

MAC Binder Section 1 – Letters From CMS

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Located online at <http://chfs.ky.gov/dms/mac.htm>

1 – CMS-Ltr to LK from JG re Approve HIT IAPDU_dte031915:

CMS approval for Kentucky's Health Information Technology (HIT) Implementation Advance Planning Document-Update (IAPD-U) effective the date of this letter.

2 – CMS-Ltr to LL from JG re App KY APCD Phase I_dte040815:

CMS approval of the contract with the University of Kentucky to facilitate the design and development of the Kentucky All Payer Claims Database (KY-APCD), Phase I.

3 – CMS- Ltr to LL from JG re Approve HealthTech Contract_dte041615:

CMS approval of a contract between the State and HealthTech Solutions; this contract is to support the Kentucky Health Information Exchange (KHIE) in performing an environmental review and assessment.

4 – CMS-Ltr to LL from JG re CMS 372 HCBS Annual Rpt Acceptance_dte051115:

CMS approval of the CMS 372 annual report for the Home and Community-Based Services Waiver.

5 – CMS-Ltr to LL from JG re App KY APCD Phase I Mod_dte052715:

CMS approval of the contract modification with the University of Kentucky to facilitate the design and development of the Kentucky All Payer Claims Database (KY-APCD), Phase I.

6 – CMS-Ltr to LL from JG re CMS Review ABI LTC Final Rpt_dte06041515:

CMS final report on their review of the ABI LTC waiver; state found to be in compliance with five of the six review components.

7 – CMS-Ltr to LL from JG re CMS Review HCBS Draft Rpt_dte061115:

CMS draft report on their review of the HCBS waiver; state found to be in compliance with all six of the review components.

8 – CMS-Ltr to LL from AMD re HCBSW Temp Extension_dte062215:

CMS approval of the Department's request for an extension of the HCBS waiver which is currently scheduled to expire June 30, 2015; a 30-day extension granted.

9 – CMS-Ltr to LL from MS re CMS app BIP prgm grant_dte070115:

CMS awards Kentucky additional funds for the State Balancing Incentive Payment Program grant.

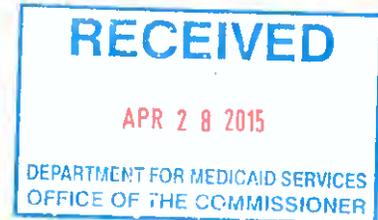
DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Chicago Regional Office
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601



Consortium for Medicaid and Children's Health Operations

March 19, 2015

Lawrence Kissner, Commissioner
Commonwealth of Kentucky, Cabinet for Health and Family Services
275 East Main Street, 6 West A
Frankfort, KY 40621



Dear Mr. Kissner:

Thank you for your correspondence dated November 7, 2014 requesting that the Centers for Medicare & Medicaid Services (CMS) approve Kentucky's Health Information Technology (HIT) Implementation Advance Planning Document-Update (IAPD-U). CMS has completed its review of this IAPD-U, (including revisions/supplemental information submitted on January 27, 2014).

Kentucky's HIT IAPD-U requests CMS funding as authorized under section 4201 of the American Recovery and Reinvestment Act of 2009 (the Recovery Act), Pub L. 111-5, and our regulations at 42 CFR § 495, subpart D.

The Social Security Act, as amended under section 4201 of the Recovery Act, as well as our final regulation at 42 CFR § 495.322, allows 90 percent federal funding participation (FFP) for administrative activities in support of implementing an incentive payment program for Medicaid eligible professionals and eligible hospitals for the adoption and meaningful use of certified electronic health record (EHR) technology. The State seeks approval of \$7,129,984 for total HIT administrative funding, \$18,093,086 for total Health Information Exchange (HIE) funding and \$648,653 for total Medicaid Management Information System (MMIS) funding covering Federal fiscal year (FFY) 2015 and FFY 2016 (October 1, 2014 through September 30, 2016).

CMS approves the State's HIT IAPD-U effective the date of this letter, in accordance with Federal regulations at 42 CFR § 495, subpart D and in accordance with Section 1903(a)(3) of the Social Security Act, and regulations found at 42 CFR § 433 Subpart C, 45 CFR § 95 Subpart F, and Part 11 of the State Medicaid Manual. This approval letter supersedes any previous letters that may have been issued for the approval period noted above.

CMS approves \$12,392,091 of HITECH FFP for FFY 2015 and \$10,308,672 of HITECH FFP for FFY 2016 as described in the table in Appendix A. Please note that this letter approves funding by Federal fiscal year. The amounts allocated per Federal fiscal year in Appendix A cannot be reallocated between Federal fiscal years, even within the period of this letter's approval, without submission and approval of an IAPD-Update. CMS' letter dated April 21, 2014 approved HIT administrative funding in the amount of \$23,388,694 (Federal share \$21,049,825) for the period October 1, 2013 through September 30, 2015. With this letter, CMS approves new funding in the amount of \$25,871,723 (Federal share \$23,284,551) for HIT administrative and HIE related activities for the period October 1, 2014 through September 30, 2016.

This supersedes any previous HITECH approval letters issued for the project including the April 21, 2014 approval letter for the period October 1, 2013 through September 30, 2015.

CMS approves \$583,788 of MMIS FFP for FFY 2015, as described in the table in Appendix A. The approved MMIS funding will expire on September 30, 2015. As shown in Appendix A, we are approving MMIS FFP at the 90% rate, not to exceed \$583,788. Federal funding associated with changes to the MMIS is approved in accordance with Section 1903(a)(3) of the Social Security Act, and regulations found at 42 CFR § 433 Subpart C, 45 CFR § 95 Subpart F, and Part 11 of the State Medicaid Manual. This MMIS funding supersedes the CMS letter dated April 21, 2014 for the period of October 1, 2013 through September 30, 2015 in the amount of \$782,840.

Only actual costs incurred are reimbursable. The State must provide adequate support for all costs claimed in addition to providing detailed records and proper audit trails. All subsequent revisions and amendments to this IAPD will require our prior written approval to qualify for FFP.

As described in our regulations at 42 CFR § 495, subpart D, Requests for Proposals (RFPs) or contracts that the State procures with funding from the herein approved IAPD, must be approved by CMS prior to release of the RFP or prior to execution of the contract.

Please refer to Appendix B for additional information about the State's responsibilities concerning activities described in the HIT IAPD. In accordance with 42 CFR § 495.342, please submit an IAPD-U no later than 12 months from the date of the approved IAPD. If the State is requesting additional funding, please provide ample time for CMS to conduct a review and issue approval.

CMS appreciates Kentucky's continued commitment and dedication to administering this important new program that will lead to improved healthcare for populations served by the Medicaid Program.

We look forward to working with you as you proceed through the implementation process of your Medicaid HIT project. If you have any questions or concerns regarding this information, please feel free to contact Samuel J. Schaffzin at (212) 616-2474 or via email at Samuel.Schaffzin@cms.hhs.gov.

Sincerely,



Jackie Garner
Consortium Administrator

Appendix A:
HITECH Detailed Budget Table
Covers Federal Fiscal Year 2015 & 2016 (ending September 30, 2016)

	HIT CMS Share (90% FFP) HIT Administrative Funding	State Share (10%)	HIT CMS Share (90% FFP) HIE Funding	State Share (10%)	HIT ENHANCED FUNDING FFP Total	State Share Total	HIT ENHANCED FUNDING TOTAL COMPUTABLE
	24C & 24D†	--	24C & 24D†	--	24C & 24D†	--	
FFY 2015	\$3,707,093	\$411,899	\$8,684,998	\$965,000	\$12,392,091	\$1,376,899	\$13,768,990
FFY 2016	\$2,709,893	\$301,099	\$7,598,779	\$844,309	\$10,308,672	\$1,145,408	\$11,454,080

	MMIS CMS Share (90% FFP)	State Share (10%)	MMIS CMS Share (75% FFP)	State Share (25%)	MMIS CMS Share (50% FFP)	State Share (50%)	MMIS ENHANCED FUNDING FFP Total	State Share Total	MMIS ENHANCED FUNDING TOTAL COMPUTABLE
	2A & 2B†	--	4A & 4B†	--	5A & 5B†	--		--	
FFY 2015	\$583,788	\$64,865	\$0	\$0	\$0	\$0	\$583,788	\$64,865	\$648,653
FFY 2016	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0

†MBES Line Item	
24A	HIT – Planning: Cost of In-house Activities
24B	HIT – Planning: Cost of Private Contractors
24C	HIT – Implementation and Operation: Cost of In-house Activities
24D	HIT – Implementation and Operation: Cost of Private Contractors
24E	HIT – Incentive Payments: Eligible Professionals
24F	HIT – Incentive Payments: Eligible Hospitals
2A	MMIS- Design, Development or Installation of MMIS: Cost of In-house Activities
2B	MMIS- Design, Development or Installation of MMIS: Cost of Private Contractors
4A	MMIS- Operations of MMIS: Cost of In-house Activities
4B	MMIS- Operations of MMIS: Cost of Private Contractors
5A	MMIS- Mechanized Systems, not approved under MMIS procedures: Cost of In-house Activities
5B	MMIS- - Mechanized Systems, not approved under MMIS procedures: Cost of Private Contractors
49	Other 50% - Title 19 (Medicaid) Other Financial Participation

Enclosures

FFP rates for specific activities and costs can be found at 76 FR 21949, available at <https://federalregister.gov/a/2011-9340>

Appendix B:
General HIT IAPD Information

Upon receipt of this HIT IAPD approval, please coordinate with the State's budget office to include the incentive payments on Form CMS-37, Medicaid Program Budget Report in the appropriate Administrative Section. The State will need to work with the CMS Regional Office Financial Management Group (FMG) staff to submit a supplemental CMS-37 that reflects this IAPD award. The State should be sure to update the 37.12 budget narrative to reflect their expected budgetary needs by quarter.

All costs identified in this HIT IAPD are understood to be estimated costs only. Allowable costs relating to the Medicaid EHR Incentive Program are determined by CMS regulations and policy described above. Only actual costs incurred are reimbursable. The State must provide adequate support for all costs claimed in addition to providing detailed records and proper audit trails.

As required in regulations at 42 CFR 495.340, the State must submit a HIT IAPD update no later than 60 days after the occurrence of project changes including but not limited to any of the following: (1) a projected cost increase of \$100,000 or more; (2) a schedule extension of more than 60 days for major milestones; (3) a significant change in planning approach or implementation approach, or scope of activities beyond that approved in the HIT IAPD; (4) a change in implementation concept or a change to the scope of the project; or, (5) a change to the approved cost allocation methodology. As required in regulations at 42 CFR 495.342, the State must submit an annual HIT IAPD 12 months from the date of the last CMS approved HIT IAPD.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303



DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

April 8, 2015

KY-15-012

Ms. Lisa Lee, Commissioner
Department for Medicaid Services
275 East Main Street, 6WA
Frankfort, KY 40621-0001



Dear Ms. Lee:

The Centers for Medicare & Medicaid Services has approved the contract with the University of Kentucky, P02 746 1500000325 1, to facilitate the design and development of the Kentucky All Payer Claims Database (KY-APCD), Phase I, which will enable broader health care market transparency, analysis of healthcare utilization, and analysis of overall quality of care delivery in Kentucky. Specifically, the database will be used by the Kentucky Medicaid Agency to determine managed care rate setting, and third party liability. The contract is in accordance with 45 CFR Part 95, Subpart F, and the State Medicaid Manual (SMM), Part 11. You are hereby authorized to execute this contract.

Please be advised that onsite reviews will be conducted to determine whether or not the objectives for which federal financial participation was approved are being accomplished, and whether or not the automatic data processing equipment or services are being efficiently and effectively utilized in support of approved programs or projects as provided for at 45 CFR Part 95, Subpart F, Section 621 and the SMM. Allowable costs are determined by 45 CFR Part 95, Subpart F, Section 631 and the SMM, Part 11. The State is reminded that this project is subject to cost allocation between all programs which benefit from it, proportional to actual use. Only actual costs incurred are reimbursable. The State must provide adequate support for all costs claimed in addition to providing detailed records and proper audit trails.

If you have any questions regarding this notice, please contact L. David Hinson at (334) 791-7826 or via email at Lawrence.hinson@cms.hhs.gov.

Sincerely,

A handwritten signature in black ink that reads "Jackie Glaze". The signature is written in a cursive, flowing style.

Jackie Glaze
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

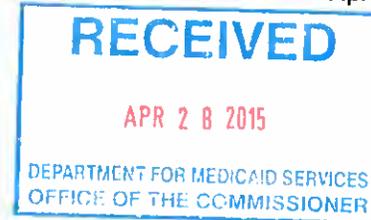
DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Chicago Regional Office
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601

Consortium for Medicaid and Children's Health Operations



April 16, 2015

Lisa Lee, Commissioner
Department for Medicaid Services
275 East Main Street – 6WA
Frankfort, KY 40621-0001



Dear Ms. Lee:

This is in response to the State of Kentucky's submission of a contract between the State and HealthTech Solutions, LLC. The request dated January 7, 2015, requests that the Centers for Medicare & Medicaid Services (CMS) review and approve the contract with HealthTech Solutions.

CMS approved the State's Implementation Advance Planning Document Update (IAPD-U) covering the contract activities on March 19, 2015. The total computable amount approved in the IAPD-U was \$25,871,723 (Federal share \$23,284,551). The approval period for the funding identified in the IAPD-U will expire on September 30, 2016.

The State's contract with HealthTech Solutions is to support Kentucky Health Information Exchange (KHIE) in performing an environmental review and assessment, in accordance with federal rules and regulations. With this contract, the State plans to conduct an environmental review and study to determine the State's status with HIE as outlined in the IAPD-U, in an amount not to exceed \$499,800 for FFY 2015. The term of the contract begins on January 1, 2015 and will end on September 30, 2015.

CMS has completed its review of the contract and approves it effective January 1, 2015, in accordance with Federal regulations at 42 CFR § 495, subpart D. Authorization of Federal funding for this contract will expire June 30, 2015, with total contract expenditures not to exceed \$499,800 (Federal share \$449,820). Please provide a copy of the signed contract once it is executed.

Any change in the approved IAPD for the project regarding scope, cost, or schedule requires CMS prior approval of an IAPD amendment in accordance with the provisions of 42 CFR Part 495, Subpart D.

CMS appreciates the State's efforts in implementing its Medicaid HIT project and looks forward to its continued success. If there are any questions concerning this information, please contact Samuel J. Schaffzin at (212) 616-2474 or via email at Samuel.Schaffzin@cms.hhs.gov.

Sincerely,

A handwritten signature in black ink that reads "Jackie Garner". The signature is written in a cursive style.

Jackie Garner
Consortium Administrator

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303



DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

May 11, 2015

Ms. Lisa Lee, Commissioner
Department for Medicaid Services
Attn: Leslie Hoffman
275 East Main Street, 6WA
Frankfort, KY 40621-0001



RE: 372 Acceptance letter – KY 40146

Dear Ms. Lee,

We have completed our review of your CMS 372 annual report for the Home and Community-Based Services (HCBS) Waiver listed below. Based on our analysis of the expenditure and recipient data submitted in this report, we find the data acceptable, subject to any future data validation reviews. A comparison of the actual data reported to the most recent CMS-approved estimates indicates that the estimated costs without the waiver were not exceeded.

- **40146 Model Waiver II**
(Waiver Year 3 – 10/01/2012 – 09/30/2013)

If you have any questions, please contact Melanie Benning at 404-562-7414.

Sincerely,



Jackie Glaze
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

cc: Michele MacKenzie, Central Office

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

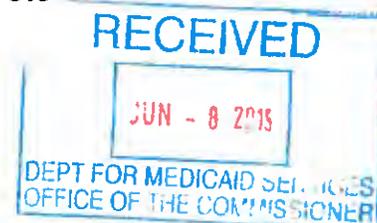


DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

May 27, 2015

KY-15-015

Ms. Lisa Lee, Commissioner
Department for Medicaid Services
275 East Main Street, 6WA
Frankfort, KY 40621-0001



Dear Ms. Lee:

The Centers for Medicare & Medicaid Services has approved the contract modification with the University of Kentucky, P02 746 1500000325 2, to extend the contract an additional 90 days, now ending September 30, 2015. The University of Kentucky will facilitate the design and development of the Kentucky All Payer Claims Database (KY-APCD), Phase I, which will enable broader health care market transparency, analysis of healthcare utilization, and analysis of overall quality of care delivery in Kentucky. Specifically, the database will be used by the Kentucky Medicaid Agency to determine managed care rate setting and third party liability. The contract is in accordance with 45 CFR Part 95, Subpart F, and the State Medicaid Manual (SMM), Part 11. You are hereby authorized to execute this contract modification.

Please be advised that onsite reviews will be conducted to determine whether or not the objectives for which federal financial participation was approved are being accomplished, and whether or not the automatic data processing equipment or services are being efficiently and effectively utilized in support of approved programs or projects as provided for at 45 CFR Part 95, Subpart F, Section 621 and the SMM. Allowable costs are determined by 45 CFR Part 95, Subpart F, Section 631 and the SMM, Part 11. The State is reminded that this project is subject to cost allocation between all programs which benefit from it, proportional to actual use. Only actual costs incurred are reimbursable. The State must provide adequate support for all costs claimed in addition to providing detailed records and proper audit trails.

If you have any questions regarding this notice, please contact L. David Hinson at (334) 791-7826 or via email at Lawrence.hinson@cms.hhs.gov.

Sincerely,

A handwritten signature in black ink that reads "Jackie Glaze".

Jackie Glaze
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

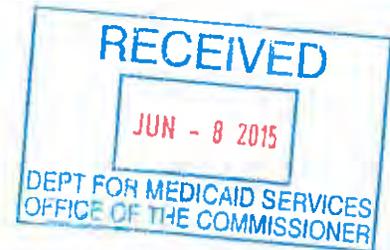
DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303



DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

June 4, 2015

Ms. Lisa Lee, Commissioner
Department for Medicaid Services
Attn: Leslie Hoffman
275 East Main Street, 6WA
Frankfort, KY 40621-0001



Dear Ms. Lee:

Enclosed is the final report of the Centers for Medicare & Medicaid Services' (CMS) review of Kentucky's Acquired Brain Injury, Long Term Care Waiver, control number 0477.R01, that serves individuals with acquired brain injury, who have reached a plateau in their rehabilitation level and require maintenance services to avoid institutionalization and live safely in the community, and meet nursing facility level of care. Thank you for your assistance throughout this process. The state's responses to CMS' recommendations have been incorporated into the appropriate sections of the report.

We would like to extend our sincere appreciation to all who assisted in the review process. We found the state to be in compliance with five of the six review components. For the area in which the state is not compliant, please ensure it is corrected at the time of renewal. We have also identified recommendations for program improvements in several of the assurance areas.

Finally, we would like to remind you to submit a renewal package on this waiver to CMS Central and Regional Offices at least 90 days prior to the expiration of the waiver, April 1, 2016. Your waiver renewal application should address any issues identified in the final report as necessary for renewal and should incorporate the state's commitments in response to the report. Please note the state must provide CMS with 90 days to review the submitted application. If we do not receive your renewal request 90 days prior to the waiver expiration date, we will contact you to discuss termination plans. Should the state choose to abbreviate the 90 day timeline, 42 CFR 441.307 and 42 CFR 431.210 require the state to notify recipients of service 30 days before expiration of the waiver and termination of services. In this instance, we also request that you send CMS the draft beneficiary notification letter 60 days prior to the expiration of the waiver.

Ms. Lisa Lee
Page 2

We again would like to express our appreciation to the Kentucky Department for Medicaid Services, who provided information for this review. If you have any questions, please contact Melanie Benning at 404-562-7414.

Sincerely,

A handwritten signature in black ink that reads "Jackie Glaze". The signature is written in a cursive, flowing style.

Jackie Glaze
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

cc: Michelle MacKenzie, CMCS



U.S. Department of Health and Human Services

**Centers for Medicare & Medicaid Services
Region IV**

FINAL REPORT

**Home and Community-Based Services Waiver Review
Kentucky's Acquired Brain Injury, Long Term Care Waiver
Control # 0477.R01**

June 4, 2015

**Home and Community-Based Services
Waiver Review Report**

Executive Summary:

The Kentucky Department for Medicaid Services (DMS) is the single state Medicaid agency that operates and has administrative authority over the Acquired Brain Injury, Long Term Care Waiver. The target population for this waiver includes individuals with acquired brain injury who have reached a plateau in their rehabilitation level, require maintenance services to avoid institutionalization and live safely in the community, and who meet nursing facility level of care. The most recent 372 report, for the waiver year ending June 30, 2012 and reported on June 19, 2014, shows an enrollment of 207 unduplicated participants with the average annual cost of \$70,070 per participant.

As requested per the CMS Interim Procedural Guidance, Kentucky submitted evidence to demonstrate that the state is meeting program assurances as required per 42 CFR 441.301. In its submission of September 9, 2014, the state provided an introduction to its overall quality management strategy, various examples and summary reports specific to each assurance.

DMS contracts with a fiscal agent that in turn contracts with a Quality Improvement Organization (QIO). The QIO determines level of care, prior authorizes requests for waiver services and approves Plans of Care. The fiscal agent provides processing and payment of provider claims.

Summary of Findings

1. State Conducts Level of Care Determinations Consistent with the Need for Institutionalization – The State substantially meets this assurance.

Suggested Recommendations

The state has developed an effective method to assure that LOC determinations are consistent with the need for nursing facility LOC, as identified in the approved waiver.

Please note that for all waivers renewed or amended after June 1, 2014, CMS requires that states update performance measures to reflect the modifications to quality measures and reporting. The sub-assurances for Level of Care have been revised. States are still required to monitor all of the waiver assurances and report on compliance and must continue to remediate identified issues; however, states are no longer required to submit reporting on individual remediation except in cases of substantiated abuse, neglect, or exploitation. In addition, if the threshold of compliance for any measure is 85% or below, CMS will require quality improvement projects and/or remediation.

2. Service Plans are Responsive to Waiver Participant Needs – The State substantially meets this assurance.

Suggested Recommendations

The state has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants. CMS has no recommendations at this time.

3. Qualified Providers Serve Waiver Participants – The State demonstrates the assurance but CMS recommends improvements or requests additional information.

Suggested Recommendations

While the state has designed a system for monitoring and addressing non-compliance regarding waiver provider qualifications, the state has identified waiver providers who did not meet certification requirements prior to rendering waiver services. The state should ensure waiver participants are referred to waiver providers who meet the state's certification requirements so that certified providers render waiver services to participants.

4. Health and Welfare of Participants – The State demonstrates the assurance but CMS recommends improvements or requests additional information.

Suggested Recommendations

While the state has designed and implemented a system for reviewing the health and welfare of participants, the state should consider differentiating the incidents reported by

type of incident and by provider in its data collection for the approved performance measures. The state should examine the number and percentage of waiver participants for whom use of a physical or chemical restraint is reported and the number and percentage of reports of inappropriate use of restraints that were remediated within the required timeframe. The state should consider incorporating such data into the waiver's quality improvement strategy. This would provide the state with a more robust data set regarding the health and welfare of participants.

5. State Medicaid Agency Retains Administrative Authority Over the Waiver Program - The State does not demonstrate the assurance.

Required Recommendations

The state must provide data for the approved performance measure for this assurance and any remediation actions that were necessary. The state must demonstrate its oversight and monitoring of the contracted fiscal agent. Also, the state should consider adding performance measures demonstrating its monitoring of the QIO during the next renewal.

6. State Provides Financial Accountability for the Waiver – The State demonstrates the assurance but CMS recommends improvements or requests additional information.

Suggested Recommendations

While the state provided evidence regarding the approved performance measures, the state should consider measuring the reported number and percentage of providers who maintain financial records according to program policy.

Introduction:

Pursuant to section 1915(c) of the Social Security Act, the Secretary of the Department of Health and Human Services has the authority to waive certain Medicaid statutory requirements to enable a State to provide a broad array of home and community-based services (HCBS) as an alternative to institutionalization. The Centers for Medicare and Medicaid Services (CMS) has been delegated the responsibility and authority to approve State HCBS waiver programs. CMS must assess each home and community-based waiver program in order to determine that assurances are met. This assessment also serves to inform CMS in its review of the State's request to renew the waiver.

State's Waiver Name: Acquired Brain Injury, Long Term Care Waiver

Operating Agency: Department for Medicaid Services

State Waiver Contact: Lisa Lee, Commissioner, Department for Medicaid Services

Target Population: Individuals with Acquired Brain Injury

Level of Care: Nursing Facility

Number of Waiver Participants: 207

Average Annual per capita costs: \$70,070 (per CMS 372 Report)

Effective Dates of Waiver: July 1, 2011 through June 30, 2016

Approved Waiver Services: Adult Day Health, Adult Day Training, Case Management, Respite, Supported Employment, Behavioral Services, Counseling, Group Counseling, Nursing Supports, Occupational Therapy, Physical Therapy, Specialized Medical Equipment, Speech Therapy, Community Guide, Financial Management Services, Goods and Services, Assessment/Reassessment, Community Living Supports, Environmental and Minor Home Modifications, Family Training, Supervised Residential Care I, Supervised Residential Care II, Supervised Residential Care III

CMS RO Contact: Melanie Benning

I. State Conducts Level of Care Determinations Consistent with the Need for Institutionalization

The State must demonstrate that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care (LOC) consistent with care provided in a hospital, nursing facility or ICF/MR.

Authority: 42 CFR 441.301; 42 CFR 441.302; 42 CFR 441.303; SMM 4442.5

The State substantially meets this assurance

(The State's system to assure appropriate level of care determinations is adequate and effective, and the State demonstrates ongoing, systemic oversight of the level of care determination process.)

Evidence Supporting This Conclusion:

(Evidence is included that supports the findings that the State substantially meets this assurance.)

The state applies the level of care criteria for nursing facility services, which is based upon review of individual medical necessity. The initial evaluation may begin outside of an individual's residence, but will be completed within the individual's residence. All applicants must have an order stating that a Nursing Facility Level of Care (LOC) is needed, which is signed by a physician, nurse practitioner, or physician assistant. Once the assessment is completed, it is reviewed by the Quality Improvement Organization (QIO), which may consist of a registered nurse, social worker, and/or physician. If the assessment meets the LOC guidelines, then the assessor is notified. Participant LOC determinations are conducted within 12 months of the participant's initial or last level of care determination.

Once a person meets the LOC criteria, those dates are entered into the Medicaid Management Information Systems (MMIS) with a 12 month span. The date begins with the date the MAP-351 (assessment form) is signed and must be updated in order for the person to continue to receive services and the provider to receive payment for delivery of the services. The DMS reviews waiver participant files annually to ensure and verify that all LOC determination instruments are utilized appropriately.

Written documentation of the evaluations and reevaluations is maintained by the case manager and agencies providing services to the participant. Electronic documentation is maintained by the QIO.

The state's fiscal agent, Hewlett Packard, is the data source for all performance measures for this assurance. For the sub-assurance that ensures that an evaluation for LOC is provided to all applicants for whom there is a reasonable indication that services may be needed in the future, the state collects data for one performance measure: the number and percentage of new waiver enrollees who received a LOC evaluation prior to receipt of services. The compliance rate for this measure was 100% in Fiscal Years (FY) 2011, 2012, and 2013.

For the sub-assurance that ensures the LOC is reevaluated at least annually or as specified in the approved waiver, the state provides one performance measure: number and percentage of waiver participants who received a redetermination of LOC within 12 months of their initial or last LOC determination. The compliance rate for this measure for FYs 2011, 2012 and 2013 was 99%,

99%, and 97% respectively. Providers who were non-compliant with timely annual redeterminations were notified via written correspondence and informed that a written corrective action plan to address the issues must be submitted to the DMS within a specified time frame; such providers were not reimbursed for services rendered to the participant prior to the completion of the reevaluation.

For the sub-assurance that the processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine LOC, the state provides one performance measure: number and percentage of waiver participants' level of care determinations with completed assessment forms on file. The compliance rate for this measure was 100% in FYs 2011, 2012, and 2013.

Suggested Recommendations:

(Although the State substantially meets this assurance, CMS may recommend improvements, though the improvements are suggestions and not requirements for renewal)

The state has developed an effective method to assure that LOC determinations are consistent with the need for nursing facility LOC, as identified in the approved waiver.

Please note that for all waivers renewed or amended after June 1, 2014, CMS requires that states update performance measures to reflect the modifications to quality measures and reporting. The sub-assurances for Level of Care have been revised. States are still required to monitor all of the waiver assurances and report on compliance and must continue to remediate identified issues; however, states are no longer required to submit reporting on individual remediation except in cases of substantiated abuse, neglect, or exploitation. In addition, if the threshold of compliance for any measure is 85% or below, CMS will require quality improvement projects and/or remediation.

State Response:

The state acknowledges the above information.

CMS Response:

The CMS has no further recommendations at this time.

II. Service Plans are Responsive to Waiver Participant Needs

The State must demonstrate that it has designed and implemented an adequate system for reviewing the adequacy of service plans for waiver participants. *Authority: 42 CFR 441.301; 42 CFR 441.302; 42 CFR 441.303; SMM 4442.6; SMM 4442.7; Section 1915(c) Waiver Format, Item Number 13*

The State substantially meets this assurance

(The State's system to monitor service plans is adequate and effective, participants are afforded choice between/among waiver services and providers and the State demonstrates ongoing, systemic oversight of service plans)

Evidence Supporting This Conclusion:

(Evidence is included that supports the findings that the State substantially meets this assurance.)

The participant's Plan of Care (POC) is developed utilizing the in-depth waiver assessment/reassessment tool. This tool includes identification of the participant's ability to perform activities of daily living and instrumental activities of daily living. The assessment further identifies the participant's current support systems and services (waiver and non-waiver), clinical information (including current medications), and health, safety and welfare risks. The POC includes identified needs (from the assessment) and identifies goals, objectives/interventions, and outcomes. The POC is developed with the participation of the participant and/or guardian, and other service providers. All individuals participating in the development of the POC must sign the document to indicate their involvement. The case manager is responsible for providing detailed information to the participant regarding available waiver services and providers to meet the identified needs. The participant is free to choose from the listing of available waiver providers and identified services.

All POCs are reviewed and the requested services prior authorized through the Quality Improvement Organization (QIO). When POCs are submitted to the QIO, a copy of the completed assessment is included in the packet. The QIO is responsible for review of the assessment, ensuring all identified needs are included and adequately addressed in the POC. Should the QIO determine identified needs are not addressed in the POC, the QIO will issue written notification to the case manager requiring additional information as to how these needs will be addressed.

The participant's case manager is responsible for the coordination and monitoring of all the participant's services including non-waiver services. The case manager conducts monthly face-to-face contacts to make arrangements for activities to ensure the participant needs are addressed. Upon the case manager's completion of the POC, the case manager is responsible for submitting the POC and assessment/reassessment to the QIO for review and service prior authorization. A prior authorization is not issued without the QIO review and approval.

The POC is updated at least every 12 months and as often as necessary to address changes in the participant's needs. Any changes in the participant's needs are identified by the case manager during the monthly face-to-face contact. All modifications to a POC are reviewed by the QIO.

The data source for all performance measures for this assurance is the Department for Medicaid Services. For the sub-assurance that ensures service plans address all the participant's assessed needs and personal goals, the state provides data for the following approved performance measure: the number and percentage of participants who had service plans that were adequate and appropriate to their needs (including health care needs) as indicated in the assessment(s). Compliance with this performance measure was 93%, 96%, and 99% for Fiscal Years (FY) 2011, 2012, and 2013, respectively. For those non-compliant service plans, the provider was requested to submit a corrective action plan outlining how compliance will be attained, within a designated time frame. The DMS conducted follow-up monitoring to ensure implementation and effectiveness of the corrective action plan, to ensure that all participants' service plans are accurate, and appropriate to their needs, including health care needs. All instances of non-compliance were remediated following a corrective action plan.

For the sub-assurance that ensures the state monitors service plan development in accordance with its policies and procedures, the state provides three approved performance measures. First, the state measured the number and percentage of waiver participants reviewed who had initial service plans that received authorization from the QIO prior to service delivery. Second, the state examined the number and percentage of waiver service plans submitted following the interdisciplinary team meeting held within the first 30 days of initial service authorization. Lastly, the state measured the number and percentage of waiver participants' receiving participant-directed services with an approved budget. Compliance for all of these performance measures was 100% for FYs 2011, 2012, and 2013.

For the sub-assurance that ensures service plans are updated/revised at least annually or when warranted by changes in the participant's needs, the state provides one approved performance measure. Specifically, the state examined the number and percentage of waiver participants whose service plans were updated and submitted prior to the annual recertification date. Compliance with this performance measure was 99%, 99% and 97% for FYs 2011, 2012 and 2013, respectively. Providers who were noncompliant with submitting timely annual recertifications were notified via written correspondence and informed that a written corrective action plan to address the issues is required and must be submitted to the DMS within a specified time frame. Providers who did not submit the recertifications in a timely manner were not reimbursed for services rendered to the participant prior to completion of the recertification.

For the sub-assurance that ensures services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan, the state provided data for the two approved performance measures. First, the state measured the number and percentage of waiver participants who received services in the type, scope, amount, and duration as specified in the service plan. Next, the state measured the number and percentage of waiver participants' who received participant-directed services within the approved budget. Compliance for both of these performance measures was 100% for FYs 2011, 2012, and 2013.

For the sub-assurance that ensures participants are offered a choice between waiver services and institutional care and between/among providers, the state uses two approved performance measures. First, the state measured the number and percentage of waiver participants' records with an appropriately completed and signed freedom of choice form specifying choice was

offered between waiver services and institutional care, waiver services, and waiver providers. Next, the state measured the number and percentage of waiver participants whose records contain confirmation of notification of the option to choose consumer directed options. Compliance for both of these performance measures was 100% for FYs 2011, 2012, and 2013.

Suggested Recommendations:

(Although the State substantially meets this assurance, CMS may recommend improvements, though the improvements are suggestions and not requirements for renewal.)

The state has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants. CMS has no recommendations at this time.

State Response:

The state acknowledges the above response.

CMS Response:

The CMS has no further recommendations at this time.

III. Qualified Providers Serve Waiver Participants

The State must demonstrate that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers. Authority: 42 CFR 441.302; SMM 4442.4

The State demonstrates the assurance but CMS recommends improvements or requests additional information

Evidence Supporting This Conclusion:

(Evidence that supports this conclusion is minimally adequate, however, there are some issues or information that warrant improvement or would benefit from additional information)

The Department for Medicaid Services (DMS), Acquired Brain Injury Branch is responsible for certifying ABI provider agencies. The Office of Inspector General (OIG) is responsible for surveying and licensing those agencies that are licensed. The DMS also enrolls non-licensed providers for waiver services, which it certifies. Where applicable, a number of ABI waiver providers are accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). All ABI waiver providers are required to ensure that each employee completes six (6) hours of continuing education regarding brain injury annually, in accordance with state requirements.

Where provider non-compliance is noted, DMS conducts monitoring of plans of correction submitted by the provider and provides technical assistance or additional training in response to survey or investigation findings to ensure implementation of the approved plan of correction and compliance with provider regulatory requirements. Remediation methods are determined by survey findings and are based on overall volume of deficiencies cited, historical deficiencies

from previous surveys or investigations, and analysis of incident management reports. DMS remediation methods may include sanctions, including contingencies with limited timeframes for correction, shortened certification lengths, moratoriums on new admissions and recommendations for termination of certification and participation as a waiver provider.

The data source for all performance measures is the DMS, which conducts first-line monitoring of all waiver providers. For the sub-assurance that the state verifies providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to furnishing waiver services, the state provides data for the three approved performance measures. First, the state measured the number and percentage of ABI waiver providers who meet certification requirements prior to the provision of waiver services. The state reported 70%, 94%, and 85% of waiver providers met certification requirements prior to provision of waiver services for Fiscal Years (FYs) 2011, 2012 and 2013, respectively. Each provider that did not meet certification requirements was cited for the deficiency and required to submit a Corrective Action Plan outlining how compliance will be attained within a specified time frame. DMS conducted follow up monitoring to ensure implementation and effectiveness of the Corrective Action Plan. Technical assistance was also provided on an ongoing basis via phone calls, emails, during monitoring visits, and through provider trainings. All instances of non-compliance with this performance measure were remediated following a corrective action plan at 100%.

Next, the state measured the number and percentage of provider agencies who continue to meet certification requirements following initial enrollment. The state reported 100%, 99%, and 100% of waiver providers continued to meet certification requirements following initial enrollment for FYs 2011, 2012 and 2013, respectively. The single provider that did not meet these requirements was cited for the deficiency and required to submit a Corrective Action Plan outlining how compliance would be attained within a specified timeframe. This instance of non-compliance was fully remediated following the corrective action plan.

The state also measured the number and percentage of providers with corrective action plans completed within required time frames. The compliance rate for this measure was 100% during FYs 2011 through 2013.

For the sub-assurance that ensures non-licensed/non-certified providers adhere to waiver requirements, the performance measures provided for this assurance apply to all waiver providers, including those that are non-licensed.

For the sub-assurance that ensures the state implements policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver, the state provided data for the two approved performance measures. First, the state measured the number and percentage of provider agencies whose staff completed mandatory training annually (i.e. CEU, CPR, First Aid, etc.). The state reported 100%, 100%, and 99% of waiver provider staff completed mandatory training annually for FYs 2011, 2012 and 2013, respectively. The single provider that did not meet the mandatory training requirements was required to submit a corrective action plan outlining how compliance would be attained within a specified timeframe. This instance of non-compliance was remediated following the corrective action plan at 100%.

Specifically, the staff who had not met mandatory training requirements within the required time frame were not allowed to provide direct services until the training requirements were met.

Suggested Recommendations:

(CMS recommendations enable the State to improve upon the process, evidence, or reporting. The submitted State evidence can be enhanced considerably with the addition of information or program improvements.)

While the state has designed a system for monitoring and addressing non-compliance regarding waiver provider qualifications, the state has identified waiver providers who did not meet certification requirements prior to rendering waiver services. The state should ensure waiver participants are referred to waiver providers who meet the state's certification requirements so that certified providers render waiver services to participants.

State Response:

The state responded, acknowledging CMS' suggested recommendation to ensure waiver participants are referred to waiver providers who meet the state's certification requirements so that certified providers render waiver services to participants.

The state notes that to enroll as a waiver service provider, a provider must meet and comply with the Kentucky Medicaid provider enrollment requirements, terms and conditions in accordance with applicable state regulations. Also, all waiver providers undergo pre-service personnel audits and pre-service site inspection prior receipt of certification to provide services. The state notes this process allows for all providers to meet state certification requirements upon initial service provision to waiver participants. For new providers, along with the initial pre-service survey, the DMS or its designee conducts a follow-up survey within 30 days of initial service provision, an additional survey upon six months of service delivery, and recertification surveys at least annually thereafter. The length of certification is determined through analysis of certification survey findings and is based on overall volume of deficiencies cited, historical deficiencies from previous surveys or investigations, and analysis of incident management reports. The DMS or its designee may initiate sanctions including contingencies with limited timeframes for correction, shortened certification lengths, moratoriums on new admissions, and recommendations for termination of certification and participation as a provider.

The state notes that all employees of enrolled waiver providers are required to provide, in advance, a criminal background check and state nurse aide abuse registry check. Additionally, all employees of waiver providers are required to submit to screening through a state-maintained abuse registry. Employee records are reviewed to examine compliance with these requirements a minimum of annually.

The state notes that its regulations require case managers to complete training that is consistent with the curriculum that has been approved by the department prior to providing case management services. Additionally, waiver providers are required by regulation to ensure that each employee complete waiver training consistent with the curriculum that has been approved by the department prior to working independently with a waiver participant. The state notes that training requirement completion is monitored by the state at a minimum of annually. Also, citations are given and plans of correction are requested of those providers where DMS

monitoring has discovered deficiencies in training, pre-hire and personnel requirements. Those discovered deficiencies were reported in the performance measure, the number and percentage of waiver providers who meet certification requirements prior to the provision of waiver services. The state notes that discovered deficiencies were remediated following corrective action plans at 100%. The DMS indicates it conducts monitoring of Plans of Correction submitted by the provider in response to survey and investigation findings to ensure implementation of the approved plan of correction and compliance with regulatory requirements.

CMS Response:

The CMS thanks the state for the additional information provided, including its description of its current processes for addressing non-compliant providers. The state should continue to monitor its processes for referral of waiver participants to waiver providers who meet the state's certification requirements.

IV. Health and Welfare of Waiver Participants

The State must demonstrate that, on an ongoing basis, it identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation. Authority: 42 CFR 441.302; 42 CFR 441.303; SMM 4442.4; SMM 4442.9

The State demonstrates the assurance but CMS recommends improvements or requests additional information

Evidence Supporting This Conclusion:

(Evidence that supports this conclusion is minimally adequate, however, there are some issues or information that warrant improvement or would benefit from additional information)

The state requires ABI waiver providers to have procedures in place to ensure that instances of abuse, neglect and exploitation are reported to the proper authorities. Waiver providers are also required to train all staff in the prevention, identification, and reporting of abuse, neglect, and exploitation.

The Department for Community Based Services receives notification of suspected abuse, neglect and/or exploitation on an on-going basis and investigates allegations of abuse, neglect and exploitation. In addition, ABI providers are required to implement an Incident Report that details the "incident," the provider's investigation, follow-up communication with the participant, or legal guardian, other providers and social and law enforcement agencies. The report also describes how the provider's policies and procedures will be revised to prevent future incidents. The providers are required to educate waiver participants, family members and legal representatives regarding the process for reporting abuse, neglect, exploitation, incidents, and filing a complaint. Waiver providers are required to report all suspected incidents of abuse, neglect and exploitation to the Department for Community Based Services/Adult Protection Services.

The state classifies incidents into three classes. A class I incident is minor in nature and does not require an investigation but does require reporting to the case manager or supports broker within

24 hours, reporting to the guardian and retaining such incident in the provider's file. A class II incident is serious in nature, includes medication errors, and must be investigated by the provider agency and reported to the case manager, guardian and the DMS with 24 hours of discovery. Such reporting to the DMS requires a follow-up complete written report within 10 calendar days of discovery. A class III incident is grave in nature, involves suspected abuse, neglect or exploitation, or a medication error that requires a medical intervention. A class III incident also includes use of a physical or chemical restraint or a death. The state allows use of a restraint only when less restrictive interventions have been determined ineffective to protect the participant, staff members, or others from harm. Should physical or chemical restraint be utilized, a critical incident report must be filed in addition to documentation illustrating evidence that less restrictive interventions were ineffective and the use of the restraint was used appropriately.

All critical incidents require an investigation by the provider agency within 24 hours of discovery and a report to the DMS, Acquired Brain Injury Branch. The use of restraint (physical or chemical) must be reviewed, documented and updated in the plan of care or treatment plan.

DMS monitoring staff review all incident reports and may request a corrective action plan from the provider when agency policies and procedures do not fully address the risks involved in a participant's care. Plans of correction may include staff education within the agency, or additional training for the provider. DMS monitoring staff may conduct an on-site investigation of the report, which may involve interviews of participants, staff, and community members as appropriate.

For the assurance that ensures that on an ongoing basis the state identifies, addresses and seeks to prevent the occurrence of abuse, neglect, and exploitation, the state provides data for the approved performance measures. The data source is the DMS' ABI incident reporting database. First, the state measured the number and percentage of critical incidents that were reported within required time frames. The state reported 95%, 100%, and 96% of critical incidents were reported within the required timeframes for FYs 2011, 2012 and 2013, respectively. Waiver providers who submitted critical incidents that were not reported within the required time frames were identified by DMS staff. Non-compliant providers were requested to submit a corrective action plan to address late submittals of critical incident reports. Those providers that were requested to provide a plan of correction did so within the specified time frame. Such plans of correction included examination of the processes and systems within the organization that require improvement to prevent future incidents from occurring.

Next, the state measured the number and percentage of critical incidents that received follow up within required time frames. The state reported 95%, 100%, and 96% of critical incidents were reported within the required timeframes for FYs 2011, 2012 and 2013, respectively. The data source was the DMS. Waiver providers that did not submit follow-up reports within the required time frames, were notified by DMS staff that a follow up was due immediately in order for the provider to remain in compliance with state requirements. Providers were requested to submit a corrective action plan to address late submittals of the follow-up to critical incident reports. Those providers that were requested to provide a plan of correction did so within the specified

time frame. Such plans of correction included examination of the processes and systems within the organization that require improvement to prevent future incidents from occurring.

The state also measured the number and percentage of class III critical incidents that were reviewed by DMS to confirm that the incident was investigated by the appropriate entity within the required timeframes. Compliance for this performance measure was 100% for each of the FYs 2011, 2012, and 2013.

Finally, the state measured the number and percentage of deaths reviewed by the DMS. Compliance for this performance measure was 100% for each of the FYs 2011, 2012, and 2013.

Suggested Recommendations:

(CMS recommendations enable the State to improve upon the process, evidence, or reporting. The submitted State evidence can be enhanced considerably with the addition of information or program improvements.)

While the state has designed and implemented a system for reviewing the health and welfare of participants, the state should consider differentiating the incidents reported by type of incident and by provider in its data collection for the approved performance measures. The state should examine the number and percentage of waiver participants for whom use of a physical or chemical restraint is reported and the number and percentage of reports of inappropriate use of restraints that were remediated within the required timeframe. The state should consider incorporating such data into the waiver's quality improvement strategy. This would provide the state with a more robust data set regarding the health and welfare of participants.

State Response:

The state acknowledges this suggested recommendation. The state currently collects incident reporting information by type of incident and provider, which is tracked in its ABI Incident Reporting Database. The state also notes it has added fields to such database regarding use of physical or chemical restraint and related remediation activities as recommended.

CMS Response:

The CMS thanks the state for providing additional information regarding its monitoring mechanism to address use of restraint in the waiver program. CMS suggests the state continue to track all incidents of use of restraint and related remediation and system improvement activities. The state should incorporate such processes into the waiver's quality improvement strategy during the next waiver renewal.

V. Administrative Authority

The State must demonstrate that it retains ultimate administrative authority over the waiver program and that its administration of the waiver program is consistent with its approved waiver application. Authority: 42 CFR 441.303; 42 CFR 431; SMM 4442.6; SMM 4442.7

The State does not demonstrate the assurance

(The State demonstrates a pervasive failure to meet this assurance and has no internal plan of correction.)

Evidence Supporting This Conclusion:

(Evidence that supports the finding that the State does not substantially meet the assurance.)

The Kentucky Department for Medicaid Services (DMS) is the single state Medicaid agency that has administrative authority for this waiver; there is no operating agency for this waiver. The Department for Medicaid Services (DMS) is responsible for assessing the performance of the contracted entities providing Quality Improvement Organization functions and the fiscal agent, Hewlett Packard.

While the state did not provide any data for this assurance, the approved waiver utilizes a single performance measure: the number and percentage of Utilization Management Reports completed in a timely manner by the Fiscal Agent.

Required Recommendations:

(CMS recommendations must include necessary rectification actions by the State at the time of renewal in order to comply with the assurance when the State does not substantially meet the assurance.)

The state must provide data for the approved performance measure for this assurance and any remediation actions that were necessary. The state must demonstrate its oversight and monitoring of the contracted fiscal agent. Also, the state should consider adding performance measures demonstrating its monitoring of the QIO during the next renewal.

State Response:

Upon review of the state's submitted evidence report, the state notes that information related to the Administrative Authority assurance was inadvertently omitted from the state's response. The state wishes to convey its apologies for this oversight.

The state notes the DMS exercises oversight of performance of the waiver functions conducted by other state and local/regional non-state agencies and contracted entities. The state monitors administration of the waiver program for consistency with the state's approved waiver application by promulgating program regulations for services and payments; generating notifications to providers when there is a clarification or policy revision; conducting oversight of the fiscal agent for provider enrollment and member services; conducting first line monitoring of 100% of the waiver providers and annual certification reviews; and monitoring of all waiver providers as needed.

The state contracts with a non-governmental agency, Hewlett Packard, to provide services as a fiscal agent. The fiscal agent in turn contracts with the QIO, Carewise Health. The QIO performs level of care reviews, eligibility determinations, prior authorization of requested services and approves the plan of care. The state continually monitors and assesses the performance of the contracted agencies through policy clarification, post payment auditing processes, second line monitoring, regulation, monthly, quarterly and annual reporting, and as included in the ABI Quality Management Strategy plan. The DMS routinely reviews all reports to identify changing trends so that proactive modifications may be implemented to ensure

continuing quality care. Based on continued analysis, the DMS initiates any needed revisions to the governing regulation. The DMS provides policy clarifications to the waiver providers, QIO and fiscal agent to monitor appropriate implementation of program policy and understanding of any programmatic or regulatory revisions as they occur.

The state notes, as part of its monitoring and oversight of the fiscal agent, the fiscal agent is required to submit monthly waiver utilization reports, Utilization Management Reports, to provide information specific to the number of active waiver participants, level of care requests received, level of care requests approved/denied, service requests received, and service requests approved/denied.

The state provides data for the single, approved performance measure for this assurance: the number and percentage of Utilization Management Reports completed in a timely manner by the fiscal agent. The compliance rate for this measure was 100% for years 2011, 2012, and 2013. The state does not specify whether the years measured are waiver years, calendar years, or fiscal years.

The state provides a plan of action to address its quality improvement strategy for this assurance. By June 2016, the state will update the current performance measure to reflect its modifications to quality measures and reporting for this assurance. Also, by June 2016, the state will develop additional performance measures, which demonstrate its monitoring of the QIO.

CMS Response:

The CMS thanks the state for providing data regarding the approved performance measure for this assurance. CMS acknowledges the state's commitment to include additional performance measures demonstrating its monitoring of the QIO as part of the next waiver renewal.

VI. State Provides Financial Accountability for the Waiver

The State must demonstrate that it has designed and implemented an adequate system for assuring financial accountability of the waiver program. *Authority: 42 CFR 441.302; 42 CFR 441.303; 42 CFR 441.308; 45 CFR 74; SMM 2500; SMM 4442.8; SMM 4442.10*

The State demonstrates the assurance but CMS recommends improvements or requests additional information

Evidence Supporting This Conclusion:

(Evidence that supports this conclusion is minimally adequate, however, there are some issues or information that warrant improvement or would benefit from additional information)

The state contracts with a fiscal agent, Hewlett-Packard, for claims processing, financial management, system maintenance and modification, and provider services, including enrollment, education and call center support for designated healthcare programs. The contracting agency conducts a quality review to verify that financial records have been submitted to Department for Medicaid Services (DMS) according to provider agreements/contracts and that payment is in accordance with the DMS reimbursement methodology for services rendered.

The DMS conducts annual audits of all waiver providers. These audits include a post-payment review of Medicaid reimbursement to the provider agency for services rendered to a waiver participant. DMS utilizes reports generated from the Medicaid Management Information System (MMIS) reflecting each service billed by the waiver provider. Comparison of payments to participant records, documentation and approved Plan of Care (POC) are conducted. If any payments were issued without the appropriate documentation or not in accordance with an approved POC, DMS will initiate recoupment of the monies. Additional billing reviews are conducted based on issues identified during certification surveys or investigations.

The state provides two approved performance measures for this assurance. The data source is the state's fiscal agent. First, the state measured the number and percentage of waiver service claims reviewed that were coded and paid in accordance with reimbursement methodology. The state reported 100% of waiver service claims reviewed were coded in accordance with reimbursement methodology during Fiscal Years (FYs) 2011 through 2013. Next, the state measured the number and percentage of waiver service claims that were submitted for ABI waiver participants who were enrolled and active in the waiver on the service delivery date. The state reported that 100% of waiver service claims were submitted for ABI waiver participants who were enrolled and active in the waiver on the service delivery date during FYs 2011 through 2013.

Suggested Recommendations:

(CMS recommendations enable the State to improve upon the process, evidence, or reporting. The submitted State evidence can be enhanced considerably with the addition of information or program improvements.)

While the state provided evidence regarding the approved performance measures, the state should consider measuring the reported number and percentage of providers who maintain financial records according to program policy.

State Response:

The state provided no additional information.

CMS Response:

The CMS has no further recommendations at this time.

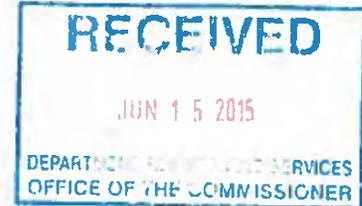
DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, GA 30303



DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

June 11, 2015

Ms. Lisa Lee, Commissioner
Cabinet for Health and Family Services
Department for Medicaid Services
275 East Main Street, 6WA
Frankfort, KY 40621



Dear Ms. Lee:

Enclosed is the draft report of the Centers for Medicare & Medicaid Services' (CMS) quality review of Kentucky's Acquired Brain Injury Home and Community Based Waiver with control number 0333.R03. This waiver serves individuals with brain injuries who are at least 18 years of age and meet the nursing facility level of care.

We would like to extend our sincere appreciation to all who assisted in the review process.

We found the state to be in compliance with all six of the review components. Please review the draft report and submit your comments within 90 days of receiving this letter. Your response will be incorporated into the final report, which will then become a public document. Should we receive no response from you by the 90th day, September 11, 2015, this draft becomes a final document. We are available to discuss the report and provide technical assistance. Please do not hesitate to let us know how we may be of assistance.

We would again like to extend our sincere appreciation to the Kentucky Department for Medicaid Services, who provided information for this review. If you have any questions, please contact Alice Hogan at 404-562-7432.

Sincerely,



Jackie Glaze
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosure
cc: Amanda Hill, CMCS



U.S. Department of Health and Human Services

**Centers for Medicare & Medicaid Services
Region IV**

DRAFT REPORT

**Home and Community-Based Services Waiver Review
Kentucky's Acquired Brain Injury Waiver
Control # 0333.R03**

June 11, 2015

**Home and Community-Based Services
Waiver Review Report**

Executive Summary:

The Kentucky Department for Medicaid Services (DMS) is the single state Medicaid agency that operates and has administrative authority over the Acquired Brain Injury Waiver. The target population for this waiver is individuals 18 and older who have a brain injury and who meet the nursing facility level of care. The most recent 372 report, for the waiver year ending December 31, 2012 and reported on October 6, 2014, shows an enrollment of 180 unduplicated participants with the average annual cost of \$109,087 per participant.

As requested per the CMS Interim Procedural Guidance, Kentucky submitted evidence to demonstrate that the state is meeting program assurances as required per 42 CFR 441.301. In its submission of February 24, 2015, the state provided summary data specific to each assurance.

DMS contracts with a non-governmental agency that performs Quality Improvement Organization (QIO) functions. The QIO conducts level of care evaluations, eligibility determinations, and prior authorizations for services. There is also a contract with a non-governmental agency to provide the services of a fiscal agent, including the processing and payment of provider claims. Kentucky's Department for Aging and Independent Living (DAIL) provides supports for individuals choosing participant-directed services.

Summary of Findings

1. State Conducts Level of Care Determinations Consistent with the Need for Institutionalization – The State substantially meets this assurance.

Suggested Recommendations

The state has developed an effective method to assure that LOC determinations are consistent with the need for nursing facility LOC, as identified in the approved waiver. CMS has no recommendations at this time.

2. Service Plans are Responsive to Waiver Participant Needs – The State substantially meets this assurance.

Suggested Recommendations

The state has developed a method to assure that it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants. CMS has no recommendations at this time.

3. Qualified Providers Serve Waiver Participants – The State substantially meets this assurance.

Suggested Recommendations

The state has developed an effective method to assure that it has designed and implemented an adequate system for ensuring that waiver services are delivered by qualified providers. CMS has no recommendations at this time.

4. Health and Welfare of Participants – The State substantially meets this assurance.

Suggested Recommendations

The state has developed an effective method to assure that it has designed and implemented an adequate system for identifying, addressing, and seeking to prevent instances of ANE. CMS has no recommendations at this time.

5. State Medicaid Agency Retains Administrative Authority Over the Waiver Program - The State substantially meets this assurance.

Suggested Recommendations

The state has developed an effective method to assure that it retains ultimate administrative authority over the waiver, and that it administers the program consistent with the approved waiver. CMS has no recommendations at this time.

6. State Provides Financial Accountability for the Waiver – The State substantially meets this assurance.

Suggested Recommendations

The state has developed an effective method to assure that it has designed and implemented an adequate system for assuring financial accountability of the waiver program. CMS has no recommendations at this time.

Introduction:

Pursuant to section 1915(c) of the Social Security Act, the Secretary of the Department of Health and Human Services has the authority to waive certain Medicaid statutory requirements to enable a state to provide a broad array of home and community-based services (HCBS) as an alternative to institutionalization. The Centers for Medicare and Medicaid Services (CMS) has been delegated the responsibility and authority to approve state HCBS waiver programs. CMS must assess each home and community-based waiver program in order to determine that assurances are met. This assessment also serves to inform CMS in its review of the state's request to renew the waiver.

State's Waiver Name: Acquired Brain Injury Waiver

Operating Agency: Kentucky Department for Medicaid Services

State Waiver Contact: Leslie Hoffman, Director

Target Population: Individuals 18+ with acquired brain injuries

Level of Care: SNF

Number of Waiver Participants: 180

Average Annual per capita costs: \$109,087 (per 2012 CMS 372)

Effective Dates of Waiver: January 1, 2012 through December 31, 2016

Approved Waiver Services: Adult Day Training, Case Management, Respite, Supported Employment, Behavioral Services, Counseling, Group Counseling, Occupational Therapy, Specialized Medical Equipment, Speech Therapy, Community Guide, Financial Management Services, Goods and Services, Assessment/Reassessment, Community Living Supports, Environmental and Minor Home Modifications, Supervised Residential Care (Levels I, II, and III)

CMS RO Contact: Melanie Benning

I. State Conducts Level of Care Determinations Consistent with the Need for Institutionalization

The State must demonstrate that it implements the processes and instrument(s) specified in its approved waiver for evaluating / reevaluating an applicant's/waiver participant's level of care (LOC) consistent with care provided in a hospital, nursing facility or ICF/MR.
Authority: 42 CFR 441.301; 42 CFR 441.302; 42 CFR 441.303; SMM 4442.5

The State substantially meets the assurance

(The State's system to assure appropriate level of care determinations is adequate and effective, and the State demonstrates ongoing, systemic oversight of the level of care determination process.)

Evidence Supporting This Conclusion:

(Evidence is included that supports the findings that the State substantially meets this assurance.)

Independent case managers perform initial level of care (LOC) evaluations and reevaluations using the state's MAP-351 form. Once the form is completed it must be signed by a physician, nurse practitioner, or physician assistant. The Quality Improvement Organization (QIO) is responsible for reviewing all LOC determinations, and provides notification to the case manager if the assessment is appropriate. LOC determinations are effective on the date the MAP-352 is signed, and must be updated within 12 months. The Kentucky Department for Medicaid Services (DMS) receives data for the LOC assurance through a utilization report provided by the QIO.

For sub-assurance a, which ensures that an evaluation for LOC is provided to all applicants for whom there is a reasonable indication that services may be needed in the future, the state uses one performance measure: the number and percentage of new enrollees who had a level of care evaluation indicating need for institutional level of care prior to receipt of services. The compliance rate was 100% for calendar years 2011, 2012, and 2013.

For sub-assurance b, which ensures that the LOC is reevaluated at least annually or as specified in the approved waiver, the state collects one performance measure: the number and percentage of waiver participants who received a redetermination of LOC within 12 months of their initial or last LOC determination. The compliance rate was 99% for 2011, 98% for 2012, and 97% for 2013. Providers that do not meet this requirement do not receive reimbursement for services rendered prior to LOC completion, are cited for a deficiency, and must submit a Corrective Action Plan (CAP) to the state. DMS conducts follow-up monitoring to ensure compliance with the CAP.

For sub-assurance c, which ensures that the processes and instruments described in the approved waiver are applied appropriately and according to the approved waiver description to determine LOC, the state uses one performance measure: the number and percentage of LOC determinations with completed 351 forms on file. The compliance rate for this measure was 100% for each year.

Suggested Recommendations:

(Although the State substantially meets this assurance, CMS may recommend improvements, though the improvements are suggestions and not requirements for renewal.)

The state has developed an effective method to assure that LOC determinations are consistent with the need for nursing facility LOC, as identified in the approved waiver. CMS has no recommendations at this time.

II. Service Plans are Responsive to Waiver Participant Needs

The State must demonstrate that it has designed and implemented an adequate system for reviewing the adequacy of service plans for waiver participants. Authority: 42 CFR 441.301; 42 CFR 441.302; 42 CFR 441.303; SMM 4442.6; SMM 4442.7; Section 1915(c) Waiver Format, Item Number 13

The State substantially meets the assurance

(The State's system to monitor service plans is adequate and effective, participants are afforded choice between/among waiver services and providers and the State demonstrates ongoing, systemic oversight of service plans.)

Evidence Supporting This Conclusion:

(Evidence is included that supports the findings that the State substantially meets this assurance.)

Case managers are responsible for the development of service plans, with input from the member and/or their guardian and service providers. Service plans must be submitted to the QIO for prior authorization. The QIO reviews the service plans to ensure that all assessed needs have been addressed, as well as potential risks to health, safety, and welfare. Written notification is sent to the case manager if the service plan is inadequate to address all identified needs. Case managers are required to meet with participants face-to-face on a monthly basis to ensure that needs continue to be met. If a service plan is updated, the QIO approves the changes.

For sub-assurance a, which ensures that service plans address all the participant's assessed needs, the state collects data on one performance measure: the number and percentage of participants reviewed who had service plans that were adequate and appropriate to their needs (including health care needs). The compliance rate was 98% for 2011, 99% for 2012, and 97% for 2013. Service plans that did not meet this assurance were identified through ongoing monitoring, annual review, and incident report investigation. Providers were required to submit CAPs, and follow-up monitoring was conducted to ensure CAPs were implemented. All non-compliant service plans were remediated to 100% compliance.

For sub-assurance b, which ensures that the state monitors service plan development in accordance with its policies and procedures, the state uses three performance measures. The first measure is the number and percentage of initial service plans that received prior authorization from the QIO prior to service delivery. The second measure is the number and percentage of updated service plans submitted following the interdisciplinary team meeting held within the first 30 days of initial service authorization. The third measure is the number and percentage of participants receiving participant-directed services with an approved budget. The state reported 100% compliance for all three performance measures in all three years.

For sub-assurance c, which ensures service plans are updated/revised at least annually or when warranted by changes in the participant's needs, the state uses one performance measure: the number and percentage of waiver participants whose service plans were updated and submitted prior to the annual recertification date. The compliance rate was 99% for 2011, 98% for 2012, and 97% for 2013. Non-compliant providers were required to submit CAPs, and follow-up monitoring was conducted to ensure CAPs were implemented. All non-compliant service plans were remediated to 100% compliance. Additionally, technical assistance is provided during monitoring and provider training.

For sub-assurance d, which ensures that services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan in accordance with the approved waiver application, the state uses two performance measures: the number and percentage of participants who received services in the type, scope, amount, and duration as specified in the service plan, and the number and percentage of participants who received participant-directed services within the approved budget. The state reported 100% compliance for both measures for all three years.

For sub-assurance e, which ensures that participants are offered a choice between waiver services and institutional care and between/among providers, the state uses two performance measures: the number and percentage of waiver participant records with an appropriately completed and signed freedom of choice form specifying choice was offered between waiver services and institutional care, waiver services, and waiver providers, and the number and percentage of waiver participants whose records contain confirmation of notification of the option to choose consumer directed options. Compliance was 100% for both measures for all three years.

Suggested Recommendations:

(Although the State substantially meets this assurance, CMS may recommend improvements, though the improvements are suggestions and not requirements for renewal.)

The state has developed a method to assure that it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants. CMS has no recommendations at this time.

III. Qualified Providers Serve Waiver Participants

The State must demonstrate that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers. Authority: 42 CFR 441.302; SMM 4442.4

The State substantially meets the assurance

(The State's system verifies that: providers meet required qualifications and adhere to other standards prior to their furnishing waiver services; providers continue to meet required qualifications; and the State implements policies and procedures for verifying qualifications and training in accordance with state requirements and the approved waiver.)

Evidence Supporting This Conclusion:

(Evidence is included that supports the findings that the State substantially meets this assurance.)

Enrollment for potential providers is continuously open and accessible to providers by phone or online. All employees must undergo a state criminal background check and abuse registry screening. This is confirmed initially and on an ongoing basis through the provider recertification process. The Department for Aging and Independent Living ensures that these checks have been completed for employees of participants self-directing their services.

For sub-assurance a, which ensures that the state verifies providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to furnishing waiver services, the state uses three performance measures. The first measure is the number and percentage of providers who meet certification requirements prior to the provision of waiver services. The state reported 100% compliance for calendar years 2011, 2012 and 2013. The second measure is the number and percentage of providers who continue to meet certification requirements following initial enrollment. The compliance rate was 100% for 2011, 99% for 2012, and 100% for 2013. The third measure is the number and percentage of providers with corrective action plans completed within required time frames. The compliance rate was 100% for all three years.

The state does not have a performance measure for sub-assurance b, which ensures non-licensed/non-certified providers adhere to waiver requirements, as they do not enroll non-licensed/non-certified providers for waiver services.

For sub-assurance c, which ensures the state implements policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver, the state uses two performance measures. The first measure is the number and percentage of provider agencies whose staff completed mandatory CEU annual training. The compliance rate was 100% for 2011 and 2012, and 99% for 2013. The second measure is the number and percentage of new provider agencies that completed mandatory pre-service (initial) training. The compliance rate for this measure was 100% for all three years.

Non-compliant findings for the qualified providers assurance result in citations for providers, as well as the requirement for providers to submit CAPs. The state conducts follow-up monitoring to ensure CAPs were implemented. All instances of non-compliance were remediated to 100%.

Suggested Recommendations:

(Although the State substantially meets this assurance, CMS may recommend improvements, though the improvements are suggestions and not requirements for renewal.)

The state has developed an effective method to assure that it has designed and implemented an adequate system for ensuring that waiver services are delivered by qualified providers. CMS has no recommendations at this time.

IV. Health and Welfare of Waiver Participants

The State must demonstrate that, on an ongoing basis, it identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation. Authority: 42 CFR 441.302; 42 CFR 441.303; SMM 4442.4; SMM 4442.9

The State substantially meets the assurance

(The State systems to identify, address, and prevent occurrences of abuse, neglect, and exploitation are adequate and effective; and the State demonstrates continuous monitoring of health and welfare.)

Evidence Supporting This Conclusion:

(Evidence is included that supports the findings that the State substantially meets this assurance.)

The state requires that three classes of incidents be reported: Class I incidents are minor in nature, Class II incidents are serious in nature, and Class III incidents are grave in nature and involve suspected abuse, neglect, or exploitation (ANE). There are policies and procedures in place regarding the required reporting process for each class of incident, as well as the timeframes for reporting and follow-up. Waiver providers must also have their own written policies for incident reporting, which must be explained to waiver participants. Case managers are required to explain ANE reporting requirements to participants who are self-directing their services.

DMS staff conducts follow-up investigations for all Class III incidents and Class II incidents where this is deemed necessary. DMS may issue citations if follow-up investigation uncovers non-compliance with regulations, and plans of correction will be requested. DMS staff also track and trend incident reports and identify the need for follow-up, technical assistance, and provider training.

For the assurance that ensures that on an ongoing basis the state identifies, addresses and seeks to prevent the occurrence of abuse, neglect, and exploitation, the state uses four performance measures. The first measure is the number and percentage of critical incidents that were reported within required time frames. The compliance rate was 91% for 2011, 94% for 2012, and 92% for 2013. Non-compliant providers were identified by DMS upon review. Providers were required to submit CAPs. DMS requires that CAPs submitted include the agency's measures to correct deficiencies, as well as an examination of the systems and processes that require improvement to prevent further instances of non-compliance.

The second measure is the number and percentage of critical incidents that received follow-up within required time frames. The state reported 100% compliance for 2011, 99% for 2012, and 100% for 2013.

The third measure is the number and percentage of Class III critical incidents that were reviewed by DMS to confirm that the incident was investigated by the appropriate entity within the required timeframes. The state reported 100% compliance for all three years.

The fourth measure is the number and percentage of deaths reviewed by DMS. The state reported 100% compliance for all three years.

Suggested Recommendations:

(Although the State substantially meets this assurance, CMS may recommend improvements, though the improvements are suggestions and not requirements for renewal.)

The state has developed an effective method to assure that it has designed and implemented an adequate system for identifying, addressing, and seeking to prevent instances of ANE. CMS has no recommendations at this time.

V. State Medicaid Agency Retains Administrative Authority Over the Waiver Program

The State must demonstrate that it retains ultimate administrative authority over the waiver program and that its administration of the waiver program is consistent with its approved waiver application. Authority: 42 CFR 441.303; 42 CFR 431; SMM 4442.6; SMM 4442.7

The State substantially meets the assurance

(The State's single State Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of the waiver functions by other State and local/regional non-State agencies (if appropriate) and contracted entities; and administration of the waiver program is consistent with the State's approved waiver application.)

Evidence Supporting This Conclusion:

(Evidence is included that supports the findings that the State substantially meets this assurance.)

The waiver is operated by the state Medicaid agency. The QIO is contracted to provide level of care eligibility determination, prior authorization, and service plan approval. The state also oversees self-directed services through a contract with Kentucky's Department for Aging and Independent Living (DAIL). DMS monitors the contracts with these agencies through post-payment auditing, second-line monitoring, and monthly, quarterly, and annual reporting.

The state has one performance measure for this assurance: the number and percentage of Utilization Management Reports completed in a timely manner by the fiscal agent. The state reported 100% compliance for all three years.

Suggested Recommendations:

(Although the State substantially meets this assurance, CMS may recommend improvements, though the improvements are suggestions and not requirements for renewal.)

The state has developed an effective method to assure that it retains ultimate administrative authority over the waiver, and that it administers the program consistent with the approved waiver. CMS has no recommendations at this time.

VI. State Provides Financial Accountability for the Waiver

The State must demonstrate that it has designed and implemented an adequate system for assuring financial accountability of the waiver program. Authority: 42 CFR 441.302; 42 CFR 441.303; 42 CFR 441.308; 45 CFR 74; SMM 2500; SMM 4442.8; SMM 4442.10

The State substantially meets the assurance

(The State has an adequate system in place to assure that claims for federal financial participation are based on state payments for services rendered to waiver participants, authorized in the service plan, and properly billed by qualified providers in accordance with the approved waiver.)

Evidence Supporting This Conclusion:

(Evidence is included that supports the findings that the State substantially meets this assurance.)

DMS conducts post-payment audits of all waiver providers. Reports from the Medicaid Management Information System (MMIS) are compared against member records and service plan documentation. DAIL conducts annual audits of financial management services entities by reviewing 25% of records for all individuals self-directing services.

The state uses two performance measures for this assurance: the number and percentage of claims reviewed that were coded and paid in accordance with reimbursement methodology, and the number and percentage of waiver service claims that were submitted for ABI waiver participants who were enrolled in the waiver on the service delivery date. The state reported 100% compliance for both measures for calendar years 2011, 2012 and 2013.

Suggested Recommendations:

(Although the State substantially meets this assurance, CMS may recommend improvements, though the improvements are suggestions and not requirements for renewal.)

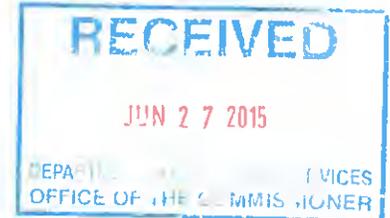
The state has developed an effective method to assure that it has designed and implemented an adequate system for assuring financial accountability of the waiver program. CMS has no recommendations at this time.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



Disabled and Elderly Health Programs Group

June 22, 2015



Ms. Lisa Lee
Commissioner
Department for Medicaid Services
275 E. Main Street, 6W-A
Frankfort, KY 40621

Dear Ms. Lee:

In response to the June 3, 2015 request from the Kentucky Department for Medicaid Services, the Centers for Medicare & Medicaid Services (CMS) is granting a 30 day temporary extension of Kentucky's Home and Community-Based Services (HCBS) waiver program for individuals who are aged or disabled, which is currently scheduled to expire June 30, 2015. The extension allows the Home and Community Based Waiver, CMS control number 0144.R05, to continue operating through, July 30, 2015, at cost and utilization levels approved for the fifth year of the waiver program with Federal financial participation.

CMS is granting this temporary extension in order to give the state time to address the informal questions on the waiver renewal which was submitted on May 28, 2015, and to give CMS time to complete the review of the responses to the informal questions as well as changes to the waiver application.

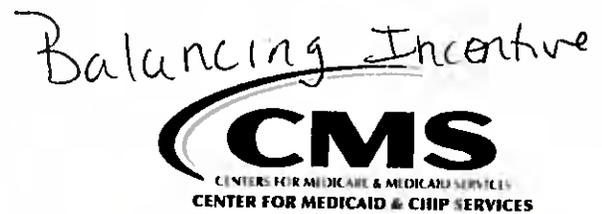
If you need any assistance, feel free to contact Melanie Benning, Melanie.Benning@cms.hhs.gov or via telephone at (404) 562-7414; or Amanda Hill, Amanda.Hill@cms.hhs.gov or via telephone at (410) 786-2456.

Sincerely,

Alissa Mooney DeBoy
Acting Director

cc: Jackie Glaze, Region IV ARA

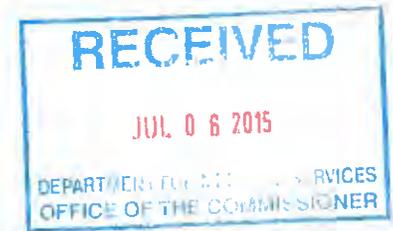
DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850



Disabled & Elderly Health Programs Group

JUL 01 2015

Lisa D. Lee
Commissioner
Department for Medicaid Services
275 E. Main St. 6W-A
Frankfort, Kentucky 40621



Dear Ms. Lee:

I am pleased to inform you that the Centers for Medicare & Medicaid Services (CMS) has awarded Kentucky additional funds for the State Balancing Incentive Payment Program grant under Section 10202 of the Affordable Care Act (hereafter referred to as the "Balancing Incentive Program.")

The Balancing Incentive Program provides a strong financial incentive to stimulate greater access to non-institutionally based long-term services and supports (LTSS.) We support Kentucky for earning the initial award and pursuing additional funds to continue to increase access to non-institutionally based LTSS.

The period of performance for this grant award remains January 1, 2014 through September 30, 2015. Kentucky will receive an enhanced match rate of 2% for non-institutional LTSS. Your award amount is \$31 million which is based upon your projected expenditures, representing an increase of \$5.4 million. The terms and conditions of the initial Kentucky Balancing Incentive Program award remain in effect.

Thank you for your commitment to improving the LTSS that is so critical to the lives of thousands of beneficiaries. We look forward to continuing to work with you throughout the grant period.

Sincerely,



Michael Smith
Acting Division Director
Division of Community Systems Transformation

cc:

Carla Crane, PhD., Kentucky Office of Health Policy
Nicole Steele, Kentucky Department of Medicaid Services
Barbara Holt, Ph.D., Division of Community Systems Transformation
Effie George, PhD., Division of Community Systems Transformation
Alice Hogan, CMS Associate Regional Administrator
Debbie Abshire, CMS Technical Director, Budget and Grants