

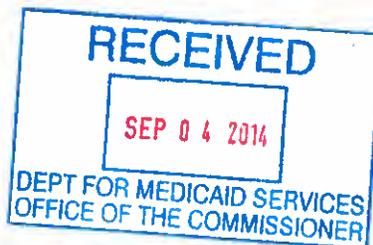
DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303



DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

August 28, 2014

Mr. Lawrence Kissner, Commissioner
Department for Medicaid Services
Attn: Leslie Hoffman
275 East Main Street, 6WA
Frankfort, KY 40621-0001



① Copy for MAC
LISA, NEVIN,
LESLIE, VANESSA
JEFF

② FILE CMS

Dear Mr. Kissner:

Enclosed is the final report of the Centers for Medicare & Medicaid Services' (CMS) review of Kentucky's Home and Community Based Waiver, control number 40146.R05, that serves individuals who are technology (ventilator) dependent who meet the nursing facility level of care. Thank you for your assistance throughout this process. The state's responses to CMS' recommendations have been incorporated in the appropriate sections of the report.

We found the state to be not in compliance with two of the review components. For those areas in which the state is not compliant, please be sure they are corrected at the time of renewal. We have also identified recommendations for program improvements in each 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, July 2, 2015. 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.

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

Sincerely,



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 Model II Waiver
Control # 40146.R05**

August 28, 2014

**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 Model II Waiver. The target population for this waiver includes individuals who are technology (ventilator) dependent who meet the nursing facility level of care. The most recent 372 report, for the waiver year ending September 30, 2012 and reported on April 21, 2014, shows an enrollment of 63 unduplicated participants with the average annual cost of \$153,757 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 December 17, 2013, the state provided an introduction to its overall quality management strategy, various examples and summary reports specific to each assurance.

The Quality Improvement Organization (QIO), with which the state contracts, monitors level of care determinations and redeterminations, plans of care approved and denied, prior authorization of services and waiver provider compliance with state and federal requirements. The Office of Inspector General and DMS investigate individual complaints regarding health and welfare. QIO nurse reviewers and DMS staff review all incident/complaints reports and issues noted in participant satisfaction surveys during provider onsite review/surveys. Additionally, DMS, through a contract with the state's fiscal agent, provides ongoing training and technical assistance to waiver providers for billing procedures and oversight of claims paid, suspended and denied. DMS reviews and adds edits/audits to the Medicaid Management Information System (MMIS) for program compliance and pursuant to any policy revisions to ensure claims are not paid erroneously.

Summary of Findings

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

Suggested Recommendations

CMS has no recommendations at this time.

2. Service Plans are Responsive to Waiver Participant Needs – The State demonstrates the assurance but CMS recommends improvements or requests additional information.

Suggested Recommendations

The state did not provide data for the performance measure in the approved waiver to demonstrate whether services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan. However, for this sub-assurance, the state did provide data for a performance measure not included in the approved waiver. The state should consider updating the approved waiver to reflect its performance measures as implemented.

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

The state did not provide data for the performance measure in the approved waiver demonstrating that the state implements policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver. Also, 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 provided a single performance measure not included in the approved waiver, indicating the performance measure provided combines the three performance measures approved for this sub-assurance into one performance measure. However, the state did not provide data for this performance measure. The state must provide data demonstrating 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 must update the approved waiver to reflect the performance measures used for this assurance as implemented.

4. Health and Welfare of Participants – The State does not fully or substantially demonstrate the assurance, though there is evidence that may be clarified or readily addressed.

Required Recommendations

The state must either provide data for the approved performance measures or amend the approved waiver to reflect the performance measures used for this assurance as implemented. In addition, the state should consider additional performance measures, such as the number and percentage of waiver participants for whom a critical incident was reported and/or the number and percentage of critical incident reports that were remediated within the required timeframe. 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 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.

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 second 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. The state should update the approved waiver to reflect the performance measures used for this assurance as implemented.

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:	Model II Waiver
Operating Agency:	Department for Medicaid Services
State Waiver Contact:	Lawrence Kissner, Commissioner, Department for Medicaid Services
Target Population:	Technology (Ventilator) Dependent Individuals
Level of Care:	Nursing Facility
Number of Waiver Participants:	63
Average Annual per capita costs:	\$153,757 (per CMS 372 Report)
Effective Dates of Waiver:	October 1, 2010 through September 30, 2015
Approved Waiver Services:	Skilled Services provided by a Licensed Practical Nurse, Skilled Services provided by a Registered Nurse, and Skilled Services provided by a Respiratory Therapist
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.)

Waiver providers perform an in-home, or if applicable, in a hospital based setting, assessment of the waiver applicant and determine whether there is a need for waiver services and case management. The Medicaid Waiver Assessment form, MAP-351A, is the assessment tool utilized.

The Quality Improvement Organization (QIO) for the Department for Medicaid Services (DMS) instructs waiver providers regarding the submission of documents for initial and ongoing Level of Care (LOC) determinations. The provider submits the clinical information to the QIO for medical necessity review via the MAP-351A form. The first level of review is based on state regulations, program manuals, program directives and contractual requirements. Upon completion of a first level review, the QIO clinician may approve the LOC request, assigning a six-month interval. The QIO may also issue a request for additional information, and if insufficient information is submitted, the "Lack of Information" process is initiated where missing information is noted and communicated to the waiver provider through written notification. The QIO may also refer the request to a Physician Advisor for a physician level of review. If referred to the Physician Advisor, the case is assigned to a QIO physician who will request additional information as necessary from the waiver provider and/or the attending physician prior to issuing a final approval or denial.

If the LOC is approved, a confirmation notice is sent to the participant, the participant's legal representative (if applicable), the provider, and the Department for Community Based Services (DCBS). Also, the QIO logs the dates of the LOC approval period into the MMIS system. In the case of a LOC denial, appeal rights are included with the denial of LOC letter.

Recertification requests are approved for six-month certification periods. The provider must notify the QIO no more than three weeks prior to the expiration of the current LOC certification to ensure that certification is consecutive, or the provider will not be reimbursed for a service provided during a period that the waiver participant was not covered by a valid LOC. If the QIO receives a recertification request greater than 60 days from the end of the previous certification period, a new assessment must be completed.

The QIO ensures all forms are used appropriately during the LOC process. The QIO performs first line monitoring of all enrolled waiver providers and participants receiving waiver services annually, including review of all waiver participant charts to ensure that the LOC is conducted in a timely manner. The state also contracts with QIO Field Nurse Reviewers to perform first line on-site monitoring and review of the medical charts to ensure that the LOC is conducted in a timely manner. Finally, the DMS performs annual, on-site second line monitoring of 25% the waiver's enrolled providers.

The QIO with which the state contracts 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 members who received LOC prior to receipt of services. The compliance rate for this measure was 100% in Calendar Years (CY) 2010, 2011, and 2012.

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 members who received a redetermination of LOC within 6 months of their initial or re-evaluation of LOC. The compliance rate for this measure for CYs 2010, 2011 and 2012 was 96%, 90%, and 96% respectively. The non-compliance rate for the three reviewed years was a result of the waiver providers not submitting all required information in a timely manner to complete the re-certification process. All providers that were non-compliant with timely re-evaluations were notified via written correspondence and informed that a corrective action was required to comply with the re-certification process, which included submission or correction of the required documents for the QIO approval. Providers that did not submit the re-evaluation in a timely manner were not reimbursed for services rendered to the participant prior to the completion of the re-evaluation.

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 members' initial evaluation or six-month re-evaluation of LOC determinations/forms/instruments that were completed as required by the DMS. The compliance rate for this measure was 100% in CYs 2010, 2011, and 2012.

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.

State Response:

The state responded, clarifying the state's performance measure for the sub-assurance that ensures an evaluation for LOC is provided to all applicants for whom there is a reasonable indication that services may be needed in the future. Specifically, the state provides the following performance measure: the number and percentage of new waiver participants who had a level of care indicating the need for institutional level of care prior to receipt of services. The state notes that the LOC review by the QIO determines that participants who are ventilator dependent and require a high level of skilled care meet the institutional level of care criteria before prior authorization and initiation of waiver services.

CMS Response:

The CMS thanks the state for the additional information provided.

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 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 QIO monitors the service plans, referred to as the Plans of Care (POCs), and prior authorization of services for the waiver, reviewing the MAP 109-MII for Waiver Services. In this role, the QIO monitors 100% of enrolled waiver providers and 100% of waiver participants. The QIO conducts on-site chart reviews to monitor the POCs, including ensuring all needs of waiver participants that have been identified on the MAP 351A assessment are met by appropriate interventions and/or services.

The MAP-351A form is utilized by a registered nurse (RN) case manager provider to identify and document all assessed needs of the participant. The needs identified on the MAP-351A are addressed on the participant's POC. The RN case manager is responsible for the completion of the assessment and for the development of the POC. Should a change in the participant's status occur, then a modification of the POC by the RN case manager is requested and submitted to the QIO for prior authorization of additional, or a change of, services.

DMS processes the on-site survey/review report packet, which details the individual participant's chart that was reviewed and whether the submission of the forms and the waiver services requested were appropriate. If waiver services and interventions are not appropriate, or identified needs have not been addressed in the POC, DMS will request from the provider that a

Corrective Action Plan (CAP) is required. The provider submits a CAP with supporting evidence of implementation of the corrective action. A follow-up on-site survey/review may be performed in approximately six months after DMS' acceptance of the provider's CAP to determine whether the corrective action plan submitted to DMS has been implemented. Also, where patterns of deficiencies are identified, rather than isolated occurrences, DMS ensures affected providers are included in sampling for a second-line, follow-up survey.

Each waiver provider must maintain documentation, including level of care information, assessments, information about waiver services received by the participant, and medical and social history, for each waiver participant. If the documentation is not available to support that the service was performed and the provider billed and was paid for the service, then DMS recoups the money for the undocumented service. DMS will also request a CAP.

The MAP-350 form is utilized to document the waiver participant choice of waiver services or institutional care, and choice of providers. Nursing facilities are required to annually inform residents of the freedom of choice to receive waiver services in home or institutional care via the MAP-350 form. Waiver participants sign the MAP-350 form at each assessment and reassessment, a minimum of once per 12-month period. Monitoring of activities of waiver providers include ensuring that the RN case manager is knowledgeable about and educates the participant and his/her family about freedom of choice. Also, DMS requires that enrolled providers present a listing of service providers to members at the time of initial assessment/reassessment. Additionally, client satisfaction surveys capture data regarding participant choice, and the DMS monitors these surveys.

The data source for all performance measures for this assurance is the Department for Medicaid Services and its contracted QIO. For the sub-assurance that ensures that service plans address all the participant's assessed needs and personal goals, the state provides data for one performance measure: the number and percentage of service plans that addressed all members' assessed health care needs including health and safety risk factors and personal goals. Compliance with this performance measure was 100% for Calendar Years (CY) 2010, 2011, and 2012.

For the sub-assurance that ensures the state monitors service plan development in accordance with its policies and procedures, the state provides one performance measure: the percentage and number of service plans developed in accordance with state policies and procedures. Compliance with this performance measure was 100% for CYs 2010, 2011, and 2012.

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 performance measure using two data sources. First, using the QIO as a data source, the state examined the number and percentage of service plans that were revised as needed to address the participant's changing service needs. Compliance with this performance measure was 100% for CYs 2011 through 2012. The state did not provide data for the time waiver period of Oct 1 – Dec. 31, 2010. The state also collected data from DMS reviews for this performance measure. Compliance with this performance measure was 100% for CYs 2010-2011 and 97% for the CY 2012. Where non-compliance with this performance measure was identified, the state cited a deficiency for non-compliance. Specifically, DMS received the provider survey packet, which included the

Summary of Findings report. A copy of the Summary of Findings report and a request for a CAP for the cited deficiency was sent to the provider. The provider was then required to develop, implement and submit the written Plan of Correction to DMS to correct the identified deficiencies.

For 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, the state provided data for a performance measure not in the approved waiver: the number and percentage of waiver participant records reviewed to ensure that services identified in the service plan are implemented. Compliance for this measure was 100%, 100% and 97% for each of the CYs 2010, 2011 and 2012, respectively. With regard to remediation of non-compliance, if services were not appropriate (i.e. not in accordance with assessments and other requirements), the QIO identified in the DMS survey summary report that a CAP is required. DMS issued a copy of the summary report to the enrolled provider and requested the CAP, and the provider submitted the CAP with supporting evidence of implementation of the corrective action(s).

For the sub-assurance that ensures participants are offered a choice between waiver services and institutional care and between/among providers, the state uses one performance measure: the number and percentage of waiver participants with an appropriately completed and signed freedom of choice form that specified choice was offered between institutional care and waiver services. The data reflected 100% compliance for CYs 2010 through 2012. Regarding choice between between/among waiver providers, that state surveyed waiver participants regarding choice of providers in year 2012. Of the 43 participants to receive or respond via phone call to the Satisfaction Survey, 2 participants indicated they did not have a choice of providers because they live in very rural communities where there was only 1 waiver provider, but were very satisfied with their services that allowed them to be in their home and community.

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.)

The state did not provide data for the performance measure in the approved waiver to demonstrate whether services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan. However, for this sub-assurance, the state did provide data for a performance measure not included in the approved waiver. The state should consider updating the approved waiver to reflect its performance measures as implemented.

State's Response:

The state responded, clarifying the state's performance measure for the sub-assurance that ensures service plans address all the participant's assessed needs and personal goals. Specifically, the state provided the following performance measure: the number and percentage of waiver participants reviewed who had service plans that were adequate and appropriate to their needs (including health care needs) as indicated in the assessment(s). The state noted that 100% of the service plans reviewed by the QIO were determined to be adequate and appropriate to meet the participants' needs, including health care needs, as indicated in the assessment(s).

The state also provided data for the following performance measure from the approved waiver: number and percent of participants who reported an unmet need on the satisfaction surveys. The state reported 100% compliance for CYs 2010 and 2011 and 90% compliance for CY 2012.

The state noted that data it provided for the performance measure included in the state's evidence submission addresses 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 also noted that the DMS has confidence when the QIO nurse field reviewers conduct onsite medical necessity/quality of care reviews and audits, they determine that services are delivered in accordance with the service plan including the type, scope, amount, duration, and frequency specified in the service plan. Also, the state provided data for a performance measure in the approved waiver: the number and percentage of participant survey respondents reporting they received all the services in their plan. The state noted 100% compliance with this performance measure for CYs 2010 and 2011, and 90% compliance with this performance measure for CY 2012. In the instance of non-compliance for CY 2012, the state noted that a participant had indicated the agency providing the private duty nursing service could not provide staff for a 12-hour shift for seven days per week.

The DMS noted it will revise this waiver's onsite monitoring tool by inserting a clearly defined survey task that will include, "Services are delivered in accordance with the plan of care including the type, scope, amount, duration, and frequency specified in the service plan." The state noted this statement will be placed in the monitoring tools effective July 15, 2014, and implemented for the 2015 survey, beginning January 2, 2015.

CMS Response:

The CMS thanks the state for the additional information provided.

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 does not fully or substantially demonstrate the assurance, though there is evidence that may be clarified or readily addressed

Evidence Supporting This Conclusion:

(Evidence that supports this conclusion is weak and not complete. Additional information is required to comply with the assurance.)

Waiver services are provided by licensed Home Health (HH) Agencies and licensed Private Duty Nursing (PDN) Agencies. The state Medicaid Agency, the DMS, does not have the authority to license agencies. The Office of Inspector General (OIG) is responsible for surveying and licensing agencies. The OIG's office has a surveying process for completing initial surveys and ensuring the timeliness of follow-up surveys.

First, the OIG sends DMS a copy of the provider license. After receiving a copy of the license and a completed provider enrollment application, DMS enrolls the provider. DMS program staff conducts on-going training and technical assistance for providers. The DMS Fiscal Agent provides on-going training regarding submission and resolution of claims.

Should an enrolled provider not observe or adhere to state and federal requirements, OIG would terminate the provider license and DMS would terminate the provider's Medicaid enrollment.

The OIG has a toll-free telephone "hotline" to report licensure violations. These reports are investigated by OIG staff. If appropriate, the results are communicated to DMS.

DMS does not enroll non-licensed providers for waiver services. Waiver services are only offered through licensed HH agencies and licensed PDN agencies.

DMS monitors waiver providers to ensure compliance with CMS and state requirements. All waiver providers are monitored annually via on-site review/surveys. Yearly monitoring of HH agencies and PDN agencies are conducted through first line monitoring by the QIO for all the enrolled and active waiver providers and all waiver participants served by this waiver.

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, while the approved waiver utilizes three performance measures, the state provides data for a single performance measure not included in the approved waiver. The state indicates the latter performance measure combines the three approved performance measures into one, through which it collects data for this sub-assurance. Specifically, the state measured the number and percentage of qualified licensed home and community based waiver providers; providers were "qualified" if they were enrolled by the Division of Program Integrity and licensed by the OIG. The data reflected 100% compliance for Calendar Years (CYs) 2010 through 2012. The data sources were the Division of Program Integrity, and the Division of Community Alternatives.

For the sub-assurance that ensures non-licensed/non-certified providers adhere to waiver requirements, the state does not utilize any performance measure in the approved waiver to address non-licensed providers as the state does not enroll non-licensed providers to provide services for this waiver.

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 approved waiver has one performance measure. However, the state did not provide data for this performance measure. Rather, the state indicates it re-evaluated the approved performance measure and revised the performance measure. Ultimately, the state added a new task/performance measure on the monitoring tool for the 2013 survey year that the state indicates was more appropriate than the approved performance measure for the waiver. The performance measure that was added on the monitoring tool measures whether newly hired staff (RN, LPN, RT) were provided ventilator training prior to providing services. While the state did not provide data for this new performance measure, the state notes it remediated non-compliance through a DMS request for a CAP.

Required Recommendations:

(CMS recommendations include those areas requiring additional information or clarification prior to approval. The State must provide the requested information to be in compliance prior to renewal.)

The state did not provide data for the performance measure in the approved waiver demonstrating that the state implements policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver. Also, 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 provided a single performance measure not included in the approved waiver, indicating the performance measure provided combines the three performance measures approved for this sub-assurance into one performance measure. However, the state did not provide data for this performance measure. The state must provide data demonstrating 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 must update the approved waiver to reflect the performance measures used for this assurance as implemented.

State's Response:

The state noted that all Home Health agencies and Private Duty Nursing agencies are reviewed and receive new licensure annually through the Office of the Inspector General (OIG). Waiver providers are licensed by the OIG and enrolled by the Division of Program Integrity. The enrollment process ensures that providers are qualified according to provider, program, waiver and policy regulations. The state noted that the OIG will notify the Division of Program Integrity when a provider's license has been revoked. The Division of Program Integrity will then notify the Division of Community Alternatives that the provider is no longer qualified to provide services. Finally, the state noted that reports for the years 2010, 2011, and 2012 from the OIG and Division of Program Integrity indicate that no waiver provider's license had been revoked.

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 provided two performance measures from the approved waiver. First, the state measured the number and percentage of provider agencies whose staff had completed required background investigations prior to rendering services. The compliance rate for CY 2012 was 100%. Next, the state measured the number and percentage of provider agencies' staff whose licensure is current prior to rendering services. The compliance rate for CY 2012 was 100%. The state noted that for CY 2012, 12 waiver providers in the state provided private duty nursing services to participants enrolled in this waiver.

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 a performance measure from the approved waiver: the number and percentage of provider agencies' staff who completed mandatory training annually (i.e. CPR, HIPAA, abuse and neglect training). The compliance rate for CY 2012 was 83%. The state noted that not all service providers in this waiver are required to complete the above-referenced annual training pursuant to state licensure requirements and other professional standards (i.e. CPR training is

valid for a two-year period, HIPAA training is not mandatory annually for licensed nurses). Accordingly, the state indicates that this performance measure should be revised during the next waiver renewal to accurately assess and evaluate training measures that are appropriate for the types of service providers for this waiver. Specifically, the state proposed the following performance measure: number and percentage of agency licensed staff who have current CPR training and have received ventilator training prior to providing services. The state also proposed the following measure: the number and percentage of provider agency staff who have completed the HIPAA and abuse and neglect training prior to providing services. The state noted it will revise this waiver's monitoring tools to include the above-referenced performances measures by July 15, 2014. Finally, the state noted that DMS added a task on the monitoring tool during the 2013 annual onsite reviews assessing for ventilator training for newly hired nurses, prior to the provision of services by such providers.

CMS Response:

The CMS thanks the state for the additional information provided. CMS recommends that the state review the current performance measures to ensure that these best capture information that will most effectively demonstrate the sub-assurances and will be most meaningful to the state for program operation.

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 does not fully or substantially demonstrate the assurance, though there is evidence that may be clarified or readily addressed

Evidence Supporting This Conclusion:

(Evidence that supports this conclusion is weak and not complete. Additional information is required to comply with the assurance.)

Home Health agencies and Private Duty Nursing agencies are responsible for the protection of adults and children in accordance with state law. Onsite surveys and reviews conducted and executed by the Office of Inspector General (OIG), QIO Nurse Field Reviewers and DMS, assess and evaluate policies, procedures and implementation of such policies by Home Health agencies and Private Duty Nursing agencies. The OIG and DMS investigate individual complaints as warranted.

Waiver providers must develop an incident report form and a process for investigation, communication, and prevention of incidents. Providers must train all staff in the prevention, identification, and reporting of abuse, neglect and exploitation. Providers must also have a complaint process in place and educate waiver members, family members and legal representatives regarding this process. Additionally, providers must develop a contingency plan for emergencies and to accommodate a back-up when usual care is unavailable.

QIO nurse reviewers and DMS staff review all incident and complaints reports that have occurred during the time period that is being monitored during onsite review/surveys. Providers must make available the toll-free Fraud and Abuse Hotline telephone number of the OIG to Home Health Agency and Private Duty Nursing agency staff, waiver participants, and other interested parties for complaints or other concerns to be reported directly to the OIG. QIO nurse field reviewers and the DMS monitor case manager documentation in the waiver participant's medical record to ensure that status changes are reflected in the participant's Plan of Care.

A DMS representative performs second line on-site reviews annually of 25% of all waiver providers. The DMS representative calls waiver participants and/or primary caregivers to assess the delivery of services and discuss questions in the waiver recipient/caregiver survey, which includes assessing for abuse, mistreatment, complaints, and emergency preparedness.

DMS provides waiver policy information, provider letters, the waiver manual, regulations that govern the waiver, electronic forms and provider updates on the DMS website, which includes disaster/contingency policy and incidents/complaints policy.

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 multiple performance measures, none of which are noted in the approved waiver. The data sources are the Division of Program Integrity, and the Division of Community Alternatives. First, the state measured the number and percentage of waiver providers who were dis-enrolled by the DMS for confirmed reports of abuse, neglect or exploitation during Calendar Years (CYs) 2010, 2011 and 2012. The state reported that no providers were disenrolled by DMS for confirmed reports of abuse, neglect or exploitation during this time period. The state did not provide information regarding whether any confirmed reports of abuse, neglect or exploitation occurred during this time that would require disenrollment of a provider.

Next, the state measured the number and percentage of participant incidents of abuse, neglect or exploitation identified by DMS/QIO monitoring staff that occurred during a 6-month provider monitoring time frame during each of the CYs 2010-2012. The data source was the DMS and QIO field nurse reviewers. The state reported zero incidents of abuse, neglect and exploitation identified by monitoring staff.

The state utilized satisfaction surveys of waiver participants during the CYs 2010-2012, for several performance measures. For CYs, 2010-2011, the data source was information compiled from the recipient/caregiver surveys that were conducted via telephone interviews by the DMS nurse reviewers. For CY 2012, the data source was fiscal agent/QIO recipient/caregiver surveys. First, the state examined the number and percentage of returned surveys that responded "No" to the question, "Have you ever felt that you were mistreated?" The state reported 100% of waiver participants responded "No" to the latter question. Next, the state reported the number and percentage of returned surveys that responded "Yes" to the question, "Are the agency staff members courteous and respectful?" Of the sampled participants, 100% of them answered "Yes" to the latter question. Finally, the survey examined whether participants reported they were mistreated or had complaints related to waiver services. All participants who responded reported they were not mistreated nor did they have complaints related to services.

Required Recommendations:

(CMS recommendations include those areas requiring additional information or clarification prior to approval. The State must provide the requested information to be in compliance prior to renewal.)

The state must either provide data for the approved performance measures or amend the approved waiver to reflect the performance measures used for this assurance as implemented. In addition, the state should consider additional performance measures, such as the number and percentage of waiver participants for whom a critical incident was reported and/or the number and percentage of critical incident reports that were remediated within the required timeframe. This would provide the state with a more robust data set regarding the health and welfare of participants.

State's Response:

The state addressed the two participant survey performance measures: "Have you ever felt that you were mistreated?" and "Are the agency staff courteous and respectful?" The state noted the latter performance measures have been implemented and monitored by the DMS for over ten years and maintains they appropriately address health and welfare issues of the recipients. The state noted it derives its data from the participants' satisfaction surveys that are conducted via telephone interviews during on-site reviews and those that have been forwarded to DMS by mail.

The state provided a performance measure from the approved waiver: the number and percentage of satisfaction survey respondents who reported that staff yell or scream at them. The state noted there were no reports or comments in CYs 2010, 2011, or 2012 of staff yelling or screaming at waiver participants reported on the surveys. The state provided another performance measure from the approved waiver: the number of participants' records reviewed where the participant and/or family or legal guardian received information/education about how to report abuse, neglect, exploitation and/or critical incidents as specified in the approved waiver. The state noted 100% compliance with this performance measure for CYs 2010 and 2011, and 97% compliance for CY 2012. Finally, from the approved waiver, the state provided the following performance measure: the number and percentage of waiver participants receiving age-appropriate preventative health care such as vaccines, flu shots and/or pneumonia vaccine. The state noted it has not collected data for this performance measure. The state indicates it will revise the waiver on-site monitoring tool by inserting a clearly defined survey task examining the number and percentage of waiver participants receiving age-appropriate preventative health care such as vaccines, flu shots, and/or pneumonia vaccines. The state noted this will be placed on the monitoring tools by July 15, 2014, and will be implemented for the 2015 survey year, beginning January 2, 2015; the state will notify waiver providers of this change.

Regarding the performance measure the state submitted in the evidence measuring the number and percentage of participant incidents of abuse, neglect or exploitation identified by DMS/QIO monitoring staff that occurred during a six-month provider monitoring time frame during CYs 2010-2012, the state noted there were no member reports of incidents of abuse, neglect, or exploitation identified by DMS or the QIO that occurred during the six-month time frames. The state notes it gathered this data from the QIO on-site review/audit surveys and the waiver monitoring tool.

The state noted it will consider incorporating the performance measures, the number and percentage of critical incidents reported and the number and percentage of critical incident reports that were remediated within the required time frame, into the waiver renewal. The state will also revise the waiver monitoring tool to add the latter two measures as tasks for the Carewise Health nurse reviewers. The waiver monitoring tool will be revised by July 15, 2014 and implemented for the 2015 survey, beginning January 2, 2015. DMS concurs with the recommendations that this data would provide the state with a strong data set regarding the health and welfare of waiver participants.

CMS Response:

The CMS thanks the state for the additional information provided. CMS recommends that the state review the current performance measures to ensure that these best capture information that will most effectively demonstrate the sub-assurances and will be most meaningful to the state for program operation.

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 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 Kentucky Department for Medicaid Services (DMS) is the single state Medicaid agency that has administrative authority for this waiver. DMS performs the following administrative functions: promulgation of program regulations for services and payments, drafting of provider manuals and updates, notification of clarification of policy revisions to providers via provider letters, and contract implementation with the fiscal agent, Hewlett-Packard's, payment system. The DMS also oversees the contract agreement between the fiscal agent and the QIO.

The DMS provides first line monitoring, via the QIO's nurse reviewers, for all enrolled, active waiver providers and all waiver participants. The DMS also conducts second line monitoring of a sample of waiver providers that were reviewed by the QIO.

DMS updates the DMS web site's waiver home page to include provider and waiver updates and provides access to manuals and regulations that govern the waiver. DMS also continuously monitors revised policy changes and how these changes impact the daily operations of the program. Finally, DMS utilizes the data collected regarding appeals to scrutinize current policy and educate state hearing officers.

The state provides two performance measures for this assurance. First, the state measured the number and percentage of Utilization Management Reports completed in a timely manner by the Fiscal Agent. The data source was HP Enterprise Services. The state reported 100% compliance for this measure for Calendar Years (CY) 2010 through 2012. The state also provided data for a performance measure that is not in the approved waiver: the number and percentage of waiver participant on-site audits/reviews of medical records completed. The state reported that audits/reviews of medical records for 100% of waiver participants were conducted during CY 2012.

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.)

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.

State's Response:

The state provided no additional information.

CMS Response:

CMS has no further 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 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)

DMS, through a contract with the fiscal agent, Hewlett-Packard (HP), provides ongoing training and technical assistance to waiver providers for billing procedures, and oversees claims paid, suspended and denied. The DMS runs ad hoc reports of paid claims to compile monthly reports for monitoring overall program expenditures. DMS reviews and adds Edits/Audits to the Medicaid Management Information System (MMIS) periodically for program compliance and as policy is revised to ensure claims are not paid erroneously. DMS also reviews the CMS-372 report for accuracy prior to submission. Finally, DMS modifies procedure codes in compliance with federal requirements.

The DMS monitors the fiscal accountability of waiver providers. DMS performs post payment audits of paid claims. The audits are conducted as part of the overall monitoring of the waiver. These audits identify billing errors and provide documentation that supports service delivery that meets the service definition in the approved waiver. The audit also monitors service appropriateness based on the waiver participants' needs.

DMS is able to identify claims that have been erroneously paid. When claims have been paid, the monitoring process identifies if the claims were paid erroneously. DMS is able to reclaim the monies through a recoupment process. The waiver provider is notified of the recoupment via certified letter. A detailed listing of claims is attached to the letter with the reason for the recoupment.

The state has two performance measures for this assurance. The data source is billing review records. The first performance measure captures the number and percentage of waiver service claims reviewed by HP that were submitted for waiver participants who were enrolled in the waiver on the service delivery date. The state reported 100% of waiver service claims were reviewed by HP that were submitted for waiver participants who were enrolled in the waiver on a service delivery date during Calendar Years (CYs) 2010 through 2012.

The state provided data for a second performance measure that is not in the approved waiver: the number and percentage of waiver providers reviewed/surveyed on-site who had money recoupment amounts identified. The state reported 25%, 20%, and 20% of waiver providers reviewed had money recoupments identified for CYs 2010 through 2012, respectively. The data for CY 2010 and 2011 was derived sampling 25% of the waiver providers. The data for CY 2012 was derived from 100% of all waiver providers. The state did not provide information regarding the reasons for these recoupments or how these situations were remediated to ensure appropriate billing and to avoid fraud.

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.)

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 second 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. The state should update the approved waiver to reflect the performance measures used for this assurance as implemented.

State's Response:

The state provided an example and described its remediation process in instances of non-compliance. The state noted that 3,533 claims were submitted by a single provider. These were identified by the state's fiscal agent, HP, as provider billing errors and did not result in payment of such claims. The state noted provider training was conducted to correct the billing practices of the provider.

The state further noted that when claims have been paid, the state's onsite monitoring process identifies the claims that were paid based on error (i.e. the rounding up of units in provider billing) and therefore non-compliant with the waiver's policy. The DMS noted it will reclaim such funds through a recoupment process and mandate a corrective action plan from the provider.

The DMS noted it agrees with and will consider CMS' recommendation to revise and clarify the second performance measure for this assurance in the 2015 waiver renewal.

CMS Response:

The CMS thanks the state for the additional information provided. CMS recommends that the state review the current performance measures to ensure that these best capture information that will most effectively demonstrate the sub-assurances and will be most meaningful to the state for program operation.