minute	$3.86
Adult Day Training	15-minute	$4.88
Assessment & Reassessment	Per Assessment	$121.00
Behavior Programming Services	15-minute	$40.67
Case Management	Per Month	$453.75
Community Living Supports	15-minute	$6.73
Community Living Supports - PDS	15-minute	$6.73
Counseling, Individual	15-minute	$28.85
Counseling, Group	15-minute	$6.96
Environmental and Minor Home Modifications	Per Year	Up to $2,420.00
Family Training	15-minute	$30.25
Financial Management Services	Per month	$121.00
Nursing Supports	15-minute	$30.25

Occupational Therapy	15-minute	$31.34
Physical Therapy	15-minute	$30.25
Respite	15-minute	$5.92
Respite - PDS	15-minute	$5.92
Speech Therapy	15-minute	$34.38
Supervised Residential Care - Level I	Per Day	$300.00
Supervised Residential Care - Level II	Per Day	$225.00
Supervised Residential Care - Level III	Per Day	$112.50
Supported Employment	15-minute	$10.54
Supported Employment - PDS	15-minute	$10.54

(b) Specialized medical equipment and supplies shall be reimbursed on a per item basis based on a reasonable cost as negotiated by the department if they meet the following criteria:

1. They are not covered through the Medicaid durable medical equipment program established in 907 KAR 1:479; and
2. They are provided to an individual participating in the ABI waiver program.

(c) Respite care may exceed 1,440 hours in a twelve (12) month period if an individual's usual caregiver is unable to provide care due to a:

1. Death in the family;
2. Serious illness; or
3. Hospitalization.

(d) If supported employment services are provided at a work site in which persons without disabilities are employed, payment shall be made only for the supervision and training required as the result of the participant's disabilities and shall not include payment for supervisory activities normally rendered.

(e)

1. The department shall only pay for supported employment services for an individual if supported employment services are unavailable under a program funded by either the Rehabilitation Act of 1973 (29 U.S.C. Chapter 16) or Pub.L. 94-142 (34 C.F.R. Subtitle B, Chapter III).
2. For an individual receiving supported employment services, documentation shall be maintained in the individual's record demonstrating that the services are not currently available under a program funded by either the Rehabilitation Act of 1973 (29 U.S.C. Chapter 16) or Pub.L. 94-142 (34 C.F.R. Subtitle B, Chapter III).

(6) Payment shall not include:

(a) The cost of room and board unless provided as part of respite care in a Medicaid certified nursing facility. If a participant is placed in a nursing facility to receive respite care, the department shall pay the nursing facility its per diem rate for that individual;

(b) The cost of maintenance, upkeep, an improvement, or an environmental modification to a group home or other licensed facility;

(c) The cost of a service that is not listed in the approved person-centered service plan; or

(d) A service provided by a family member unless provided as an approved participant-directed service.

(7) A participating provider shall:

(a) Maintain fiscal and service records for a period of at least six (6) years. If the Secretary of the United States Department of Health and Human Services requires a longer document retention period, pursuant to 42 C.F.R. 431.17, the period established by the secretary shall be the required period;
(b) Provide, as requested by the department, a copy of, and access to, each record of the ABI Waiver Program retained by the provider pursuant to paragraph (a) of this subsection or 907 KAR 1:672; and
(c) Upon request, make available service and financial records to a representative or designee of the:
1. Commonwealth of Kentucky, Cabinet for Health and Family Services;
2. United States Department for Health and Human Services, Comptroller General;
3. United States Department for Health and Human Services, Centers for Medicare and Medicaid Services (CMS);
4. General Accounting Office;
5. Commonwealth of Kentucky, Office of the Auditor of Public Accounts; or
6. Commonwealth of Kentucky, Office of the Attorney General.

Section 12. Electronic Signature Usage. The creation, transmission, storage, and other use of electronic signatures and documents shall comply with the requirements established in KRS 369.101 to 369.120.

Section 13. Appeal Rights.
(1) An appeal of a department decision regarding a Medicaid beneficiary based upon an application of this administrative regulation shall be in accordance with 907 KAR 1:563.
(2) An appeal of a department decision regarding Medicaid eligibility of an individual based upon an application of this administrative regulation shall be in accordance with 907 KAR 1:560.
(3) An appeal of a department decision regarding a provider based upon an application of this administrative regulation:
(a) Regarding a provider's reimbursement shall be in accordance with 907 KAR 1:671, Sections 8 and 9; or
(b) Not regarding a provider's reimbursement shall be in accordance with 907 KAR 1:671.

Section 14. Incorporation by Reference.
(1) The following material is incorporated by reference:
(a) "MAP 10, Waiver Services Physician's Recommendation", June 2015;
(b) "MAP – 115 Application Intake – Participant Authorization", May 2015;
(c) "MAP – 116 Service Plan – Participant Authorization", May 2015;
(d) "MAP – 531 Conflict-Free Case Management Exemption", October 2015;
(e) "MAP-350, Long Term Care Facilities and Home and Community Based Program Certification Form", June 2015;
(f) "MAP 351, Medicaid Waiver Assessment", July 2015;
(g) "MAP-2000, Initiation/Termination of Participant-Directed Services (CDO)", June 2015;
(h) "Mayo-Portland Adaptability Inventory-4", March 2003;
(i) "Family Guide to the Rancho Levels of Cognitive Functioning", August 2006;
(j) "Kentucky Participant-Directed Services Employee Provider Contract", June 2015; and
(k) "MAP 4100a Acquired Brain Injury Waiver Program Provider Information and Services", September 2009.
(2) This material may be inspected, copied, or obtained, subject to applicable copyright law:
(a) At the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m.; or

(b) Online at the department's Web site at https://www.chfs.ky.gov/agencies/dms/dca/Pages/abi.aspx[~~http://www.chfs.ky.gov/dms/incorporated.htm~~].

CONTACT PERSON: Krista Quarles, Policy Analyst, Office of Legislative and Regulatory Affairs, 275 East Main Street 5 W-A, Frankfort, Kentucky 40621; phone 502-564-7476; fax 502-564-7091; email CHFSregs@ky.gov.

Andy Beshear
GOVERNOR

CABINET FOR HEALTH AND FAMILY SERVICES

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June 9, 2025

Senator Stephen West, Co-Chair
Representative Derek Lewis, Co-Chair
c/o Emily Caudill
Administrative Regulation Review Subcommittee
Legislative Research Commission
083, Capitol Annex
Frankfort KY 40601

907 KAR 7:015. Reimbursement for home and community based waiver services version 2.
Dear Co-Chairs West and Lewis:

After discussions with Administrative Regulation Review Subcommittee staff of the issues raised by 907 KAR 7:015, the Department for Medicaid Services proposes the attached suggested substitutes to 907 KAR 7:015.

If you have any questions, please feel free to contact Jonathan Scott, Regulatory and Legislative Advisor with the Department for Medicaid Services at (502) 564-4321 ext. 2015.

Sincerely,

Office of Legislative and Regulatory Affairs
Cabinet for Health and Family Services

Final Version: 06/04/25 at 9:18 a.m.
SUGGESTED SUBSTITUTE – *TO ORDINARY ONLY*

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Fiscal Management

907 KAR 7:015. Reimbursement for home and community based waiver services version 2.

RELATES TO: 42 C.F.R. 441 Subparts B, G, 42 U.S.C. 1396a, 1396b, 1396d, 1396n
STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3)
NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, is required to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed, or opportunity presented, by federal law to qualify for federal Medicaid funds. This administrative regulation establishes the Medicaid Program reimbursement requirements and provisions for home and community based waiver services version 2.

Section 1. Definitions.
(1) "ADHC" means adult day health care.
(2) "ADHC center" means an adult day health care center that is:
(a) Licensed in accordance with 902 KAR 20:066; and
(b) Certified for Medicaid participation by the department.
(3) "Department" means the Department for Medicaid Services or its designee.
(4) "Fixed upper payment limit" means the maximum amount the department shall reimburse per unit.
(5) "HCB" means home and community based waiver.
(6) "Participant" means a recipient who:
(a) Meets the nursing facility level of care criteria established in 907 KAR 1:022; and
(b) Meets the eligibility criteria for HCB services established in 907 KAR 7:010.
(7) "Recipient" is defined by KRS 205.8451(9).

Section 2. HCB Service Reimbursement.
(1)
(a) Except as ***established~~[provided]~~*** in Section 3, 4, or 5 of this administrative regulation, the department shall reimburse for a home and community based waiver service or item at the lesser of the billed charges or the fixed upper payment limit for each unit.
(b) The base payment rate~~[fixed upper payment limits]~~, unit amounts, and reimbursement maximums established in the following table shall apply:

Service	Unit	Base Rate Effective January 1, 2025
Adult Day Health Care - Level I	15-Minute	$3.82

Adult Day Health Care - Level II	15-Minute	$4.15	
Attendant Care - Traditional	15-Minute	$7.26	
Attendant Care - PDS	15-Minute	$7.26	
Conflict Free Case Management	Per Month	$425.92	
Environmental and Minor Home Modifications	Per Year	Up to $3,025	
Financial Management	Per Month	$196.63	
Goods and Services - Traditional	Per Year	Up to $4,235	
Goods and Services - PDS	Per Year	Up to $4,235	
Home Delivered Meals	Per Meal	$9.08	
Non-Specialized Respite - Traditional	15-Minute	$5.92	
Non-Specialized Respite - PDS	15-Minute	$5.92	
Specialized Respite - Level I	15-Minute	$5.92	
Specialized Respite - Level II	15-Minute	$12.10	
Specialized Respite - Level I (Congregate Setting)	15-Minute	$5.92	
Specialized Respite - Level II (Congregate Setting)	15-Minute	$12.10	
[~~Service~~]	[~~Fixed Upper Payment Limit~~]	[~~Unit Amount~~]	[~~Maximum~~]
[~~PDS coordination~~]	[~~$162.50 per unit~~]		[~~Two (2) units per month~~]

[Case management]	[$100.00]	[One (1) month]	[One (1) unit per month]
[Attendant care not as a PDS]	[$24.00 per hour]	[One (1) hour]	[$200 per day alone or in combination with ADHC services. Travel to and from the participant's residence shall be excluded]
[Home and community supports]	[$2.88 per unit]	[Fifteen (15) minutes]	[Forty-five (45) hours per week; Maximum of $200 per day alone or in combination with ADHC services; Travel to and from the participant's residence shall be excluded]
[Non-specialized respite]	[$2.75 per unit]	[Fifteen (15) minutes]	[$200 per day alone or in combination with specialized respite. Non-specialized respite alone or in combination with specialized respite shall not exceed $4,000 per level of care year.]
[Goods and services]	[$3,500 per level of care year]	[Level of care year]	[$3,500 per level of care year; shall not be covered unless prior authorized]
[Home delivered meals]	[$7.50 per hot meal]	[One (1) hot meal]	[One (1) hot meal per day and five (5) hot meals per week]
[Adult day health care services]	[$2.83 per unit for Level I services;$3.43 per unit for Level II services except for specialized respite, which shall be $10.00 per unit for Level II]	[Fifteen (15) minutes]	[200 units per week]
[Specialized respite]	[$4.00 per unit for Level I;$10.00 per unit for Level II]	[Fifteen (15) minutes]	[$200 per day alone or in combination with non-specialized respite. Specialized respite alone or in combination with non-specialized respite shall not exceed $4,000 per level of care year.]
[Environmental or minor home adaptation]	[$2,500 per level of care year]	[One (1) level of care year]	[$2,500 per level of care year; shall not be covered unless prior authorized]

(a) Reimbursement for a service provided as a PDS shall not exceed the department's allowed reimbursement for the same service as established in the table in subsection (1) of this section.

(b) Participants receiving services through the PDS option shall have three (3) months from the date of level of care recertification to comply with the reimbursement limit established in paragraph (a) of this subsection.

(3)

(a) Three (3) quotes from a prospective provider shall be required for:

1. An environmental or minor home adaptation; or
2. Goods and services.

(b) Documentation justifying the need for the following shall be uploaded into the MWMA:

1. An environmental or minor home adaptation; or
2. Goods and services.

(4) A service listed in subsection (1) of this section shall not be subject to cost settlement by the department unless ***the service is*** provided by a local health department.

Section 3. Local Health Department HCB Service Reimbursement.

(1) The department shall reimburse a local health department for HCB services:

(a) Pursuant to Section 2 of this administrative regulation; and

(b) Equivalent to the local health department's HCB services cost for a fiscal year.

(2) A local health department shall:

(a) Each year complete a Home Health and Home and Community Based Cost Report completed in accordance with the Home Health and Home and Community Based Cost Reporting Instructions; and

(b) Submit the Home Health and Home and Community Based Cost Report to the department at fiscal year's end.

(3) The department shall determine, based on a local health department's most recently submitted annual Home Health and Home and Community Based Cost Report, the local health department's estimated costs of providing HCB services by multiplying the cost per unit by the number of units provided during the period.

(4) If a local health department's HCB service reimbursement for a fiscal year is less than its cost, the department shall make supplemental payment to the local health department equal to the difference between:

(a) Payments received for HCB services provided during a fiscal year; and

(b) The estimated cost of providing HCB services during the same time period.

(5) If a local health department's HCB service cost as estimated from its most recently submitted annual Home Health and Home and Community Based Cost Report is less than the payments received pursuant to Section 2 of this administrative regulation, the department shall recoup any excess payments.

(6) The department shall audit a local health department's Home Health and Home and Community Based Cost Report if ***the department[~~it~~]*** determines an audit is necessary.

Section 4. Reimbursement for an ADHC Service.

(1) Reimbursement for an ADHC service shall:

(a) Be made:

1. Directly to an ADHC center; and
2. For a service only if the service was provided on site and during an ADHC center's posted hours of operation;

(b) If made to an ADHC center for a service not provided during the center's posted hours of operation, be recouped by the department; and

(c) Be limited to 200 units per calendar week per participant.

(2) Level I reimbursement shall be the lesser of:

(a) The provider's usual and customary charges; or

(b) The base payment rate established for this service in the table established in Section ***2[~~3~~]*** [~~Two (2) dollars and eighty-three (83) cents per unit of service~~].

(3)

(a) Except as established in paragraph (b) of this subsection, Level II reimbursement shall be the lesser of:

1. The provider's usual and customary charges; or
2. The base payment rate established for this service in the table established in Section 3[~~Three (3) dollars and forty-three (43) cents per unit of service~~].

(b)

1. The department shall pay a Level II reimbursement for specialized respite provided by a:
   a. Registered nurse; or
   b. Licensed practical nurse under the supervision of a registered nurse.
2. The Level II reimbursement for specialized respite shall be the lesser of:
   a. The ADHC center's usual and customary charges; or
   b. The base payment rate established for this service in the table established in Section 3[~~Ten (10) dollars per unit of service~~].

(c) An ADHC center's reimbursement for Level II services shall be:

1. Per participant; and
2. Based upon the participant's assessed level of care and most recent person-centered service plan.

(4) An ADHC basic daily service shall constitute care for one (1) participant.

(5) One (1) unit of ADHC basic daily service shall equal fifteen (15) minutes.

(6) The level of and reimbursement rate for any ADHC service provided to a participant shall be determined by an assessment of the participant using the Kentucky Home Assessment Tool (K-HAT).

Section 5. Criteria for High Intensity Level II Reimbursement and Home Health Level II Reimbursement.

(1) Any ADHC service provided to a participant by an ADHC center shall qualify for Level II reimbursement if the participant meets the Level II High Intensity criteria established in the Kentucky Home Assessment Tool (K-HAT).

(2)

(a) Specialized respite care provided to a participant by a home health agency shall qualify for Level II reimbursement if:

1. The participant meets the Level II High Intensity criteria established in the Kentucky Home Assessment Tool (K-HAT); and
2. Provided by a:
   a. Registered nurse; or
   b. Licensed practical nurse under the supervision of a registered nurse.

(b) The Level II reimbursement for specialized respite provided by a home health agency shall be the reimbursement established in Section 4(3)(b) of this administrative regulation.

(3) If a participant's assessment determines that:

(a) ADHC services to the participant do not qualify for Level II reimbursement, the department shall reimburse the Level I rate to the ADHC center for services provided to the participant; or

(b) Specialized respite care to the participant does not qualify for Level II reimbursement, the department shall reimburse the Level I rate to the ADHC center or home health agency for the specialized respite care service.

Section 6. Applicability. The reimbursement provisions and requirements established in this administrative regulation shall:

(1) Apply to services or items provided to individuals who receive home and community based services version 2 pursuant to 907 KAR 7:010; and

(2) Not apply to services or items provided to individuals receiving home and community based services version 1 pursuant to 907 KAR 1:160.

Section 7. Appeal Rights. An HCB service provider may appeal a department decision as to the application of this administrative regulation as it impacts the provider's reimbursement in accordance with 907 KAR 1:671, Sections 8 and 9.

Section 8. Incorporation by Reference.

(1) The following material is incorporated by reference:

(a) "Kentucky Home Assessment Tool (K-HAT)", July 1, 2015;

(b) "The Home Health and Home and Community Based Cost Report", November 2007; and

(c) "The Home Health and Home and Community Based Cost Report Instructions", November 2007.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law:

(a) At the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m.; or

(b) Online at the department's Web site at https://www.chfs.ky.gov/agencies/dms/dca/Pages/hcb-waiver.aspx[~~http://www.chfs.ky.gov/dms/incorporated.htm~~].

CONTACT PERSON: Krista Quarles, Policy Analyst, Office of Legislative and Regulatory Affairs, 275 East Main Street 5 W-A, Frankfort, Kentucky 40621; phone 502-564-7476; fax 502-564-7091; email CHFSregs@ky.gov.

Andy Beshear
GOVERNOR

CABINET FOR HEALTH AND FAMILY SERVICES

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June 9, 2025

Senator Stephen West, Co-Chair
Representative Derek Lewis, Co-Chair
c/o Emily Caudill
Administrative Regulation Review Subcommittee
Legislative Research Commission
083, Capitol Annex
Frankfort KY 40601

907 KAR 10:840. Hospital Rate Improvement Program.

Dear Co-Chairs West and Lewis:

After discussions with Administrative Regulation Review Subcommittee staff of the issues raised by 907 KAR 10:840, the Department for Medicaid Services proposes the attached suggested substitutes to 907 KAR 10:840.

If you have any questions, please feel free to contact Jonathan Scott, Regulatory and Legislative Advisor with the Department for Medicaid Services at (502) 564-4321 ext. 2015.

Sincerely,

Office of Legislative and Regulatory Affairs
Cabinet for Health and Family Services

SUGGESTED SUBSTITUTE
Final Version: 6/4/2025 3:00 PM

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Fiscal Management
(Amendment)

907 KAR 10:840. Hospital Rate Improvement Program.

RELATES TO: KRS ***[~~45.229, 142.303, 205.565, 205.637, 205.638, 205.639, 205.640,~~]***205.6405, 205.6406, 205.6407, 205.6408, ***205.6411,*** 216.380, 42 C.F.R. 413.17, 433.51, 438.340, ***438.6,*** 440.140, 447.271, 447.272, 42 U.S.C. 1396a, 1395ww
STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.560, 205.6406(13), ***[~~205.6411,~~]***205.6412***(3),*** 42 C.F.R. 447.252, 447.253, 42 U.S.C. 1396a
NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has ***the*** responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed, or opportunity presented, by federal law to qualify for federal funds. KRS 205.6406(13) requires the department to promulgate an administrative regulation to implement the Hospital Rate Improvement Program, ***established in*** KRS 205.6405 to 205.6408. This administrative regulation establishes the requirements for implementing the Hospital Rate Improvement Program for qualifying hospitals.

Section 1. Definitions.
(1) "Assessment" is defined by KRS 205.6405(1).
(2) "Department" means the Department for Medicaid Services or its designee.
(3) "Federal financial participation" is defined by 42 C.F.R. 400.203.
(4) "Program year" is defined by KRS 205.6405(14).
(5) "Qualifying hospital" is defined by KRS 205.6405(16) ***or KRS 205.6411(4), as appropriate***.
(6) "Received date" means the date a claim is accepted and approved into the Medicaid Management Information System and does not mean the date a claim is actually paid.
(7) "Upper payment limit" or "UPL" is defined by KRS 205.6405(19).

Section 2. Hospital Rate Improvement Program.
(1) Prior to the start of each program year and in accordance with the payment methodology required by KRS 205.6406(2), the department shall calculate for each qualifying hospital:
(a) A per-discharge uniform add-on amount that the qualifying hospital is eligible to receive as a supplemental payment for the program year for Medicaid fee-for-service discharges; and
(b) A per discharge uniform add-on amount that the qualifying hospital is eligible to receive as a supplemental payment for the program year for Medicaid managed care discharges.
(2) With the exception of the initial implementation year, no less than thirty (30) days prior to the beginning of each program year, the department shall provide each qualifying hospital written notice of the total per-discharge uniform add-on amounts for both Medicaid fee-for-service and Medicaid managed care discharges. The notice shall include the data sources and methodologies used to arrive at the value for each variable upon which the qualifying hospital's per-discharge uniform add-on amounts shall be calculated for the program year.
(3) For each quarter in a program year, the department shall:

(a) Calculate each qualifying hospital's supplemental payments for Medicaid fee-for-service and Medicaid managed care in accordance with KRS 205.6406(3) through (11) by:

1. Excluding all inpatient claims with discharge dates preceding October 1, 2018**,** from enhanced payment calculations;

2. Reducing the number of inpatient claims eligible for enhanced reimbursement by the number of previously enhanced claims that have been voided in the Medicaid Management Information System; and

3. Excluding from enhanced payment calculations partial or adjusted inpatient claims that have previously received an enhanced payment;

(b) Make a quarterly Medicaid fee-for-service supplemental payment to each qualifying hospital, or its designee acting as a fiscal intermediary, in accordance with the methodology ***established*** in KRS 205.6406(3)(a) and (c); and

(c) Make a quarterly Medicaid managed care supplemental payment to each qualifying hospital, or its designee acting as a fiscal intermediary, in accordance with the methodology ***established*** in KRS 205.6406(3)(b), (d), and (e).

(4) Payment of the quarterly Medicaid managed care supplemental payment shall be made by distribution to each Medicaid managed care organization through a quarterly supplemental capitation payment.

(5) The department shall submit with, or prior to, the quarterly supplemental capitation payment directions to the Medicaid managed care organization for the payment of the quarterly Medicaid managed care supplemental payments to qualifying hospitals.

(6) In accordance with KRS 205.6406(6), each Medicaid managed care organization shall remit to each qualifying hospital, or its designee, as directed by the department the quarterly Medicaid managed care supplemental payment within five (5) business days of receipt of the quarterly supplemental capitation payment. The department shall establish contractual penalty provisions to require that each Medicaid managed care organization remit the required amounts within five (5) business days.

(7) In accordance with KRS 205.6406(9), a qualifying hospital may seek review by the department of any quarterly supplemental payment that the qualifying hospital suspects is in error.

(a) The qualifying hospital shall submit a detailed listing of any disputed claim or claims for department consideration and potential updates to the Medicaid Management Information System.

(b) Once each claim is received and validated in the Medicaid Management Information System, the department shall adjust the qualifying hospital's future quarterly supplemental payment to account for any warranted correction.

(c) If the department determines that a correction is not warranted, the hospital may request an administrative appeal pursuant to 907 KAR 1:671.

(8) In order to receive a supplemental payment and to pay the assessment for that quarter, an entity shall be a qualifying hospital each day of a quarter for the program year.

(9) Medicaid Management Information System (MMIS) fee-for-service and managed care encounter data, queried by the claim received date, shall be utilized to calculate the quarterly payments.

(10) For each quarter in a program year, the department shall:

(a) Calculate each qualifying hospital's per-discharge hospital assessment in accordance with the methodology in KRS 205.6406(3)(g)***, (i), and (k)*** [~~***and (h)***~~]; and

(b) Provide notice to each qualifying hospital in accordance with KRS 205.6406(3)***(l)*** [~~***(i)***~~].

(11) A qualifying hospital's per-discharge hospital assessment shall be calculated using the Medicare cost report period ending in the calendar year that is two (2) calendar years prior to the first day of a

program year. For example, for the program year beginning July 1, 2019, cost report periods ending in calendar year 2017 shall be utilized.

(a) If a qualifying hospital's cost report period referenced in this subsection is greater than or less than a normal calendar year of 365 days, the total discharges used in accordance with KRS 205.6406(3)(g) shall be annualized to a 365-day period.

(b) If a qualifying hospital is newly enrolled in the Medicaid program and does not have cost report information available for the period established in this subsection, the department may utilize the cost report information of a comparable hospital to approximate the newly enrolled hospital's utilization.

(12) A qualifying hospital shall pay its calculated per-discharge hospital assessment in accordance with KRS 205.6406(7).

(13) If a hospital assessment is not received in a timely manner, the department may deny or withhold future quarterly supplemental payments until the assessment is submitted.

(14) A qualifying hospital may authorize a third-party entity to serve as a fiscal intermediary to facilitate the implementation of this administrative regulation by providing letter notice to the department.

Section 3. Reporting Requirements.

(1) Throughout a program year, a qualifying hospital shall submit any documentation or information to the department that the department requests in a timely manner as designated by the department. This request may include any documentation pertaining to:

(a) Resolution of a quarterly supplemental payment that the qualifying hospital suspects is in error; or

(b) Quality metrics set forth in the department's Quality Strategy filed with the Centers for Medicare and Medicaid Services pursuant to 42 C.F.R. 438.340.

(2) If a qualifying hospital fails to provide the department with any requested documentation in a timely manner, the department may deny or withhold future quarterly supplemental payments, until the documentation is submitted.

Section 4. Kentucky Trauma Hospital Rate Improvement (K-THRI).

(1) If consistent with federal approval, the department shall operate K-THRI as a supplemental payment arrangement that provides an average commercial rate reimbursement for inpatient hospital services, outpatient hospital services, and professional services.

(a) The methodology for determining a rate increase shall be applied equally to all providers within K-THRI.

(b) Adjustments to payments shall be made as necessary to ensure that aggregate hospital rate improvement program payments and K-THRI payments do not exceed the statewide average commercial rate limit.

(c) K-THRI payments shall be made by distribution to each Medicaid managed care organization through a quarterly supplemental capitation payment.

(d) The department shall submit with, or prior to, the K-THRI payment directions to the Medicaid managed care organization for the payment of the quarterly K-THRI payment to qualifying hospitals.

(e) In accordance with KRS 205.6406(6), each Medicaid managed care organization shall remit to each qualifying hospital, or its designee, as directed by the department the K-THRI supplemental payment within five (5) business days of receipt of the quarterly K-THRI supplemental capitation payment. The department shall establish contractual penalty provisions to require that each Medicaid managed care organization remit the required amounts within five (5) business days.

(f) The payments received by the K-THRI providers shall be reconciled to actual utilization on a quarterly basis after a reasonable claims runout period. Future payments shall be withheld or increased in order to reconcile K-THRI hospitals to the amount of the enhanced payment.

(2)

(a) Twenty (20) percent of the amount calculated shall be determined by the department and withheld by the managed care organization.

(b) The amount withheld shall be subject to the qualifying hospital meeting the ***same*** requirements established pursuant to ***the separate university directed payment program established pursuant to 42 C.F.R. 438.6*** ~~***[an annual listing of twenty-one (21) performance quality measures established by the department]***~~. The quality measures shall be identical to the performance measures that academic hospitals meet under the separate ***university directed payment*** program for academic hospitals.

(c) In order to be eligible for a quality performance payment, a K-THRI provider shall meet the ***same number of*** performance ***targets*** ~~***[target]***~~ on ***the*** ~~***[at least seven (7) of the twenty-one (21)]***~~ annual metrics listed pursuant to paragraph (b) of this section.

(d) If less than ***the established performance target*** ~~***[seven (7) of the twenty-one (21)]***~~ metrics are met, there shall be no partial payment of the quality performance payment. ~~***[For illustrative purposes only, a K-THRI provider meeting criteria for five (5) of the twenty-one (21) metrics would not receive any partial or pro-rated quality withhold payment.]***

(e) The initial performance targets shall be a two (2) percent improvement over the most recent program year's established targets.

(f) In order to qualify for evaluation pursuant to this subsection a measure shall have at least twenty (20) cases in the K-THRI hospital during the evaluation period. A measure that does not meet the twenty (20) case threshold shall be considered as a reporting-only measure and shall not be included in determining the value-based payments.

(3) Consistent with KRS 205.6412, in order to be eligible for the K-THRI portion of the HRIP program, a provider shall:

(a) Have a trauma center that has received a designation as of Level II, III, or IV;

(b) Be located in a county with a higher proportion of residents enrolled in Medicaid than the statewide median; and

(c) Have an agreement with a university-affiliated graduate medical education program or a pediatric teaching hospital to host and provide clinical rotations at that facility to train providers.

(4) The methodology for determining a rate increase ***pursuant to*** ~~***[under]***~~ this section shall be applied to all qualifying hospitals equally as a uniform dollar increase.

Section 5. Upper Payment Limit. A supplemental payment referenced in this administrative regulation is not intended to cause aggregate Medicaid hospital reimbursement to exceed the aggregate statewide upper payment limit for privately-owned and non-state government-owned hospitals established in:

(1) 42 C.F.R. 447.271;

(2) 42 C.F.R. 447.272; or

(3) Any other applicable statute or administrative regulation.

Section 6.[~~Section 5.~~] Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the coverage; and

(2) Centers for Medicare and Medicaid Services' approval for the coverage.

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