



**CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES**

Steven L. Beshear
Governor

275 East Main Street, 6W-A
P: (502) 564-4321
F: (502) 564-0509
Frankfort, KY 40621
www.chfs.ky.gov

Audrey Tayse Haynes
Secretary

Lawrence Kissner
Commissioner

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Jackie Glaze, Associate Regional Administrator
Division of Medicaid and Children's Health
Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St Ste 4T20
Atlanta, GA 30303-8909

RE: KY's HCBW Program / Response to March 31, 2014, Letter

Dear Ms. Glaze:

This letter is in response to your letter dated March 31, 2014, regarding the Centers for Medicare & Medicaid Services' (CMS) quality review of Kentucky's Home & Community Based Waiver Program (control # 0314.R03), requesting data for non-compliant assurances.

Below is our response to your findings and recommendations for compliance:

1. State Conducts Level of Care Determinations Consistent with the Need for Institutionalization – The State does not fully or substantially demonstrate the assurance, though there is evidence that may be clarified or readily addressed.

Required Recommendations: While the state provided data for an approved performance measure for the sub-assurance to ensure 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 also provided data for a performance measure that is not in the approved waiver. For the performance measure provided for the sub-assurance that the LOC is reevaluated at least annually or as specified in the approved waiver, the state did not provide summary data regarding remediation of all instances of non-compliance.

CMS requires review of the performance measures provided for the above-referenced sub-assurances to determine the measures that most effectively capture this sub-assurance, and revise them accordingly in the next waiver renewal. CMS requires use of this data to enhance system evaluations to address this assurance.

State's Response: The approved performance measures include: the percent of waiver applicants who had a level of care indicating the need for services, the percent of waiver participants whose level of care was reevaluated within



12 months of their initial level of care evaluation, and the percent of level of care eligibility determination **packets that were returned**. The additional analysis showed that all **new enrollees** met level of care. The additional information provided was not meant to supplant the approved measures.

Remediation:

- Percent of waiver **applicants** who had a level of care indicating the need for institutionalization

N= Total number of applicants who had a level of care evaluation indicating the need for institutionalization

D= Total number of waiver applicants.

The results ranged from 99.3% to 99.8% of the applicants in each of the years of the waiver.

- Percent of waiver participants whose level of care was reevaluated within 12 months of their initial level of care evaluation or of their last annual level of care evaluation

N= Total number of participants who had a level of care redetermination within 12 months

D= All waiver participants.

The results ranged from 97% to 98% of the participants in each of the years of the waiver.

- Percent of level of care eligibility determination packets that were returned

N=Total number of level of care eligibility determination packets returned

D=Total number of level of care determinations

The results ranged from 3.1% to 4.3% of the in each of the years of the waiver.

2. Service Plans are Responsive to Waiver Participant Needs – The State does not fully or substantially demonstrate the assurance, though there is evidence that may be clarified or readily addressed

Required Recommendations: While the state utilized performance measures in accordance with the approved waiver, when non-compliance occurred the state did not demonstrate remediation or system improvement for the following sub-assurances: the sub-assurance that ensures service plans address all the participant's assessed needs and personal goals and the sub-assurance that ensures that services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan. CMS requires data regarding any remediation activities and system improvement the state has undertaken in response to instances of less than 100% compliance.

CMS requires development of a performance measure demonstrating participants are offered a choice between waiver services and institutional care prior to the next waiver renewal.

State's Response: The State currently contracts with Hewlett Packard (HP) who in turn contracts with the utilization management firm CareWise. CareWise performs the Level of Care and processes the prior authorizations for the services. When an initial or recertification packet is received by CareWise, CareWise first evaluates the assessment to determine what services are needed. The assessment is compared to the Plan of Care (POC) to determine if the services are matched to the information on the assessment. If an error is found or if it is determined that the POC does not incorporate the services that are needed, a Lack of Information (LOI) letter is sent to the provider so the POC can be corrected, or the services are denied and a denial letter is sent to the member and the provider with appeal rights. If a LOI letter is sent, the provider has 14 days to correct the error. Should the State find that the service plans are not in compliance, the State has the right, in accordance with the contract with HP, to either fine HP and/or request a corrective action plan. Please find enclosed the waiver dashboard report showing the LOC requests, denials and the service requests and denials.

The State requests to work with HP, CareWise and the Department for Behavioral Health, Developmental and Intellectual Disabilities (BHDID) on new performance measures.

The MAP 350 which was included in the evidence report includes both choice between waiver services and institutional and choice of provider. While both are included on the form and are expected for each participant, it is noted that the approved performance measure only refers to choice of providers. The State is recommending the following performance measure:

- Percent of participants/guardians who have signed the service plan signature page indicating they were given choice between waiver services and institutional care.

N= Percent of participants/guardians who have signed the service plan signature page indicating they were both given choice between waiver services and institutional care.

D= Total number of service plans reviewed.

Remediation:

- Percent of service plans in which services and supports align with assessed needs.

N= Total number of service plans reviewed that reflect assessed needs and preferences.

D= Total number of service plans reviewed

The results ranged from 97% to 99% of the in each of the years of the waiver.

- Percent of service plans that reflect individual goals and preferences

N= Total number of service plans reviewed that reflect individual goals and preferences.

D= All service plans reviewed

The results for this performance measure were 100%, so there was no need for remediation.

- Percent of records reviewed that demonstrate that the correct type, amount, scope and frequency of services were provided according to the person centered plan.

N--the number of records reviewed that demonstrate that the correct type, amount, scope and frequency of services were provided according to the person centered plan

D--total number of records reviewed.

3. Qualified Providers Serve Waiver Participants – The State does not fully or substantially demonstrate the assurance, though there is evidence that may be clarified or readily addressed.

Required Recommendations: 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, CMS requires consideration of meaningful system evaluation to address non-compliance with the following performance measure: the number and percentage of enrolled waiver providers that meet regulatory requirements at time of certification review. CMS requires additional provider training or additional performance measures to address this during the next waiver renewal. The state should also consider adding a performance measure examining the number and percentage of waiver providers that meet OIG's licensure requirements.

State's Response: The State is recommending the following performance measure:

- Percent of OIG licensed waiver providers that meet OIG licensing requirements at review
N= all OIG licensed waiver providers that meet OIG licensing requirements at time of certification review.
D= all OIG licensed waiver providers who had an OIG licensing review

A work group will be formed to develop the performance measures for the next waiver renewal.

A focus of the technical assistance that quality administrators conduct is aiding providers in understanding that the onus of quality is on them and that focus on quality is to be continuous, rather than only following a review or assistance. Three trends have been identified for systemic quality improvement and an action plan has been developed for each of them.

Goal	Action Plan with Timeframe
All participants are healthy and safe	<ul style="list-style-type: none"> • Collect additional data FY 14 Q3 on risk assessment and risk mitigation through new CMS Quality Assurances data collection mechanism. • Collect additional data through citation frequency FY 14 Q3 • Identify action plan to address issues identified in baseline assessment period in collaboration with Provider Development during FY 14 Q4 • Implement action plan FY 15 Q1; measure improvement using CMS Quality Assurances (improvement in risk assessment and risk mitigation data) and Citations (reduction in health/safety/welfare citations).
Medications are administered without error	<ul style="list-style-type: none"> • Collaborate with Risk Management • Risk Management personnel are auditing providers' Medication Administration classes • Additional requirements for nurse trainers implemented FY 14 Q2 • Clarification to all QA's on what is expected in personnel and training records regarding medication administration provided FY 14 Q2 • Collect baseline data after these interventions in FY 14 Q3 • Develop additional interventions FY 15 Q1 • Implement plan FY 15 Q2
Day Training is person centered and non-diversional	<ul style="list-style-type: none"> • Collect baseline data from Site Visits and Citations FY15 Q1 • Develop action plan FY15 Q2 • Implement Plan FY15 Q3

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

Suggested Recommendations: The state should consider adding a performance measure to examine the number of reported use of restraints out of the total number of waiver participants. Specifically, the state could measure data from the date the state noted a revision in its policy regarding use of restraints. This would allow for systemic evaluation regarding use of restraints and the effectiveness of the state's efforts to prevent their use.

State's Response: The State is recommending the following performance:

- Percent of participants with no restraint
N= Number of participants with no restraint.
D= Total number of participants

Reported restraints are being measured through the incident reporting process. Systematic evaluation is done regarding all reported incidents, including effectiveness of the states' efforts. A risk management meeting is held every other month to review incidents, trends, what is being done about them, and determine whether wider training is needed.

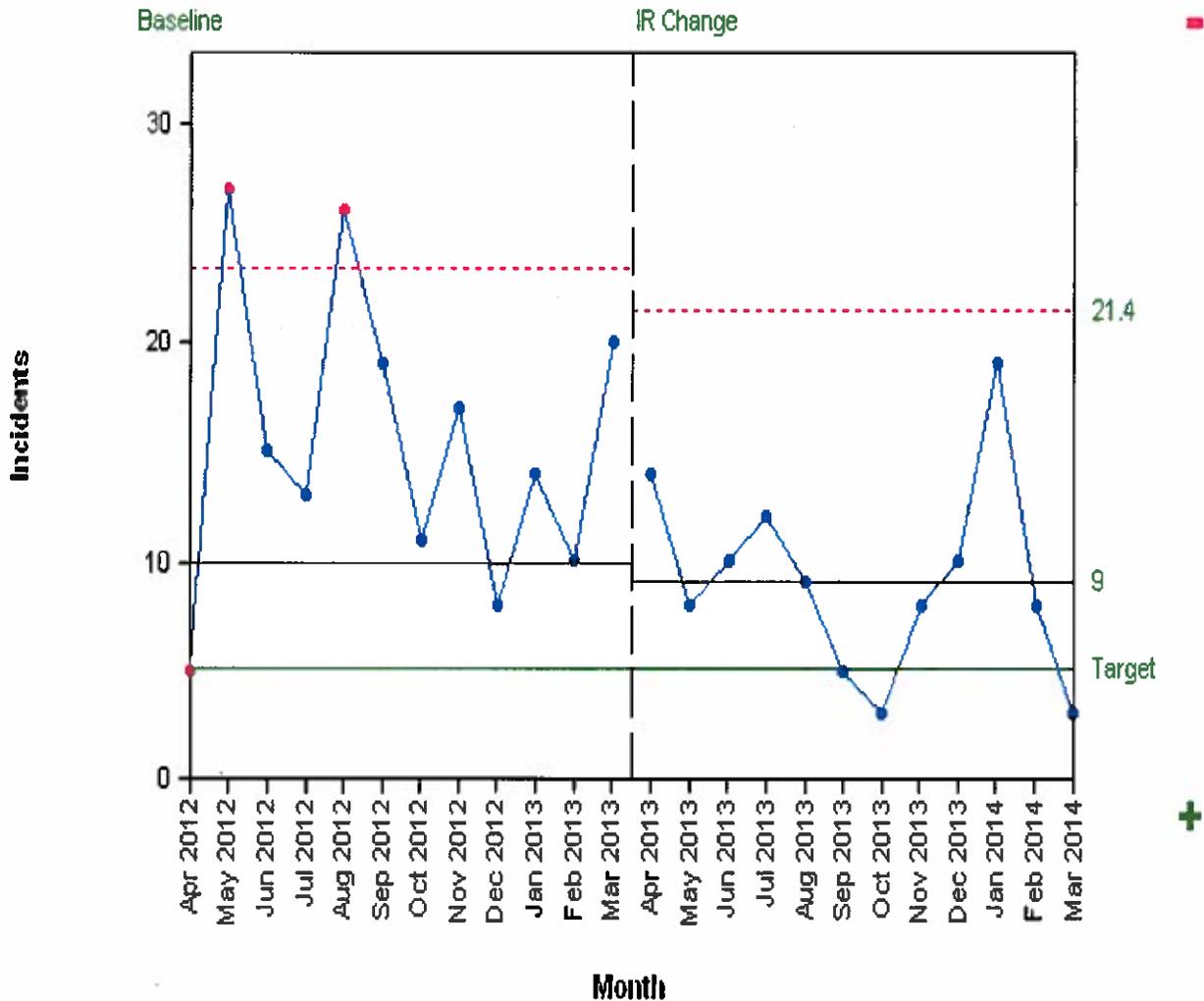
For the period April, 2012-March 2014, 16 providers (of the 236 current providers) have reported one or more use of chemical restraint. One provider in particular has reported the most use of restraints. The BHDID nurse assigned to this provider has worked with them to update their protocols and reduce/eliminate the use of restraint. The 3 sigma chart below includes the process change in April, 2013.

I Chart 3-Sigma

SCL Chemical Restraint

Provider = ALL

Summary



Provider Table
Apr 2013 to Mar 2014

Provider	Incidents
CAKY Lexington	78
Active Day of Louisville	8
Kentuckiana Nursing Services	3
Lord's Legacy Life Ministries, Inc	3
A Brighter Choice, LLC	2
CAKY Winchester	2
Communicare, Inc	2
Community Living, Inc	2
Lincoln Way	2
A Brighter Future	1
CAKY Henderson	1
CAKY Louisville	1
CAKY Owensboro	1
NorthKey Community Care	1
Quest Farm, Inc	1
Strategic Partnerships	1

During that same timeframe, 28 providers have reported a physical restraint. Two providers in particular have had the most instances. The BHDID regional nurses assigned to those providers are working with them to reduce/eliminate the instances.

All instances of restraint are addressed by the regional nurses and the BHDID quality administrators are also included in technical assistance.

5. State Medicaid Agency Retains Administrative Authority Over the Waiver Program - The State demonstrates the assurance but CMS recommends improvements or requests additional information.

Suggested Recommendations: The state should consider adding additional performance measures during the next renewal based on deliverables in the contract between the QIO and DMS, such as the number and percentage of reports that the QIO provides to DMS within the required timeframes. The state should also consider adding measures regarding the contract between the DBHDID and the DMS and the timeliness of functions performed by BHDID such as the number and percentage of findings reports and notice of length of provider certifications that BHDID sends to the DMS within the DMS required timeframe.

State's Response: At the time of the next renewal, the following performance measures will be added:

- Percent of required reports the QIO provides to DMS within the required timeframes
 $N = \text{Reports the QIO provides to DMS within the required timeframes.}$
 $D = \text{Total reports required of the QIO.}$

- Percent of required reports the BHDID provides to DMS within the required timeframes
N= Reports BHDID provides to DMS within the required timeframes.
D= Total reports required of BHDID.

The State has rewritten the contract between the State and BHDID which includes a number of reports regarding provider certifications, waiting list report, schedule of reviews, quality improvement data, case manager trainings, and new provider report. DMS is considering adding performance measures on the number of providers that received recoupment out of the number of providers reviewed.

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

Suggested Recommendations: The state should implement and report on a clear process to remediate individual and systemic errors that result in erroneously paid claims. In addition, the state should consider revising the existing third performance measure for clarity, and including the reported number and percentage of providers who maintain financial records according to program policy as an additional performance measure.

State's Response: The State is recommending the following performance measure:

- Percent of the providers who maintain financial records according to the program policy.
N= Providers who maintain financial records according to program policy.
D= Total providers.
- Percent of the providers who maintain financial records according to the program policy.
N = Providers who maintain financial records according to program policy.
D= Total providers.

The State would also like to revise this performance measure:

Number and percent of system defects identified in the Supports for Community Living waiver program and corrected on a quarterly basis.

So that it reads:

- Percent of system defects identified and corrected in the Supports for Community
N = System defects corrected
D = System defects identified and submitted for correction

Currently the State contracts with HP for paying provider claims and with BHDID to complete the billing reviews. BHDID performs billing reviews on 100% of the Supports for Community Living 236 providers. An adhoc is developed showing the paid claims for a certain time span. BHDID conducts on-site visits with each provider to review the documentation against the adhoc to insure that the services were delivered and documented with correct the date, time and place that the service was performed. Determination of the appropriateness of each service is also reviewed. If the documentation is not on the member's record, then the amount paid to the provider is recouped.

Once the billing review is completed, it is sent to DMS. DMS processes the recoupment and sends a letter noting appeal rights to the provider notifying them of the recoupment. The provider has a right to a Dispute Resolution or a Document Consideration in accordance with the regulation 907 KAR 1:671. Once the Dispute Resolution or the Document Consideration is completed, then the provider is notified if there is a change in the amount of repayment to Medicaid. Should the provider feel that the recoupment was completed in error, the provider may request an Administrative Hearing.

The providers are only obligated to maintain documentation up to six years. It is through this documentation that DMS is able to recoup the monies that were paid in error to the providers.

The State is currently reviewing at all performance measures across all waivers to identify which measures may need to be revised or updated. The State will meet with HP, BHDID and other waiver programs to identify the needs of all the waivers in order to align the process for reporting from HP and with those entities that administer the waiver programs. The State would appreciate if the performance measures can be refitted to the actual program at the time the waiver is renewed.

Quality Improvement Topic and Timeline Synopsis

I. Continue implementation of provider quality improvement plan.

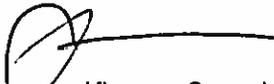
Goal	Identified Trend	Data Source	Action Plan with Timeframe
All participants are healthy and safe	Significant number of H/S/W citations; initial data collection underway with new CMS Quality Assurances measures	Citations (certification reviews, desk level, and investigative) Quality Assurances Incident Reports	Collect additional data FY 14 Q3 on risk assessment and risk mitigation through new CMS Quality Assurances data collection mechanism. Collect additional data through citation frequency FY 14 Q3 Identify action plan to address issues identified in baseline assessment period in collaboration with Provider Development during FY 14 Q4 Implement action plan FY 15 Q1; measure improvement using CMS Quality Assurances (improvement in risk assessment and risk mitigation data) and Citations (reduction in health/safety/welfare citations).
Medications are administered without error	Significant number of citations related to medication administration	Citations (certification reviews, desk level, and investigative) Medication Error Reports Incident Reports	Collaborate with Risk Management Risk Management personnel are auditing providers' Medication Administration classes Additional requirements for nurse trainers implemented FY 14 Q2 Clarification to all QA's on what is expected in personnel and training records regarding medication administration provided FY 14 Q2 Collect baseline data after these interventions in FY 14 Q3 Develop additional interventions FY 15 Q1 Implement plan FY 15 Q2
Day Training is person centered and non-diversional	ADT sites are observed to provide diversional activity. Citations regarding this noted	Citations Site Visit observations (certification reviews, desk level, investigative)	Collect baseline data from Site Visits and Citations FY15 Q1 Develop action plan FY15 Q2 Implement Plan FY15 Q3

II. Submit the **Waiver Renewal** with the following performance measures:

Waiver Section	Performance Measure
Service Plans	Percent of participants/guardians who have signed the service plan signature page indicating they were given choice between waiver services and institutional care. N= Percent of participants/guardians who have signed the service plan signature page indicating they were both given choice between waiver services and institutional care. D= Total number of service plans reviewed.
Qualified Providers	Percent of OIG licensed waiver providers that meet OIG licensing requirements at review N= all OIG licensed waiver providers that meet OIG licensing requirements at time of certification review. D= all OIG licensed waiver providers who had an OIG licensing review
Health and Welfare of Participants	Percent of participants with no restraint N= Number of participants with no restraint. D= Total number of participants
Financial Accountability	Percent of providers who maintain financial records according to program policy. N = Percent of the providers who maintain financial records according to the program policy. D= Total providers.
Financial Accountability	Percent of system defects identified and corrected in the Supports for Community Living Waiver Program N = System defects corrected D = System defects identified and submitted for correction (Revised from Number and percent of system defects identified in the Supports for Community Living waiver program and corrected on a quarterly basis)
Administrative Authority	Percent of required reports the QIO provides to DMS within the required timeframes N=Reports the QIO provides to DMS within the required timeframes. D= Total reports required of the QIO.
Administrative Authority	Percent of required reports the DDID provides to DMS within the required timeframes N= Reports DDID provides to DMS within the required timeframes. D= Total reports required of DDID.

Should you have any questions or require clarification or additional information, please do not hesitate to contact me or my staff.

Sincerely,



Lawrence Kissner, Commissioner
Department for Medicaid Services

Attachment

cc: Michele MacKenzie, CMS
Neville Wise, DMS
Lisa Lee, DMS
Veronica Cecil, DMS

LK/km/kl

