

MAC Binder Section 1 – Letters From CMS

Table of Contents with Document Summary

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

1 – CMS-Ltr to LL from AMD re Approve NEMT Ext_dte062515:

CMS approval for an extension of the KY-06.R01 waiver to operate the NEMT program; this temporary extension will expire Sept. 30, 2015.

2 – CMS-Ltr to LL from MS re addtl funds BIP_dte070115:

CMS awards Kentucky additional funds for the State Balancing Incentive Payment Program (BIP). BIP provides a strong financial incentive to stimulate greater access to non-institutionally based long-term services and supports (LTSS).

3 – CMS- Ltr to LL from VW re ext cost alloc CHIP_dte072015:

CMS approves a one-time extension allowing human services programs to benefit from investments in the design and development of state eligibility-determination systems for state-operated marketplaces, Medicaid, and CHIP. This one-time extension provides an additional 3 years, through December 31, 2018.

4 – CMS-Ltr to LL from RL re review STP_dte072315:

CMS completed review of Kentucky's Statewide Transition Plan (STP); additional information on the results of the site-specific assessments requested.

5 – CMS-Ltr to LL from JG re MPW Review_dte072415:

CMS final report on their review of the Michelle P. Waiver (MPW); state found to be in compliance with three of the six review components.

6 – CMS-Ltr to LL from JG re HCBW Review_dte072915:

CMS final report on their review of the Home and Community Based Waiver (HCBW); state found to not be in compliance with three of the review components.

7 – CMS-Ltr to LL from AMD re ext MMC 1915b_dte073015:

CMS approves a 90-day extension of the Kentucky Medicaid Managed Care 1915(b) waiver program; this temporary extension will expire on October 31, 2015.

8 – CMS-Ltr to LL from JG re App MCO contracts and amend_dte080515:

CMS approval of Kentucky's submission of the Managed Care Organization (MCO) rates, contracts, and amendments.

MAC Binder Section 1 – Letters From CMS

Table of Contents with Document Summary

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9 – CMS-Ltr to LL from JG re Acknowledge DSH SPRY2011_dte081015:

CMS acknowledges receipt of the Department's submission of the Kentucky's state plan rate year (SPRY) 2011 Disproportionate Share Hospital (DSH) audit and report.

10 – CMS-Ltr to LL from JG re app SOW SERCH_dte081015:

CMS approves the Statement of Work (SOW) with HealthTech Solutions to provide consultant services for the SERCH collaborative.

11 – CMS-Ltr to LL from JG re SPA 14-005 Approved_dte081115:

CMS approves SPA 14-005 which clarifies that foster children and women receiving treatment through the breast and cervical cancer program are exempt from certain cost sharing requirements in the state plan.

12 – CMS-Ltr to LL from JG re RAI HCBW0144 Renew_dte082115:

CMS request for additional information (RAI) in response to the state's request to renew Kentucky's Home and Community Based Waiver (HCBW) for individuals with disabilities or aged 65 and older who would otherwise require placement in a NF.

13 – CMS-Ltr to LL from JG re RAI HCBW0314 Renew_dte082115:

CMS request for additional information (RAI) in response to the state's request to renew Kentucky's Home and Community Based Waiver (HCBW) for individuals who are developmentally and/or intellectually disabled who meet the intermediate care facility LOC.

14 – CMS-Ltr to LL from JG re ICD10 IAPDU#5 auth_dte082715:

CMS authorizes DMS to add an ICD-10 post-implementation phase from October 1, 2015, until March 31, 2016, and carry forward approved funding (no new funding approved for this project).

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

JUN 25 2015



Lisa D. Lee, Commissioner
Cabinet for Health and Family Services
Department for Medicaid Services
275 East Main Street, 6W-A
Frankfort, KY 40621

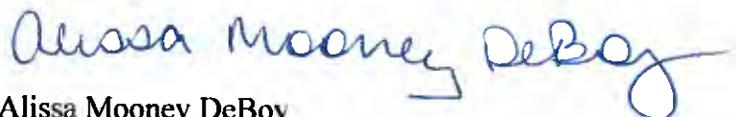
Dear Commissioner Lee:

The Centers for Medicare & Medicaid Services (CMS) received your request, dated June 23, 2015, for a temporary extension of Kentucky's Non-Emergency Medical Transportation (NEMT) 1915(b) waiver program under CMS control number KY-06.R01. The current temporary waiver authority expires on June 30, 2015.

You have requested this extension to ensure the state has time to submit a complete waiver application and cost effectiveness spreadsheets with actuarial soundness. CMS is granting an extension of the KY-06.R01 waiver to operate the NEMT program under section 1915(b) of the Social Security Act (the Act). This temporary extension will expire on September 30, 2015.

The CMS will continue to work with your staff during the extension period. If you have any questions, please contact Cheryl Brimage, in the Atlanta Regional Office, at (404)562-7116 or Lovie Davis, of my staff, at (410) 786-1533.

Sincerely,



Alissa Mooney DeBoy
Acting Director

cc: Cheryl Brimage, Atlanta Regional Office
Shantrina Roberts, Atlanta Regional Office
Jackie Glaze, Atlanta Regional Office

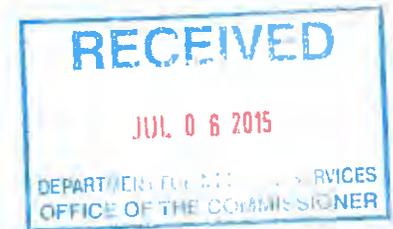
DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850



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.

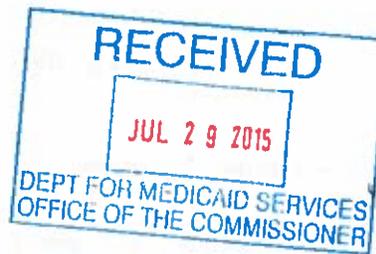
Sincerely,



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



United States Department of Agriculture

July 20, 2015

Dear Medicaid, Children's Health Insurance Program, and Health and Human Services Directors, and State Marketplace CEOs:

On August 10, 2011, we announced a time-limited, specific exception to the cost allocation requirements set forth in Office of Management and Budget (OMB) Circular A-87 (Section C.3) and Section 200.405 of the superseding "Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards" (2 CFR 200 issued December 19, 2014). These provisions generally require the costs associated with building shared state-based information technology systems to be allocated across all benefitting programs. The exception reflected the Administration's focus on streamlining enrollment in health and human services programs while leveraging funding efficiencies at the state-level. The original timeline allowed human services programs to benefit from investments in the design and development of state eligibility-determination systems for state-operated Marketplaces, Medicaid, and the Children's Health Insurance Program (CHIP), through December 31, 2015. This letter provides a one-time extension of that timeline for an additional 3 years, through December 31, 2018, and provides additional guidance on how states may take advantage of the exception and the extended timeframe to leverage these investments to better serve consumers' multiple programs and needs. The U.S. Departments of Health and Human Services (HHS) and Agriculture (USDA) are committed to a strong partnership with states and our federal stakeholders as we work together to implement our shared vision of interoperable, integrated and consumer-focused health and human services systems.

The underlying premise for the waiver remains the same: to maintain the progress states have made, and to promote further integration. This will enable states experiencing unanticipated delays with the development of the Medicaid Modified Adjusted Gross Income (MAGI) functionality in their eligibility systems, procurement challenges, and other unforeseen barriers to complete that work and then effectively use the waiver extension to streamline their eligibility systems, improve access to health and human service programs, and maximize efficiency.

This extension of the exception to certain OMB cost allocation requirements, along with the proposed indefinite extension of enhanced Federal funding for Medicaid systems, will enable states to fund the initial development costs needed to retire their legacy eligibility determination systems and integrate their functionalities into improved systems. Moreover, this extension will provide states more time to develop, refine, or test integrated systems to fully comply with Affordable Care Act functionalities.

Please refer to the January 23, 2012, Tri-Agency letter for requirements and additional details on considerations for using the exception and suggested system functionalities that can be integrated (<http://www.medicaid.gov/federal-policy-guidance/downloads/smd-01-23-12.pdf>).

Please refer questions to the federal analyst responsible for your program area.

Sincerely,

/s/

Victoria Wachino
Director
Center for Medicaid and CHIP Services,
Centers for Medicare & Medicaid Services,
Department of Health & Human Services

/s/

Kevin Concannon
Under Secretary for Food, Nutrition
and Consumer Services,
U.S. Department of Agriculture

/s/

Mark Greenberg
Acting Assistant Secretary for
Administration for Children and Families,
and Department of Health & Human Services

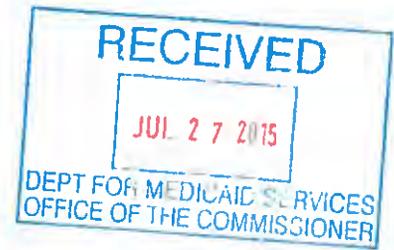
/s/

Kevin Counihan
Deputy Administrator and Director
Center for Consumer Information
Insurance Oversight,
Centers for Medicare & Medicaid
Services, Department of Health & Human
Services

Disabled & Elderly Health Programs Group

July 23, 2015

Lisa Lee
Commissioner, Department for Medicaid Services
Commonwealth of Kentucky, Cabinet for Health and Family Services
275 East Main Street, 6 West A
Frankfort, KY 40621



Dear Ms. Lee,

The Centers for Medicare & Medicaid Services (CMS) has completed its review of Kentucky's revised Statewide Transition Plan (STP) to bring state standards and settings into compliance with new federal home and community-based settings requirements. Kentucky submitted this revised STP to CMS on April 14, 2015, in response to feedback from CMS on the original STP submitted on December 19, 2014. While Kentucky has addressed several of CMS' concerns and made some important additions to the STP, CMS still needs some additional information on the results of the site-specific assessments. The remaining concerns and related questions for the state are summarized below.

Assessments

- **Systemic assessments.** In the revised version of its STP, Kentucky has added citations from the state's regulations that the state reviewed for each waiver. However, the STP does not specify which citation addresses which of the federal home and community based settings regulatory requirements or whether any of the state regulations will need to be revised to come into full compliance. Please provide this information in the next iteration of the state's STP.
- **Site-specific assessment process.** Kentucky has updated its STP to include estimates of the number of residential settings falling into each of four compliance categories. These categories include: fully align with the federal requirements; do not comply with the federal requirements and will require modifications; cannot meet the federal requirements and require removal from the program and/or the relocation of individuals; and are presumptively non-HCB but for which the state will provide evidence to show that those settings do not have the characteristics of an institution and do have the qualities of HCB settings. The state has not yet provided the requested additional information about the provider-specific assessments and surveys. Did the providers attest to meeting the federal regulations through their policies and procedures, or did the providers conduct site visits? A reliable validation process should be developed and used by the state that ensures the reliability of the provider information. The state should include information in the STP on the validation process it used to substantiate the information collected on both residential and non-residential settings.

- **Non-residential settings assessments.** Once Kentucky receives the completed compliance plan templates regarding non-residential settings, the state should be sure to include estimates of the number of non-residential settings (not just the number of providers or percentages) falling into each of the four compliance categories in its updated STP.
- **Site-specific assessment results.** CMS needs information on what types of settings fall into each of the 4 compliance categories and whether the setting is residential or non-residential. The STP should provide more detail on the settings that fall into the fourth category of settings presumed to have institutional characteristics but for which the state will provide evidence to show that those settings do not have the characteristics of an institution and do have the qualities of home and community-based settings (to be evaluated by CMS through the heightened scrutiny process). Please identify which specific settings fall into each of these categories due to their location (i.e., settings located in a building that is also a publicly or privately operated facility providing inpatient institutional treatment; and settings located in a building on the grounds of, or immediately adjacent to, a public institution) and which specific settings fall into each of these categories because they have the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.

Heightened Scrutiny. What process has/will the state use to identify settings presumed to have the characteristics of an institution for which evidence will be submitted for the application of heightened scrutiny? Given the estimated large number of settings that fall into the categories of “potentially isolating” and “isolating,” the state may be initiating the heightened scrutiny process far too late in the compliance transition period to allow adequate time for corrections or relocation to other compliant settings if the settings in question cannot be deemed to have the required qualities of a home and community-based setting.

Remedial Actions

- Please provide any remedial actions that are specific to individual settings. Once Kentucky receives the completed compliance plan templates from providers, the STP should be updated to include more details on remedial actions.
- CMS needs to understand the length of time it will take to change needed regulations, licenses and certifications, or to issue sub-regulatory guidance to providers and stakeholders.
- The timeline for bringing providers into compliance by March 17, 2019 may not allow enough time for implementation of the “second round changes identified in the STP,” which are the more complex and difficult changes for providers to implement. As noted above, CMS has significant concerns about the potential number of sites that may require heightened scrutiny or removal from the pool of settings if the state determines the institutional presumption should stand. While the state provided some rationale in the revised STP, CMS remains concerned about the timeline and believes the state should revisit its approach on this issue. Please describe how the state intends to complete all necessary assessment and action steps by the March 2019 compliance date.

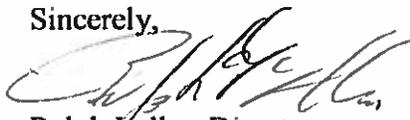
- Kentucky's STP describes the state's current monitoring process for HCBS waiver providers, but should include details on the monitoring process it intends to use to ensure that all timelines and milestones in the remedial process are met, and the processes the state will use to ensure continued compliance of its settings with the federal requirements. If the state is updating their licensure/certification requirements to ensure the licensing/certification entities and processes monitor compliance on an ongoing basis it should indicate this in the STP.
- The state provides an assurance that it will provide reasonable notice and due process to beneficiaries who must be relocated, and includes the timeline for the relocation processes. However, the STP does not include a description of the actual processes for assuring that beneficiaries, through the person-centered planning process, will be given the opportunity, the information, and the supports necessary to make an informed choice of an alternate setting that aligns with the regulation, and that critical services/supports are in place in advance of the individual's transition. CMS is requesting the state ensure this information is available in the STP.

Timeline for Updated Statewide Transition Plan

- In the updated STP submitted on April 16, Kentucky states that it intends to update the STP again with the complete results of the site-specific assessments, publish the STP for public comment, and re-submit it to CMS in December 2015. In the timeline on pp. 4-6 of the STP, Kentucky also indicates that it will update the STP with evidence for heightened scrutiny review in 2017, and re-submit the STP to CMS by April 15, 2017. CMS is concerned this latter timeframe for re-submission occurs too late in the transition period to ensure that all individuals receiving HCBS are in a compliant setting by March 17, 2019. In the version of its STP to be submitted December 31, 2015, please set a more expeditious schedule for processing and forwarding heightened scrutiny requests to CMS.

Please do not hesitate to reach out to Michele MacKenzie at 410-786-5929
Michele.MacKenzie@cms.hhs.gov, the CMS central office analyst taking the lead on this STP, with any questions.

Sincerely,



Ralph Lollar, Director
Division of Long Term Services and Supports

cc. J. Glaze

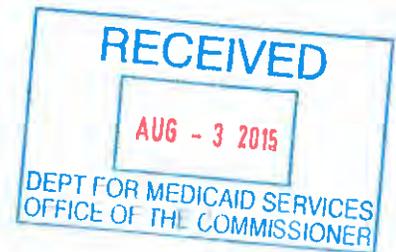
DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303



DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

July 24, 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 Michelle P. Waiver, control number 0475.R01, that serves individuals who have intellectual and/or developmental disabilities and otherwise need institutional services from an ICF/IID. Thank you for your assistance throughout this process. The state's response 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 three of the six review components. For those areas in which the state is not compliant, please ensure they are 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, June 2, 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,



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

cc: Amanda Hill, 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 Michelle P. Waiver
Control # 0475.R01**

July 24, 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 has administrative authority over the Michelle P. Waiver. The Division of Developmental and Intellectual Disabilities (DDID) within the Department of Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) serves as the operating agency of the waiver through a contract with the DMS. The target population for this waiver includes individuals who have intellectual and/or developmental disabilities and otherwise need institutional services from an ICF/IID. The most recent 372 report, for the waiver year ending August 31, 2012 and reported on June 17, 2014, shows an enrollment of 6,796 unduplicated participants with the average annual cost of \$27,544 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 October 31, 2014, the state provided an introduction to its overall quality management strategy, various examples and summary reports specific to each assurance.

The Department for Medicaid Services (DMS) is responsible for assessing the performance of the contracted entities providing Quality Improvement Organization (QIO) functions, the fiscal agent, and the DBHDID. The DMS contracts with Hewlett Packard (HP) as the fiscal agent. HP subcontracts with the QIO, CareWise. The QIO determines the Level of Care and completes prior authorization of services for the waiver. The state requires waiver providers to conduct participant satisfaction surveys, and the state utilizes these satisfaction surveys in the agency's Quality Improvement Plan. DDID staff track and investigate complaints regarding allegations of abuse, neglect and exploitation. Also, Kentucky participates in the National Core Indicators, which are measures used to assess participant satisfaction and outcomes of services. The indicators address choice, service planning, health, safety, rights, employment, and community inclusion. The DMS monitors the fiscal accountability of waiver providers.

Summary of Findings

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

The evidence provided indicates the QIO reviews and issues LOC determinations. The evidence also indicates that regional Community Mental Health Centers (CMHCs) perform the assessments and reassessments for the Level of Care (LOC) for the waiver. This is not consistently reflected in the approved waiver, which provides that the Operating Agency, the Division of Developmental and Intellectual Disabilities, determines the level of care for this waiver and which does not include performance of LOC assessments by the CMHCs. The state must update language in the next waiver renewal to reflect that the QIO determines LOC for this waiver and to clarify the role of CMHCs in performance of waiver assessments and reassessments.

While the state provided data for the sub-assurance that an evaluation for level of care is provided to all applicants for whom there is reasonable indication that services may be needed in the future, one of the performance measures was a revised version of an approved performance measure. Also, the state did not provide data for a performance measure in the approved waiver to demonstrate whether the processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine LOC. However, for the latter sub-assurance, the state did provide data for a performance measure not included in the approved waiver. For all performance measures provided for the LOC assurance, the state must update the approved waiver to reflect its performance measures as implemented for the next waiver renewal.

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

Required Recommendations

The evidence provided indicates the QIO reviews and approves POCs and manages prior authorization of services. This is inconsistent with the waiver renewal and corresponding amendment approved during the period of 09/01/2011 - 11/20/2014, which provide that, by Waiver Year 2, the Operating Agency, the Division of Developmental and Intellectual Disabilities, would review and approve POCs and manage prior authorization of services. The DMS notes this discrepancy in its evidence submission. The state must update this language in the next waiver renewal to remedy this inconsistency and reflect its processes as implemented.

The evidence provided indicates the MAP-351 form is used to develop waiver participants' POC. This is inconsistent with the waiver renewal and corresponding amendment approved during the period of 09/01/2011 - 11/20/2014, which provide that the state would phase in a POC development process whereby the waiver participant's POC is developed utilizing the Supports Intensity Scale and the Health Risk Screening Tool. The DMS notes this discrepancy in its evidence submission. The state must update the approved waiver during the next renewal to accurately reflect its service plan development tools and processes.

While the state provided data for the approved performance measures, the state also provided data for two performance measures not in the approved waiver and revised versions of two approved performance measures. The DMS notes it is in the process of rewriting the performance measures for this waiver. The state must update the approved waiver to reflect the performance measures used for this assurance as implemented during the next waiver renewal.

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

Suggested Recommendations

The state should review the outcome of quality improvement activities that it notes are in progress to address non-compliance with the following sub-assurance: 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 should also consider including additional quality improvement activities to address this sub-assurance.

The state should consider revising the following performance measure: the number and percentage of waiver providers with documented plans of correction. The state should examine whether those providers that do not meet required licensure and/or certification

standards have an appropriate plan of correction in place. This would provide the state with a more robust data set with which to develop system improvements to address non-compliance.

While the state included data for the approved performance measure for the sub-assurance that ensures non-licensed/non-certified providers adhere to waiver requirements, the state did not report the timeframe over which such data was measured. The state should develop performance measures that are measurable during the time period of the approved waiver, and update the waiver accordingly during the next renewal.

The state should examine whether the sample size of waiver providers the DMS and QIO monitors is statistically significant for purposes of data collection for quality improvement activities.

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. The state should also measure the outcome of its system improvement efforts to reduce use of restraints, and initiate additional system improvements where non-compliance continues to be noted. This would allow for systemic evaluation regarding use of restraints and the effectiveness of the state's efforts to prevent their use.

During the next waiver renewal, the state should consider including additional performance measures that would address safeguarding the health and welfare of waiver participants through the provision of medical screenings and services.

5. State Medicaid Agency Retains Administrative Authority Over the Waiver Program - The State does not fully or substantially demonstrate the assurance, though there is evidence that may be clarified or readily addressed.

Required Recommendations

The evidence submitted by the state notes the following: "The Operating Agency was to be the Division of Developmental and Intellectual Disabilities (DDID) within the Department of Behavioral Health, Developmental and Intellectual Disabilities (DBHDID), and was supposed to determine level of care, prior authorize requests for services and approve the Plans of Care. Level of Care continues to be handled by the QIO, as contracted by HP. The DMS continues to be the operating authority for the Michelle P. waiver." The evidence provided also indicates the QIO reviews and approves POCs and manages prior authorization of services. The state must update the next waiver renewal to accurately describe the QIO's and DDID's administrative and

operational functions for this waiver, and how the single state agency monitors whether such entities' administration of the waiver program is consistent with its approved waiver.

While the state provided data for the approved performance measure for this assurance, the state did not report the timeframe over which such data was measured. The state should develop performance measures that are measurable during the time period of the approved waiver, and update the waiver accordingly during the next renewal. Also, the state provided data for a performance measure not included in the approved waiver. The state must update the approved waiver to reflect its performance measures as implemented for the next waiver 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 data for approved performance measures for this assurance, the state did not specify the time period over which data was collected for one of the performance measures. The state also did not provide the source from which it derived data for two of its performance measures for this assurance. The state should develop performance measures that are measurable during the time period of the approved waiver, and update the waiver accordingly during the next renewal.

The state provided data for a performance measure not included in the approved waiver. The state must update the approved waiver to reflect its performance measures and data sources as implemented for the next waiver renewal.

The state should implement and report on a clear process to remediate individual and systemic errors that result in recoupments. In addition, the state should consider revising the last performance measure provided for clarity. Finally, the state should consider including the number and percentage of providers who maintain financial records according to program agreements or contracts as an additional performance measure.

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: Michelle P. Waiver

Operating Agency: Division of Developmental and Intellectual Disabilities (DDID) within the Department of Behavioral Health, Developmental and Intellectual Disabilities (DBHDID)

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

Target Population: Developmentally and/or Intellectually Disabled Individuals

Level of Care: ICF/IID

Number of Waiver Participants: 6,796

Average Annual per capita costs: \$27,544 (as of June 17, 2014)

Effective Dates of Waiver: September 1, 2011 through August 31, 2016

Approved Waiver Services: Adult Day Health, Case Management, Community Access, Day Training, Personal Assistance, Respite, Shared Living, Supported Employment, Occupational Therapy, Physical Therapy, Speech Therapy, Community Guide, Goods and Services, Natural Supports Training, Transportation, Assessment/Reassessment, Community Transition, Consultative Clinical and Therapeutic Services, Environmental Accessibility Adaptation Services, Person Centered Coaching, Positive Behavior Supports, Specialized Medical Equipment and Supplies, Vehicle Adaptation

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 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.)

Kentucky's regional Community Mental Health Centers (CMHCs), through a contract with the Department for Medicaid Services (DMS), perform Level of Care (LOC) assessments and reassessments for the waiver. The Medicaid Waiver Assessment form, MAP-351, is the assessment tool that is utilized.

The state contracts with a fiscal agent, Hewlett Packard (HP), who in turn, contracts with Care Wise Health, the Quality Improvement Organization (QIO), for implementation of the LOC process. The CMHC submits clinical information to the QIO for medical necessity review using the MAP-351 form. The MAP-351 assesses the following: an individual's needs in conducting Activities of Daily Living; Instrumental Activities of Daily Living; neurological, emotional, and behavioral functioning; clinical needs; environmental/living conditions; and informal supports. Upon completion of a review, the QIO clinician may approve the level of care request, and if approved, a 6-month or 12-month certification interval is assigned. Where insufficient information is submitted, the QIO may issue a Lack of Information Sheet. The QIO may also refer the request to a Physician Advisor for 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 of services.

Appeal rights are included in the denial of LOC letter. 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.

The CMHC performs reassessments to determine the continuing need for waiver services. LOC reassessments are conducted at least every 12 months using the Medicaid Management Information System (MMIS), managed through HP. Once a LOC is approved, the dates for the LOC are logged into the MMIS system by the QIO. The CMHC must notify the QIO no more than 21 days prior to expiration of the current LOC certification or by the last day of the certification to ensure that certification is consecutive. If this does not occur, the provider will not be reimbursed for a service provided during a period that a waiver participant is not covered by a valid LOC.

The QIO performs first line monitoring on an annual basis of enrolled licensed Home Health Agencies and Adult Day Health Care providers that deliver waiver services to waiver participants. The Department for Behavioral Health, Developmental and Intellectual Disabilities also monitors, on an annual basis, the providers that deliver waiver services. The Department for Aging and Independent Living, through a contract with the DMS, monitors the Area Agencies on Aging and the CMHCs, which provide Support Brokerage and Financial Management to waiver participants for participant-directed services. During this monitoring process, a random selection of participant charts is reviewed to ensure that the LOC assessments are conducted in a timely manner.

The data source for all performance measures is HP Enterprise Services. 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. Specifically, the state measures the number and percentage of waiver applicants who had a level of care evaluation indicating the need for institutionalization prior to receipt of services. The compliance rate for this measure was 100% for Waiver Years (WYs) 2012, 2013 and 2014.

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: the number and percentage of waiver participants who received a redetermination of level of care within 12 months of their initial or last level of care determination. The compliance rate for this measure was 97%, 98% and 99% for WYs 2012, 2013 and 2014, respectively. The state did not provide information regarding remediation activities.

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 data for a performance measure that is not in the approved waiver: the number and percentage of level of care determinations with completed assessment forms on file. The compliance rate for this measure was 100% for WYs 2012, 2013 and 2014. The state also provides data for the following approved performance measure: the number and percentage of level of care eligibility determination packets that were returned (i.e. because the provider did not include all required documentation, the QIO notified provider that more information was needed). For WYs 2012, 2013, and 2014, 11%, 16% and 3% of the eligibility determination packets were returned, respectively. The state determined the increase in non-compliance for year 2013 resulted from a change in policy requiring testing and/or other professional documentation (i.e. IEP, M.D. note) supporting an intellectual disability or developmental disability diagnosis and IQ score. The state notes the decrease in non-compliance during year 2014 resulted from a policy directive regarding administrative approval of all recertifications.

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 evidence provided indicates the QIO reviews and issues LOC determinations. The evidence also indicates that regional Community Mental Health Centers (CMHCs) perform the assessments and reassessments for the Level of Care (LOC) for the waiver. This is not

consistently reflected in the approved waiver, which provides that the Operating Agency, the Division of Developmental and Intellectual Disabilities, determines the level of care for this waiver and which does not include performance of LOC assessments by the CMHCs. The state must update language in the next waiver renewal to reflect that the QIO determines LOC for this waiver and to clarify the role of CMHCs in performance of waiver assessments and reassessments.

While the state provided data for the sub-assurance that an evaluation for level of care is provided to all applicants for whom there is reasonable indication that services may be needed in the future, one of the performance measures was a revised version of an approved performance measure. Also, the state did not provide data for a performance measure in the approved waiver to demonstrate whether the processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine LOC. However, for the latter sub-assurance, the state did provide data for a performance measure not included in the approved waiver. For all performance measures provided for the LOC assurance, the state must update the approved waiver to reflect its performance measures as implemented for the next waiver renewal.

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 LOC 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 elects to address the non-complaint assurances during waiver renewal.

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 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.)

The state's process for developing a participant's Plan of Care (POC) is based on a comprehensive assessment of the waiver participant. A team composed of a registered nurse and social worker, or two registered nurses, is responsible for completion of the participant's assessment.

A case manager is responsible for the POC and for tracking when and if a new assessment is needed due to changes in the participant's health. Should a change in the appropriateness of a participant's POC occur, a modification of the POC is requested by the case manager and submitted to the QIO for prior authorization of services. The case manager is responsible for education, referral, and coordinating community resources to meet the needs of participants by ensuring all activities documented meet the service definitions of the approved waiver, services are provided in accordance with the approved POC, and participants are involved in the care planning process.

Providers submit a service packet to the QIO for medical necessity review. The packet includes the MAP-351 form, which is utilized to identify and document the needs of the waiver participant. The needs identified on the MAP-351 must be addressed on the participant's POC. If the participant's needs are not documented in the POC, then the QIO contacts the case management agency, and the case manager has 14 days to resubmit the corrected POC to the QIO. The QIO reviews all information prior to issuing a determination and prior authorizations, and services are authorized or denied based on the information provided in the service packet.

Monitoring of POC and prior authorization for waiver services documentation for all enrolled providers is conducted through first line monitoring by the QIO, Division of Developmental and Intellectual Disabilities (DDID), and the Department for Aging and Independent Living (DAIL), using a sample of participants served in the waiver. Monitoring the POC's include reviewing whether all needs of the participants are met by appropriate interventions or services; this includes the coordination of non-waiver services, and determination of the appropriateness and adequacy of the services given the nature and severity of the participant's disability. The minimum schedule under which these reviews occur is every 12 months.

The DMS performs second line monitoring of the QIO, DDID, and DAIL to review whether such entities conduct monitoring in accordance with their respective contracts. The QIO, DDID, and DAIL submit the service packet to the DMS, which then reviews whether the services requested were appropriate by using a detailed monitoring report. If services are not appropriate, a Corrective Action Plan (CAP) may be needed. The enrolled provider then submits a CAP to the QIO with supporting evidence of implementation of the corrective action.

Waiver participants complete randomized satisfaction surveys. The surveys are used to demonstrate whether the participant is satisfied or unsatisfied with the services they are receiving in the waiver program.

Regarding choice being offered to all participants, the LTC Facilities and Community Based Program Certification Form is utilized to document the participants' choice of waiver services or institutional care and between/among waiver providers. Waiver participants sign this form at each assessment and reassessment, a minimum of once per 12 month period. Nursing facilities are also required to annually inform residents of the freedom of choice to receive waiver services or institutional care via this form. Finally, the Client Satisfaction Survey captures data regarding participant choice.

Monitoring of activities of enrolled providers includes ensuring that the case management team is knowledgeable about and educates participants about freedom of choice. DMS has implemented a requirement that enrolled providers present a listing of service providers to participants at the time of assessment/reassessment. Specifically, during the assessment process, the participant is informed of the option to use traditional services, participant-directed services or blended services, which is a combination of both traditional and participant-directed options. If the participant chooses traditional services, then the participant is provided a list of provider agencies that perform the waiver services. If the participant chooses the participant-directed option or blended services, then the participant is directed to their Community Mental Health Center where they will work with a Support Broker who serves as a Case Manager. A listing of providers the participant has chosen is listed in the POC.

For the sub-assurance that ensures service plans address all the participant's assessed needs and personal goals, the state collects data for multiple performance measures. First, the state measures the percentage and number of participants reviewed who had service plans that were adequate and appropriate to their needs (including health care needs) as indicated in the assessment. The compliance rate for this measure was 100%, 98%, and 100% for WYs 2012, 2013 and 2014, respectively. The data source was HP Enterprise Services. Next, the state measures the percentage of services plans that reflect individual goals and preferences. The compliance rate was 100% for each of the WYs 2012 through 2014. Also, the state measures the number and percentage of sampled service plans that include a risk assessment. Compliance with this performance measure was 100% for WYs 2012 through 2014. The data source was onsite record reviews. In addition, the state measures the percentage of sampled service plans with risk assessments that have appropriate risk mitigation. Compliance with this performance measure was 86% during WY 2012, 86% during WY 2013, and 87% during WY 2014. The data source was onsite record reviews. The state demonstrated remediation by providing non-compliant providers with technical assistance and requiring corrective action plans. The state identified the most common compliance issue pertained to crisis prevention plans, participant summaries failing to identify all risks, and incomplete prevention strategies. The state demonstrated system improvement when it revised the monitoring form used by DDID Quality staff for record reviews to capture additional data regarding POC non-compliance issues. Following the latter efforts, the state reported a reduction in the number of service plans that do not fully align with a participant's assessed needs.

The state surveyed families of waiver participants to identify the percentage of families who were satisfied with the services and supports their family member receives. Compliance with this performance measure was 86% for WY 2013. The state did not provide data for this measure for WYs 2012 and 2014. The data source was the National Core Indicators. Using the

same data source, the state surveyed waiver participants to identify the number and percentage who were satisfied that their case manager provides them with the services and supports they need. Compliance with this performance measure was 88%, 90%, and 86% for WYs 2012, 2013 and 2014, respectively. The state noted that it addressed non-compliance with the above-referenced performance measures by communicating the results of the surveys during a provider webinar. The state also discussed person-centered planning during case management training.

For the sub-assurance that ensures the state monitors service plan development in accordance with its policies and procedures, the state provides data for the approved performance measures. First, the state measured the percentage of providers that are in compliance with the waiver's service plan requirements (i.e. completeness of the service plan and submission of the service plan within the required timeframe). The data source was onsite record review of providers. The compliance rate was 94%, 94%, and 95% for WYs 2012, 2013, and 2014, respectively. In each instance of non-compliance, the state provided technical assistance to the providers, and if warranted, required corrective action plans for the providers. The state verified that it received, accepted and monitored all corrective action plans from non-compliant providers. The state also measured the percentage of service plans that are based on "what is important to and important for" the person. The compliance rate was 100% for each of the WYs 2012 through 2014. Finally, the state provided data for a performance measure not in the approved waiver: the number and percentage of participants receiving participant-directed services within an approved budget. The compliance rate was 100% for each of the WYs 2012 through 2014.

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 data for a performance measure not in the approved waiver: the number and percentage of waiver participants with a service plan that was updated and submitted prior to the annual certification date. Compliance with this performance measure was 97%, 98% and 99% for WYs 2012, 2013, and 2014, respectively. The state did not provide information regarding remediation activities. The data source was HP Enterprise Services. The state also provides data for the approved performance measure, the number and percentage of service plans indicating appropriate change in service related to documented change in participants needs within the year. The compliance rate was 100% for each of the WYs 2012 through 2014.

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 provides data for one performance measure: the number and percentage of participants who received services in the type, scope, amount, and duration as specified in the service plan. The compliance rate was 100% for each of the WYs 2012 through 2014. The data source was HP Enterprise Services.

For the sub-assurance that ensures participants are offered a choice between waiver services and institutional care and between/among providers, the state provides data for several performance measures: the first performance measure is a revised version of a measure from the approved waiver, and the second measure provided is not in the approved waiver. The data source was HP Enterprise Services. First, the state 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. The compliance rate was 100% for each of the WYs 2012 through 2014. Next, the state provides data for the following performance measure: the number and percentage of waiver participants whose records contain confirmation of notification of the option to choose participant-directed options. The compliance rate was 100% for each of the WYs 2012 through 2014.

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 evidence provided indicates the QIO reviews and approves POCs and manages prior authorization of services. This is inconsistent with the waiver renewal and corresponding amendment approved during the period of 09/01/2011 - 11/20/2014, which provide that, by Waiver Year 2, the Operating Agency, the Division of Developmental and Intellectual Disabilities, would review and approve POCs and manage prior authorization of services. The DMS notes this discrepancy in its evidence submission. The state must update this language in the next waiver renewal to remedy this inconsistency and reflect its processes as implemented.

The evidence provided indicates the MAP-351 form is used to develop waiver participants' POC. This is inconsistent with the waiver renewal and corresponding amendment approved during the period of 09/01/2011 - 11/20/2014, which provide that the state would phase in a POC development process whereby the waiver participant's POC is developed utilizing the Supports Intensity Scale and the Health Risk Screening Tool. The DMS notes this discrepancy in its evidence submission. The state must update the approved waiver during the next renewal to accurately reflect its service plan development tools and processes.

While the state provided data for the approved performance measures, the state also provided data for two performance measures not in the approved waiver and revised versions of two approved performance measures. The DMS notes it is in the process of rewriting the performance measures for this waiver. The state must update the approved waiver to reflect the performance measures used for this assurance as implemented during the next waiver renewal.

State Response:

The state elects to address the non-complaint assurances during waiver renewal.

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)

Waiver providers are licensed Home Health Agencies that perform waiver services, licensed Adult Day Healthcare Centers (ADHC) and certified Supports for Community Living providers that are in good standing. The Office of Inspector General (OIG) is responsible for surveying and licensing such agencies. The OIG has a survey process for completing initial surveys and uses specified timelines to complete follow-up surveys. The OIG sends DMS a copy of the license. After receiving a copy of the license and a completed provider enrollment application, the DMS enrolls the provider. Should an enrolled provider not meet requirements to provide waiver services, OIG would terminate the provider license, and the DMS would terminate the provider's Medicaid enrollment.

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

The DMS fiscal agent, Hewlett Packard, provides ongoing training regarding submission and resolution of claims. DMS program staff also conducts ongoing training and technical assistance for providers.

The DMS monitors 10% of providers for compliance with waiver requirements. Also, 50% of waiver providers are monitored annually via onsite visits by the QIO, and 30% of the ADHC agencies are monitored by the QIO. The Division of Developmental and Intellectual Disabilities (DDID) and Department for Aging and Independent Living (DAIL) monitor all enrolled participant-directed service providers using a sample of the participants served by the waiver.

The participant-directed option is the only program for which providers are not certified or licensed. This program allows participants to hire their family members and other qualified persons. The DAIL monitors the Area Agencies on Aging (AAA) who assist the participants by serving as the Support Broker. When DAIL monitors an AAA, they also make several home visits to verify that services are being provided and that the participant is satisfied with the services they are receiving.

The QIO submits a packet to DMS that describes which participant's chart was reviewed and if the submission of the forms and the services requested were appropriate, using a detailed monitoring report. If services are not appropriate, the QIO may reflect in the report that a

Corrective Action Plan (CAP) is needed. The report is then issued to the enrolled provider, which includes the CAP request. The enrolled provider responds with submission of the CAP with supporting evidence of implementation of corrective action. Corrective action plans are required from the provider within a maximum 45 day timeframe. If the provider fails to make satisfactory correction in the CAP, a recommendation is made to DMS to not renew the provider's certification.

Regarding provider training requirements, DMS performs provider trainings when changes to waiver policies and requirements occur and upon request of 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 approved waiver utilizes three performance measures. The data source is the Department of Behavioral Health, Developmental and Intellectual Disabilities (BHDID) Certification Database. First, the state measures the number and percentage of newly certified waiver providers that meet health, safety, and welfare regulations' requirements within the initial six months of service provision. The compliance rate was 65%, 61%, and 69% for WYs 2012, 2013, and 2014, respectively. In each instance of non-compliance, the state required implementation of a CAP where appropriate, and DDID staff delivered technical assistance to the providers. Regarding system improvement, regional meetings of BHDID Quality Administrators, which offer technical assistance to providers individually, included discussion of systemic issues and how to remediate such issues. Quarterly provider webinars also included training for system improvements, which addressed the following goals: all participants are healthy and safe, medications are administered without error, and day training is person-centered and non-diversional.

Next, the state measures the number and percentage of enrolled waiver providers that meet regulatory requirements at time of certification review. The compliance rate was 45%, 50%, and 52% for WYs 2012, 2013, and 2014, respectively. The state also measured the number and percentage of waiver providers with documented plans of correction. The state notes that 45%, 50%, and 52% of providers had no plans of correction in place during WYs 2012, 2013, and 2014, respectively. For both above-referenced performance measures, in each instance of non-compliance, the DDID provided technical assistance and a CAP was implemented for non-compliant providers where citations were noted. The state also implemented a systemic quality improvement plan addressing health, safety and welfare, medication administration, and day training. The state notes this quality improvement plan is currently in process, and it is examining how to more clearly define its determination of the length of certification of providers.

For the sub-assurance that ensures non-licensed/non-certified providers adhere to waiver requirements, the state measures the percentage of participant-directed employees who completed the required training. While the state reports 100% compliance for this measure, the state did not report the timeframe over which such data applied or information about type of training required for participant-directed employees.

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 two performance measures. The data source was onsite training record review using the provider certification checklist. First, the state measures the percentage of reviewed providers in which staff have successfully completed mandatory training annually. The compliance rate was 91%, 92% and 94% for WYs 2012, 2013 and 2014, respectively. The state also measures the number and percentage of reviewed agencies that provide case management services in which case managers have successfully completed all required case management training. The compliance rate was 92%, 94%, and 96% for WYs 2012, 2013, and 2014, respectively. In each instance of non-compliance, the DDID provided technical assistance and a CAP was implemented for non-compliant providers where citations were noted.

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 review the outcome of quality improvement activities that it notes are in progress to address non-compliance with the following sub-assurance: 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 should also consider including additional quality improvement activities to address this sub-assurance.

The state should consider revising the following performance measure: the number and percentage of waiver providers with documented plans of correction. The state should examine whether those providers that do not meet required licensure and/or certification standards have an appropriate plan of correction in place. This would provide the state with a more robust data set with which to develop system improvements to address non-compliance.

While the state included data for the approved performance measure for the sub-assurance that ensures non-licensed/non-certified providers adhere to waiver requirements, the state did not report the timeframe over which such data was measured. The state should develop performance measures that are measurable during the time period of the approved waiver, and update the waiver accordingly during the next renewal.

The state should examine whether the sample size of waiver providers the DMS and QIO monitors is statistically significant for purposes of data collection for quality improvement activities.

State Response:

The state provided no additional information.

CMS Response:

The CMS has no further 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 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)

Waiver providers are mandatory reporters of abuse, neglect, and exploitation pursuant to state requirements. Providers are also required to train all staff in the prevention, identification, and reporting of abuse, neglect and exploitation.

Where an alleged, suspected, or actual occurrence of an incident that can reasonably be expected to result in harm (or death) to the individual has occurred, documentation of such occurrence must be maintained on an incident form at the provider site, immediately reported to Department for Community Based Services, Adult Protective Services, the case manager, and the participant's guardian. The person discovering the incident is required to take immediate action to ensure the health, safety, and welfare of the at-risk individual. If the occurrence is not potential abuse, neglect, or exploitation, the occurrence must be reported to the participant's case manager, guardian and Division of Developmental and Intellectual Disabilities (DDID) Regional nurse within 8 hours of its discovery.

The use of mechanical restraints, seclusion and manual restraints, including any manner of prone or supine restraint, is expressly prohibited. The use of chemical restraint is also expressly prohibited. A chemical restraint is defined as use of a medication either over the counter or prescribed, to temporarily control behavior, restrict movement or the function of an individual, and is not a standard treatment for the participant's medical or psychiatric diagnosis. Providers must report all physical and chemical restraints as a critical incident using the incident reporting process.

The state requires waiver providers to develop an incident report form and a process for investigation, communication, and prevention of incidents. Specifically, waiver providers must have a complaint process in place and educate waiver participants, family members and legal representatives regarding this process. DMS Monitoring Staff review all incident reports. Licensed Home Health Agencies (HHAs) and Licensed Adult Day Health Care (ADHCs) providers are required to follow the state's incident reporting requirements. Also, incident reports are kept on file at the HHAs and ADHCs and checked by Office of Inspector General (OIG) and the QIO during on-site visits.

Waiver providers are required to make the OIG's toll-free Fraud and Abuse Hotline telephone number available to waiver participants, and other interested parties. The purpose of this telephone hotline is to enable complaints or other concerns to be reported to the OIG.

Waiver providers must deliver at least one case management contact per month, a face to face meeting, to assess the waiver participant and the service delivery. The case management contacts are monitored when the QIO and OIG review documentation in the participant's medical record.

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. The data source was the DDID incident management database. First, the state measures the number and percentage of critical incident reports of potential abuses that were submitted to DDID within the required time frames. Compliance with this measure was 88%, 87%, and 88% for WYs 2012, 2013 and 2014, respectively. The state addressed non-compliance by the provision of technical assistance by DDID risk management staff to non-compliant providers. Next, the state measures the number and percentage of participants who had at least one report of suspected abuse, neglect, or exploitation during the year in WYs 2012-2014. Out of all waiver participants, 4%, 3% and 3% had at least one such report during WYs 2012, 2013, and 2014, respectively. In each case, technical assistance was provided by DDID risk management staff, DCBS and risk management staff reviewed the case, and the reported abuse, neglect and exploitation was addressed. The state also measured the number and percentage of participants who had injury reported due to restraint during WYs 2012-2014. During WY 2012, out of the total restraints (19) reported, no injuries were reported. During WY 2013, out of the total restraints (28) reported, no injuries were reported. Finally, during WY 2014, out of the total restraints (18) reported, no injuries were reported. The state noted that no remediation occurred because there was 100% compliance with no injuries occurring as a result of the use of restraints. While the state did not report remediation activities to address those specific instances of use of restraints with waiver participants, the state noted that when a use of restraint is reported, a BHDID Nurse contacts the provider to provide technical assistance. Regarding system improvement, the state noted that crisis prevention and intervention training became mandatory for providers in February of 2013.

The state examines the number and percentage of audited providers in which direct support staff had criminal background checks prior to providing services. Of the audited providers, 90%, 91% and 91% had completed the requisite criminal background checks prior to providing waiver services during WYs 2012, 2013 and 2014, respectively. The data source was onsite training record review using the provider certification checklist. As a result of the survey, the DDID provided technical assistance to non-compliant providers and, where appropriate, implementation of a corrective action plan was required.

The state utilizes surveys of waiver participants using the National Core Indicator (NCI) survey for several performance measures. First, the state examined the number and percentage of surveyed participants who responded on the NCI survey that they are always/sometimes afraid or scared in their home or their neighborhoods. For WY 2012, the state reported 91% of participants were not afraid or scared at home and 91% were not afraid or scared in their neighborhood. For WY 2013, the state reported 91% of participants were not afraid or scared at home and 95% were not afraid or scared in their neighborhood. For WY 2014, the state reported 92% of participants were not afraid or scared at home and 91% were not afraid or scared in their neighborhood. The results of this survey were communicated during a provider webinar. The

state also noted that case managers review participant health, safety and welfare on a monthly basis.

Next, the NCI survey asked participants whether they had a physical examination in the last year. During WYs 2012, 2013, and 2014, 83%, 82% and 82%, respectively, of waiver participants had a physical examination within the last year. The results of this survey were communicated during a provider webinar, and the importance of an annual physical was emphasized. Also, the survey asked female participants whether they had an OB/GYN examination in the past year. The state specifically surveyed whether participants reported having a “pap test” and mammogram within the past year. For WY 2012, of the sampled participants, 83% had a “pap test” in the past year and 28% had mammograms. For WY 2013, of the sampled participants, 82% had a “pap test” in the past year and 18% had mammograms. For WY 2014, of the sampled participants, 82% had a “pap test” in the past year and 31% had mammograms. The results of this survey were communicated during a provider webinar, and the importance of medical screenings was emphasized. Further, the survey asked male participants whether they had a prostate examination in the past year. During WYs 2012 and 2013, 13% and 6%, respectively, of sampled participants had a prostate examination in the past year. The state did not provide WY 2014 data for this measure. The results of this survey were communicated during a provider webinar, and the importance of medical screenings was emphasized. Additionally, the survey asked participants whether they had a routine dental examination in the past year. During WYs 2012, 2013 and 2014, 79%, 80% and 73%, respectively, of the sampled participants had a routine dental examination in the past year. The results of this survey were communicated during a provider webinar, and the importance of regular dental care was emphasized. Regarding remediation of non-compliance noted in the above-referenced performances measures, the state notes that because NCI data is de-identified data, the state does not know which participants responded that they did not have an examination. Therefore, the state notes it was not able to remediate each individual instance of non-compliance. The state notes that non-compliance was addressed, at a systemic level, by BHDID nurses and quality administrators through individual contact with providers.

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 a performance measure to examine the number of reported use of restraints out of the total number of waiver participants. The state should also measure the outcome of its system improvement efforts to reduce use of restraints, and initiate additional system improvements where non-compliance continues to be noted. This would allow for systemic evaluation regarding use of restraints and the effectiveness of the state’s efforts to prevent their use.

During the next waiver renewal, the state should consider including additional performance measures that would address safeguarding the health and welfare of waiver participants through the provision of medical screenings and services.

State Response:

The state provided no additional information.

CMS Response:

The CMS has no further recommendations at this time.

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 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.)

The State Medicaid Agency, the Department for Medicaid Services (DMS) has administrative authority for this waiver. DMS performs administrative functions, such as promulgation of program regulations for services and payments, drafting of provider letters and updates, clarification of policy revisions to Hewlett Packard (HP) and providers, contract implementation with HP payment system and oversight of the contract agreement between HP and the QIO. The DMS performs second line monitoring of 10% of enrolled providers. The DMS also conducts oversight of the contract with the CMHCs that perform the waiver assessment/reassessments. Further, DMS continuously monitors compliance regarding revised policy changes and how these changes impact the daily operations of the program. Finally, the DMS utilizes the data collected regarding appeals to scrutinize current policy and educate state hearing officers.

DBHDID serves as the operating agency for the waiver through a contract with the DMS. The DMS oversees DBHDID performance of assigned waiver functions in accordance with waiver requirements. Specifically, the DMS reviews and approves waiver policy and clarifications, DBHDID submits correspondence and reports to DMS, DMS and DBHDID engage in regular quarterly meetings, and DMS conducts an annual review of the contract to ensure DBHDID meets all requirements.

The DMS contracts with HP as the fiscal agent. HP subcontracts with the QIO, CareWise to provide QIO services. The QIO determines the level of care and completes prior authorization of services for the waiver.

The state monitors the QIO's administration of the waiver program through random quality audits. All information concerning initial and recertification reviews are scanned and stored in

an on-base program, which can be accessed by DMS at any time. Problems are also addressed through provider and member complaints. Should an issue be found, it is addressed with the QIO.

The state provides a performance measure for this assurance that is not in the approved waiver: the number and percentage of initial service plans that received prior authorization from the QIO prior to service delivery. The data source was HP Enterprise Services. The state reports 100% compliance for this measure for WYs 2012, 2013 and 2014. The state also provides an approved performance measure for this assurance: the number and percentage of utilization management reports completed in a timely manner by the fiscal agent. While the state reports 100% compliance for this measure, the state did not specify the waiver year(s) to which such data applies.

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 evidence submitted by the state notes the following: “The Operating Agency was to be the Division of Developmental and Intellectual Disabilities (DDID) within the Department of Behavioral Health, Developmental and Intellectual Disabilities (DBHDID), and was supposed to determine level of care, prior authorize requests for services and approve the plans of care. Level of Care continues to be handled by the QIO, as contracted by HP. The DMS continues to be the operating authority for the Michelle P. waiver.” The evidence provided also indicates the QIO reviews and approves POCs and manages prior authorization of services. The state must update the next waiver renewal to accurately describe the QIO’s and DDID’s administrative and operational functions for this waiver, and how the single state agency monitors whether such entities’ administration of the waiver program is consistent with its approved waiver.

While the state provided data for the approved performance measure for this assurance, the state did not report the timeframe over which such data was measured. The state should develop performance measures that are measurable during the time period of the approved waiver, and update the waiver accordingly during the next renewal. Also, the state provided data for a performance measure not included in the approved waiver. The state must update the approved waiver to reflect its performance measures as implemented for the next waiver renewal.

State Response:

The state elects to address the non-complaint assurances during waiver renewal.

CMS Response:

The 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)

The DMS, through a contract with Electronic Data Systems, is able to provide ongoing training and technical assistance to waiver providers for billing procedures and oversee claims paid, suspended, and denied.

The DMS has the capability of running ad hoc reports of paid claims to compile monthly reports for monitoring overall program expenditures. DMS reviews and adds edits and audits to the Medicaid Management Information System periodically for program compliance and as policy is revised to ensure claims are not paid erroneously. DMS also modifies procedure codes in accordance with federal requirements.

The DMS monitors the fiscal accountability of waiver providers. Specifically, the 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 support service delivery that meets the service definition in the approved waiver. The audits also monitor service appropriateness based on waiver participant needs.

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

The state contracts with HP for the utilization of the QIO to perform billing reviews. A detailed list of claims (billing ad hoc) for authentication, through the use of the provider's billing process, is printed for use by the QIO for the billing review process. The QIO is able to match the actual documentation of the provider against the list of claims on the ad hoc and is able to verify if the claim is legitimate according to the documentation. The QIO performs billing reviews for 50% of the waiver providers on an annual basis.

The state provides data for a performance measure that is not in the approved waiver. Specifically, the state measures the number and percentage of claims reviewed that were coded and paid in accordance with reimbursement methodology. The state reports 100% compliance for WYs 2012, 2013, and 2014. The data source was HP Enterprise Services.

The state also provides data for approved performance measures. First, the state measures the number and percentage of waiver service claims that were submitted for waiver participants who were enrolled in the waiver on the service delivery date. The data source was HP Enterprise Services. Compliance with this performance measure was 100% for WYs 2012 through 2014. Next, the state measures the number and percentage of providers reviewed that resulted in an unsatisfactory audit and recoupment. The state did not provide a data source for this measure. For Calendar Years 2011, 2012, 2013, and 2014, the state reported 14%, 0%, 28% and 28%, respectively, of audits of HHA providers resulted in recoupment. 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. The state also measures the number and percentage of system defects identified in the waiver program and corrected on a quarterly basis. It is unclear if this measure refers to MMIS defects, systemic policy defects, or other issues. The state reports that in year 2012, one system defect was identified and corrected, and in years 2013 and 2014, no system defects were identified. The state did not indicate whether the years measured were waiver years, calendar years or fiscal years, and did not provide a data source for this measure.

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 data for approved performance measures for this assurance, the state did not specify the time period over which data was collected for one of the performance measures. The state also did not provide the source from which it derived data for two of its performance measures for this assurance. The state should develop performance measures that are measurable during the time period of the approved waiver, and update the waiver accordingly during the next renewal.

The state provided data for a performance measure not included in the approved waiver. The state must update the approved waiver to reflect its performance measures and data sources as implemented for the next waiver renewal.

The state should implement and report on a clear process to remediate individual and systemic errors that result in recoupments. In addition, the state should consider revising the last performance measure provided for clarity. Finally, the state should consider including the number and percentage of providers who maintain financial records according to program agreements or contracts as an additional performance measure.

State Response:

The state provided no additional information.

CMS Response:

The CMS has no further recommendations at this time.

C/U 2/1/15

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DEPARTMENT FOR MEDICAID SERVICES
OFFICE OF THE COMMISSIONER

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

July 29, 2014

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

1 on 1 w/
Leslie

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 0314.R03, that serves individuals who are developmentally and/or intellectually disabled who meet the intermediate care facility for individuals with intellectual disabilities' 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 three 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, June 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,

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 Supports for Community Living Waiver
Control # 0314.R03**

July 29, 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 has administrative authority over the Supports for Community Living Waiver. The Division of Developmental and Intellectual Disabilities (DDID) within the Department of Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) serves as the operating agency of the waiver through a contract with the DMS. The target population for this waiver includes individuals who are developmentally and/or intellectually disabled who meet the intermediate care facility for individuals with intellectual disabilities' level of care. The most recent 372 report, for the waiver year ending August 31, 2010 and reported on April 23, 2012, shows an enrollment of 3,442 unduplicated participants with the average annual cost of \$76,664 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 November 20, 2013, the state provided an introduction to its overall quality management strategy, various examples and summary reports specific to each assurance.

A Quality Improvement Organization (QIO) provides waiver status reports to DMS on a monthly basis, covering information including level of care determinations conducted, plans of care approved and denied, and services denied. Waiver providers are required to conduct participant satisfaction surveys, and the state utilizes these satisfaction surveys in the agency's Quality Improvement Plan. DDID staff track and investigate all complaints regarding allegations of abuse, neglect and exploitation. Additionally, the state's fiscal agent provides utilization management operational status reports that provide data to the DMS about the administration and operations functions of the waiver. In addition, the DDID conducts annual utilization reviews of each provider agency to ensure claims billed meet the waiver service definitions. Finally, Kentucky participates in the National Core Indicators (NCI), which are measures used to assess the satisfaction and outcomes of services. The indicators address choice, service planning, health, safety, rights, employment, and community inclusion. The state provides technical assistance and education efforts to waiver providers based on the areas of improvement identified in survey results from the NCI.

Summary of Findings

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

The evidence provided indicates the QIO reviews and issues LOC determinations. This is inconsistent with the waiver renewal and corresponding amendments approved during the period of 09/01/2010 - 1/22/2014, which provide that the Operating Agency, the Division of Developmental and Intellectual Disabilities (DDID), determines the level of care for this waiver. CMS notes an amendment to this waiver was approved 1/27/2014 with an effective date of 1/23/2014 that provides for the QIO to make LOC determinations for this waiver.

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.

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

The evidence provided indicates the QIO reviews and approves POCs and manages prior authorization of services. This is inconsistent with the waiver renewal and corresponding amendments approved during the period of 09/01/2010 - 1/22/2014, which provide that the Operating Agency, the Division of Developmental and Intellectual Disabilities (DDID), reviews and approves POCs and manages prior authorization of services. CMS notes an amendment to this waiver was approved 1/27/2014 with an effective date of 1/23/2014 that provides for the QIO to review and approve POCs and manage prior authorization of services.

While the state utilized performance measures in accordance with the approved waiver, where 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.

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.

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.

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 DDID such as the number and percentage of findings reports and notice of length of provider certifications that the DDID sends to the DMS within the DMS required timeframe.

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.

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: Supports for Community Living Waiver

Operating Agency: Division of Developmental and Intellectual Disabilities (DDID) within the Department of Behavioral Health, Developmental and Intellectual Disabilities (DBHDID)

State Waiver Contact: Director, Division of Community Alternatives

Target Population: Developmentally and/or Intellectually Disabled Individuals

Level of Care: ICF/IID

Number of Waiver Participants: 3,442

Average Annual per capita costs: \$76,664

Effective Dates of Waiver: September 1, 2010 through August 31, 2015

Approved Waiver Services: Case Management, Community Access, Day Training, Personal Assistance, Residential Support I, Respite, Shared Living, Supported Employment, Occupational Therapy, Physical Therapy, Speech Therapy, Community Guide, Goods and Services, Natural Supports Training, Transportation, Assessment/Reassessment, Community Transition, Consultative Clinical and Therapeutic Service, Environmental Accessibility Adaptation Service, Person Centered Coaching, Positive Behavior Supports, Residential Support Level II, Specialized Medical Equipment and Supplies, Technology Assisted Level I Residential Support and Vehicle Adaptation

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 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.)

The Quality Improvement Organization (QIO) for the Department for Medicaid Services instructs waiver providers regarding the submission of documents for the initial and ongoing Level of Care (LOC) determination. To obtain LOC determination, providers fax the completed Medicaid Assessment form (MAP-351) to the QIO. The MAP-351 assesses the following: an individual's needs in conducting Activities of Daily Living (ADLs); Instrumental Activities of Daily Living (IADLs); neurological, emotional, behavioral and functioning; clinical needs; environmental/living conditions; and informal supports. The QIO may request additional documentation from the provider prior to the issuance of a final approval or denial of waiver services. Once the LOC determination is finalized, the waiver providers are notified of the decision. When the LOC is granted, the QIO logs the effective dates in the Medicaid Management Information System (MMIS).

The QIO completes a waiver status report monthly, listing the number of active waiver beneficiaries and the number of LOC denials. The Division of Developmental and Intellectual Disabilities (DDID) monitors a sample of the records of waiver beneficiaries to ensure that each record includes a current LOC and MAP-351. DDID also conducts monitoring activities during the course of certification surveys, investigations and technical assistance visits.

The data source for all performance measures is HP Enterprise Services, the DMS fiscal agent. 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 two performance measures. First, the state measured the number and percentage of waiver applicants who had a level of care evaluation indicating the need for institutionalization. The compliance rate for this measure for CYs 2010, 2011, 2012 and 2013 (Jan. 1 – Oct. 31, 2013) was 99.8%, 99.3%, 99.3% and 99.4% respectively. The state did not provide remediation information regarding this measure. The next performance measure was the percentage of all new waiver enrollees who met the level of care. The compliance rate for this measure was 100% in Calendar Years (CYs) 2010, 2011, 2012 and 2013 (Jan. 1 – Oct. 31, 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: the number and percentage 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. The compliance rate for this measure for CYs 2010, 2011, 2012 and 2013 (Jan. 1 – Oct. 31, 2013) was 98%, 97%, 97% and 98% respectively. The state provided an example of remediation where written notification was sent to a participant that the provider had not submitted all information in a timely manner to complete the recertification process and that the provider must submit additional documentation to the QIO. However, the state did not provide data regarding whether remediation occurred in all instances of non-compliance or the outcome of such remediation.

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 two performance measures. First, the state measured the number and percentage of participants' initial or six month LOC determinations/forms/instruments that were completed as required by the state. The compliance rate for this measure was 100% in CYs 2010, 2011, 2012 and 2013 (Jan. 1 – Oct. 31, 2013). The next performance measure was the percentage of "level of care eligibility redetermination packets that were returned" (i.e. did not include all of the required documentation) out of the total number of level of care determinations. The non-compliance rate for this measure for CYs 2010, 2011, 2012 and 2013 (Jan. 1 – Oct. 31, 2013) was 3.1%, 4.3%, 3.6% and 3.4% respectively. The state addressed non-compliance as follows: when determination packets are submitted without all documentation required for LOC determination, the QIO issues a letter requesting more information.

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 evidence provided indicates the QIO reviews and issues LOC determinations. This is inconsistent with the waiver renewal and corresponding amendments approved during the period of 09/01/2010 - 1/22/2014, which provide that the Operating Agency, the Division of Developmental and Intellectual Disabilities (DDID), determines the level of care for this waiver. CMS notes an amendment to this waiver was approved 1/27/2014 with an effective date of 1/23/2014 that provides for the QIO to make LOC determinations for this waiver.

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 state noted the additional information provided in the evidence submission was not meant to supplant the approved performance measures. The state also responded by providing data, which it refers to as "remediation." First, the state measured the percentage of waiver applicants who had a level of care indicating the need for institutionalization; the state noted compliance ranged from 99.3% to 99.8% in each of the waiver years. Next, the state measured the percentage 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; the state noted compliance ranging from 97% to 98% of the participants in each of the waiver years. Finally, the state measured the percentage of level of care eligibility determination packets that were returned. Of the total number of level of care determinations, the state notes between 3.1% to 4.3% level of care eligibility determination packets were returned for each of the waiver years.

CMS Response:

While we thank the state for responding with additional information, the state's response regarding remediation provides the same information the state submitted in the evidence submission, in which the state did not demonstrate remediation activities. The state must submit information regarding remediation activities in the next waiver renewal.

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 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.)

Upon admission of an applicant to the waiver program and at least annually thereafter, case management providers submit a service packet to the QIO for review, approval and prior authorization of services. The service packet includes the MAP 351 and the MAP 109, which the state uses to develop the service plan; the state refers to the service plan as the Plan of Care (POC). Effective January 1, 2014, the state also uses the Supports Intensity Scale (SIS) assessment to link specific questions from the assessment to participant goals in the POC.

The POC identifies factors in the planning process including health and safety risk factors, the type and amount of each waiver service chosen by the individual to meet their individual support needs, the provider chosen for each service, the provision of any non-waiver services, personal outcomes and the specific service and training objectives to be implemented. Based on the

QIO's review of the POC, the QIO may request additional documentation to ensure the appropriateness of the plan. Additional requested information may include but is not limited to service assessments, past service provision notes, therapy evaluation, crisis prevention plans and behavior support plans.

During the initial team planning meeting and at least annually thereafter in team planning meetings, the POC team discusses each of the items on the Long Term Care Facilities and Home and Community Based Program Certification Form (MAP 350), including the participant's choice of waiver services or institutional care and choice of providers. Case management providers must maintain detailed documentation of the decision making process during the planning meeting and provide a complete listing of providers to allow participant choice of any certified provider. Case management providers document the provision of education to the individual regarding the negative impact a refusal of service may have for the participant. The state monitors this documentation during onsite monitoring visits, provider certification surveys, and during follow-up for complaints, incident reports and investigations.

The case manager facilitates the service planning process, education, referrals and coordinates community resources to meet the needs of waiver participants. Specifically, the case manager ensures the following: the provision of waivers services in accordance with waiver service definitions and the approved POC, the involvement of participants, legal representatives and others in the planning process, the POC is updated at least annually and the POC is updated as participant needs change. Also, case managers utilize the Kentucky Focus Tool on a monthly basis to monitor individuals' satisfaction with their services and supports.

For modification to POCs, case management providers submit modifications to the QIO for review and authorization within 14 days of any change in support needs or choice of the individual.

DDID provides training and technical assistance to waiver providers regarding the person-centered planning process, completing, and modifying the POCs. The DDID provides onsite technical assistance at provider locations on at least a quarterly basis. Required training for waiver providers includes the components of values, community inclusion, person-centered planning, positive behavior support, self-determination and strategies to successful teaching. The DDID maintains a listing of the required training lessons on its website.

DDID conducts interviews with waiver participants during each certification survey and during technical assistance visits. Also, the state collects data from the DDID Quality Administrators, staff persons who monitor and review performance of case management providers, regarding the percentage of service plans in which risk management and risk mitigation issues are found.

The state participates in the National Core Indicators (NCI) measures to assess the satisfaction and outcome of services. The indicators address choice, service planning, health, safety rights, employment and community inclusion. DDID provides technical assistance and education efforts based upon the areas of improvement identified in survey results from the NCIs.

For the sub-assurance that ensures that service plans address all the participant's assessed needs and personal goals, the state collects data on several performance measures. First, the state measures percentage and number of a sampled service plans in which services and supports align with assessed needs. Compliance with this performance measure was 98%, 97%, 98% and 99% for CYs 2010, 2011, 2012 and 2013 (Jan. 1 – Oct. 31, 2013), respectively. The data source was HP Enterprise Services. The state did not provide information about remediation activities for non-compliance or system improvement. Next, the state measured the percentage and number of sampled service plans that reflect individual goals and preferences. Compliance with this performance measure was 100% for CYs 2010, 2011, 2012 and 2013 (Jan. 1 – Oct. 31, 2013). The data source was HP Enterprise Services. The state did not provide information about remediation activities. Also, the state measured the percentage of sampled service plans that include a risk assessment. Compliance with this performance measure was 100% for Waiver Years (WYs) 2010 through 2013. The data source was onsite record reviews. In addition, the state measured the percentage of sampled service plans with risk assessments that have appropriate risk mitigation. Compliance with this performance measure was 75% for WYs 2010 through 2013. The data source was onsite record reviews. The state demonstrated remediation of case management providers without appropriate risk mitigation in the POCs by providing non-compliant providers technical assistance and requiring corrective actions plans. The state demonstrated system improvement when it revised the monitoring form used by DDID Quality staff for record reviews to capture additional data regarding POC non-compliance issues.

The state surveyed waiver participants to identify the percentage of participants who were satisfied that their case manager gets them the services and supports they need. Compliance with this performance measure was 88.2% for Fiscal Years (FYs) 2011 through 2012. The data source was the National Core Indicators. In addition, the state surveyed families of waiver participants to identify the percentage of families who were satisfied that their case manager gets the participant the services and supports they need. Compliance with this performance measure was 88.9% for FYs 2011 through 2012. The data source is the National Core Indicators. The state identified remediation and system improvement addressing the above-referenced performance measures. Specifically, the state communicated the results of the survey during a provider webinar. The state also discussed person centered planning in case management training and addressed this item in a tool used by case management providers.

For the sub-assurance that ensures the state monitors service plan development in accordance with its policies and procedures, the state uses several performance measures. First, the state measures the percentage of service plans that are in compliance with the waiver's service plan requirements (i.e. completeness of the service plan and submission of the service plan within the required timeframe). The data source was onsite record review of providers undergoing certification review. The compliance rate was 95% for WYs 2010 through 2013. In each instance of non-compliance, the state provided technical assistance to the providers. As a system improvement, the state provided a "certification record review" worksheet that is used for monitoring the completeness of the POCs. Also, the state measured the percentage of service plans that are based on "what is important to and important for" the person. Compliance with this performance measure was 100% for CYs 2010, 2011, 2012 and 2013 (Jan. 1 – Oct. 31, 2013). The data source was HP Enterprise Services.

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 uses one performance measure: the number and percentage of service plans indicating appropriate change in service relating to documented change in participants needs within the year. The compliance rate was 100% for each of the CYs 2010 through 2013 (Jan. 1 – Oct. 31, 2013). The data source was HP Enterprise Services.

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 approved waiver has one performance measure: the number and percentage of records reviewed that demonstrate the correct type, amount, scope and frequency of services were provided according to the person-centered plan. Compliance for this measure was 98%, 97%, 98% and 99% for each of the CYs 2010, 2011, 2012, and 2013 (Jan. 1 – Oct. 31, 2013), respectively. The state did not provide information about remediation or system improvement for this performance measure.

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 parents/guardians who have signed the service plan signature page indicating they were given choice of providers. The data reflected 100% compliance for CYs 2010 through 2013 (Jan. 1 – Oct. 31, 2013). The state did not provide a performance measure demonstrating participants are offered a choice between waiver services and institutional care.

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 evidence provided indicates the QIO reviews and approves POCs and manages prior authorization of services. This is inconsistent with the waiver renewal and corresponding amendments approved during the period of 09/01/2010 - 1/22/2014, which provide that the Operating Agency, the Division of Developmental and Intellectual Disabilities (DDID), reviews and approves POCs and manages prior authorization of services. CMS notes an amendment to this waiver was approved 1/27/2014 with an effective date of 1/23/2014 that provides for the QIO to review and approve POCs and manage prior authorization of services.

While the state utilized performance measures in accordance with the approved waiver, where 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 described the remediation process and provided data for the service plan subassurance that ensures service plans address all the participant's assessed needs and personal goals. Specifically, the state contracts with Hewlett Packard (HP), which in turn contracts with the utilization management firm, CareWise. CareWise performs the Level of Care determinations 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 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 Plan of Care does not incorporate the services needed, a Lack of Information (LOI) letter is sent to the provider so the Plan of Care 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.

The state requests to work with HP, CareWise and the KY Department for Behavioral Health, Developmental and Intellectual Disabilities (BHDID) to develop new performance measures. The MAP 350 form, which was included in the evidence submitted, includes both choice between waiver services and institutional care and choice of provider. While both are included on the form and are expected for each participant, the state notes the approved performance measure only refers to choice of providers. The state recommends adding a new performance measure to the waiver: percentage of participants/guardians who have signed the service plan signature page indicating they were given choice between waiver services and institutional care.

Finally, the state responded by providing data, which it refers to as "remediation." First, the state measured the percentage of service plans in which services and supports align with assessed needs; the state noted compliance ranged from 97% to 99% in each of the waiver years. Next, the state measured the percentage of service plans that reflect individual goals and preferences; the state noted compliance was 100% for each of the waiver years. Finally, the state measured the percentage of records reviewed that demonstrate that the correct type, amount, scope and frequency of services were provided according to the person-centered plan; the state did not provide a compliance rate for each of the waiver years; however, this measure is identical to the performance measure submitted in the state's evidence, in which the state provided compliance rates ranging from 97% and 99% for each of the waiver years.

CMS Response:

We thank the state for responding with additional information regarding remediation activities. We note the state's above-response regarding remediation provides the same information the state submitted in the evidence submission, in which the state did not demonstrate remediation activities for two of the subassurances. However, we note the state's response does provide remediation data for the subassurance that ensures service plans address all the participant's assessed needs and personal goals. In the next waiver renewal, the state should ensure it provides information about remediation activities for this assurance.

We thank the state for providing an additional performance measure to address the subassurance that ensures participants are offered a choice between waiver services and institutional care and between/among providers.

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.)

The state uses a certification process to enroll SCL Waiver providers. Each potential provider is assigned to a Provider Development Specialist, a DDID staff member who offers technical assistance to the provider during the certification process. The Provider Development Specialist requests and reviews provider documentation, including the credentials of and background checks of the Executive Director, and policies and procedures. The Provider Development Specialist tracks this documentation in a checklist, which the Provider Development Specialist reviews for compliance with regulatory requirements. The Provider Development Specialist invites potential providers to attend a provider training and schedules the on-site pre-service survey. Once the Provider Development Specialist successfully completes the on-site survey, DDID recommends to DMS that the provider be approved for certification in the SCL waiver for an initial period of up to six months. DMS then issues the Medicaid SCL provider number.

Within 45 days of providing services to the first individual, the Provider Development Specialist and the DDID Quality Administrator (QA) assigned to the provider conduct a 45-day survey. When a provider successfully completes the on-site survey, the provider may be certified for an additional period of up to six months. If deficiencies are found during the review, a corrective action plan (CAP) is required.

DDID monitors waiver providers on a regular basis to ensure continued compliance with state and federal requirements. The QAs conduct re-certification surveys of providers, ensuring that provider certifications are met. Certification survey results are documented on a Findings and Corrective Action Plan Tracking Report. The DDID Waiver Manager and QAs that participated in the certification surveys discusses all survey findings. The length of provider recertification is determined through this analysis process that considers deficiencies, historical deficiencies from previous surveys and investigations, health, safety and welfare issues found and analysis of incident management reports. DDID sends the findings report and notice of length of certification survey to the SCL waiver provider and to the DMS. Citations are issued for items found to be out of compliance. Corrective action plans are required from the provider within a

maximum 45 day timeframe. If the SCL provider fails to make satisfactory correction in the CAP, a recommendation is made to DMS to not renew the provider's certification.

The SCL waiver offers Supports for Participant Direction, which allows waiver participants the opportunity to direct some or all of their non-residential, non-medical waiver services. The Department for Aging and Independent Living monitors certification of the Participant Direction Services providers, the only non-licensed waiver providers in this waiver, and monitors quality assurance for these providers.

Regarding provider training requirements, potential SCL Waiver providers must complete competency-based training. Additionally, provider training webinars are held on a quarterly basis addressing topics such as issues identified from analysis of certification surveys, investigations, and suggestions from providers regarding quality improvement.

The only providers that are licensed are Adult Day Health Centers, which the Office of Inspector General (OIG) licenses and monitors. The DDID also certifies and monitors these providers through the SCL waiver's provider certification process.

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 approved waiver utilizes three performance measures. First, the state measures the number and percentage of newly certified waiver providers that meet regulatory requirements within the initial 6 months of service provision. The compliance rate was 84.5% for WYs 2010 through 2013. In each instance of non-compliance, the state required implementation and acceptance of a CAP and QAs provided technical assistance to the providers. Next, the state measured the number and percentage of enrolled waiver providers that meet regulatory requirements at time of certification review. The compliance rate was 53% for WYs 2010 through 2013. In each instance of non-compliance, the state required technical assistance by QAs, implementation by the provider agency of a CAP, and either acceptance or revision of the CAP, or the provider agency was closed. The state measured the outcomes of this remediation, sampling waiver providers with documented plans of correction. The result was that 32 instances of non-compliant providers were addressed in accordance with the state's standards. The data source for the above-referenced performance measures was the DDID Certification database.

For the sub-assurance that ensures non-licensed/non-certified providers adhere to waiver requirements, the state includes a performance measure to address the providers of participant-directed services. Specifically, the state measures the percentage of participant-directed employees who completed the required training. The data source was participant-directed employee records. The state reported 100% compliance for this measure for WYs 2010 through 2013.

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 two performance measures. The data source was onsite record review. First, the state measures the number and percentage of reviewed providers in which staff have

successfully completed mandatory annual training (i.e. 6 hours of professional development or continuing education units). The compliance rate was 91% for WYs 2010 through 2013. The state also measures the number and percentage of reviewed agencies that provide case management services in which case managers have successfully completed all required case management training. The compliance rate was 93% for WYs 2010 through 2013. In each instance of non-compliance for the above-referenced performance measures, the state required implementation of a CAP by each provider and the provision of technical assistance by QAs to providers.

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.)

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 recommended adding a new performance measure: the percentage of OIG licensed waiver providers that meet OIG licensing requirements at review. The state notes a work group will be formed to develop the performance measures for this assurance for the next waiver renewal. The state also notes it is focusing on technical assistance where quality administrators help providers to understand 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. Additionally, the state identified three trends for systemic quality improvement, and the state developed an action plan for each of them. The three trends are as follows: all participants are healthy and safe, medications are administered without error, and day training is person-centered and non-diversional. In the state's response, the state aligned each of these trends with an action plan and a timeframe for implementation of quality improvement activities.

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 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 Community Based Services (DCBS) is the state agency responsible for investigating and substantiating allegations of abuse, neglect, and exploitation of children and vulnerable adults. The DDID also reports and conducts collaborative investigations when incidents of abuse, neglect or exploitation occur when participants are enrolled in the SCL waiver. DDID staff conducts crisis prevention and intervention training for all SCL providers at least quarterly.

In order to ensure the health and welfare of participants, all waiver providers are mandated reporters of abuse, neglect, and exploitation. Providers are required to develop an incident report form and a process for the investigation and communication of critical incidents within a specific timeframe, as well train all staff in the prevention, identification, and reporting of critical incidents. Further, providers are required to have a complaint process in place and to educate waiver participants, family members, and legal representatives about how to utilize their grievance process, which includes external review of complaints. Providers are also required to perform background checks on all new employees and volunteers. They also must annually, randomly select at least 25% of employees to perform updated background checks and at least 5% of employees to perform drug testing.

DDID staff reports data received from provider incident notifications to a risk management database. DDID staff identifies area of concern, repeat occurrences and inappropriate follow-up, by provider type or classification of incident, or by each individual involved. The data is then used to address these issues with providers. Complaints, assigned investigations and follow-ups are tracked and submitted electronically. Each incident category is evaluated across all providers, on an individual provider basis and by individuals to determine patterns that need further evaluation.

A critical incident is defined as an alleged, suspected, or actual occurrence of an incident that can reasonably be expected to result in harm to the participant and may include, but is not limited to suspected abuse, neglect, and exploitation, serious medication errors which are defined as any medication error that requires or has the potential to require medical intervention or treatment, death, homicidal or suicidal ideation, or a missing person. The DDID tracks and investigates critical incidents. This includes any complaints received from waiver participants, legal representatives, providers and the general public.

Statewide, fourteen Community Mental Health Centers (CMHCs) provide community-based crisis prevention and intervention services for adults, 18 years or older, with intellectual/developmental disabilities. This system brings enhanced supports to individuals, agencies, and families in the community to help them work through challenging, emotional events. SCL providers are required to exhaust all resources and tools prior to accessing this CMHC Crisis Response System. Contacting the CMHC with a crisis call is also a critical incident that is tracked in the DDID risk management database to allow for follow-up by DDID staff.

Providers are required to report medication errors on a monthly medication error report that is submitted to DDID in order to track trends and identify issues for follow-up. Medication errors that require a medical intervention, or are suspected abuse, neglect or exploitation follow the critical incident notification and documentation processes.

Pursuant to state regulations effective February 1, 2013, providers are to foster a restraint-free environment where the use of mechanical restraints, seclusion, manual restraints, including any manner of prone or supine restraint or chemical restraints, is prohibited. Providers must report all physical and chemical restraints as a critical incident.

Providers notify the DDID through a critical incident notification that a death has occurred. A detailed review and analysis of the issues preceding the death of an individual receiving SCL supports is conducted to determine how the system responded to the individual's specific needs, and an investigation may also occur.

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. The data source was the DDID incident management database. First, the state measured the number and percentage of critical incident reports of potential abuses that were submitted to DDID within the required time frames. Compliance with this measure was 81% for WYs 2010 through 2013. The state addressed non-compliance by providing technical assistance to non-compliant providers. Next, the state measured the number and percentage of participants who had at least one report of suspected abuse, neglect, or exploitation during the year for the WYs 2010-2013. Out of all SCL waiver participants, 45.6% had at least one such report. In each case, technical assistance was provided, DCBS and DDID reviewed the case, and the abuse, neglect and exploitation was addressed. The state also measured the number and percentage of participants who had injury reported due to restraint for the WYs 2010-2013. Out of the total restraints (1645) reported, there were 5 injuries. The state notes that where restraints were used, DDID conducted a risk management review, provided technical assistance and DDID field staff monitored the provider with a restraint reduction plan. The state notes that revisions to state regulations effective February 1, 2013, prohibiting the use of restraints, led to a reduction in the use of restraints. However, the state did not provide performance measure data measuring the use of restraints since implementation of the latter regulatory revisions.

The state utilizes surveys of waiver participants using the National Core Indicator (NCI) survey for the period of FY 2011-2012, for several performance measures. First, the state examined the number and percentage of surveyed participants who responded on the NCI survey that they are

always/sometimes afraid or scared in their home or their neighborhoods. The state reported 93% of participants are not afraid or scared at home or in their neighborhood. The results of this survey were shared with the appropriate agency staff, communicated during a provider webinar, and case managers use a focus tool to assess health, safety and welfare every month. Next, the survey asked participants whether they had a physical examination in the last year. Of the sampled participants, 96.3% of them had a physical examination within the last year. As a result of this survey, technical assistance was provided to providers that an annual physical exam of participants is expected. Also, the survey asked female participants whether they had an OB/GYN examination in the past year. Of the sampled participants, 86.4% had an OB/GYN examination in the past year. As a result of the survey, technical assistance was provided to providers that such an annual exam of female participants is expected. Further, the survey asked male participants whether they had a prostate examination in the past year. Of the sampled participants, 53.8% had a prostate examination in the past year. As a result of the survey, technical assistance was provided to providers that such an annual exam of male participants is expected. Additionally, the survey asked participants whether they had a routine dental examination in the past year. Of the sampled participants, 80.4% had a routine dental examination in the past year. As a result of the survey, technical assistance was provided to providers that routine dental examinations of participants are expected. Finally, the survey examined the number and percentage of audited providers in which direct support staff had criminal background checks prior to providing services. Of the audited providers, 91% had completed the requisite criminal background checks prior to providing waiver services. As a result of the survey, technical assistance was provided to non-compliant providers by the QAs and implementation of a corrective action plan was required of each non-compliant provider.

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 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 regulations 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 recommended adding a new performance measure: the percentage of participants with no restraint out of the total number of participants. The state also notes reported restraints are measured through the incident reporting process. Further, systematic evaluation occurs with respect to all reported incidents, including examination of the effectiveness of the state's efforts. The state notes that a risk management meeting is held every other month to review incidents, trends, actions taken to address them, and to determine whether wider training is needed.

The state provided data regarding use of restraints. Specifically, for the period of April 2012-March 2014, 16 providers (of the 236 current providers) reported one or more use of chemical restraint. One provider in particular reported the most use of restraints. The state noted that the BHDID nurse assigned to this provider has worked with them to update their protocols and

reduce/eliminate the use of restraint. The state also provided charts demonstrating a reduction in use of restraints in the time period immediately following the state's policy change in the year 2013. During that same timeframe, 28 providers have reported use of a physical restraint. Two providers in particular have had the most instances. The state notes the BHDID regional nurses assigned to those providers are working with them to reduce/eliminate the instances. Finally, the state notes that all instances of restraint are addressed by the regional nurses, and the quality administrators are also engaged in technical assistance.

CMS Response:

The CMS thanks the state for the additional information provided. As stated previously, 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 the SCL Waiver. The Division of Developmental and Intellectual Disabilities (DDID) within the Department of Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) serves as the operating agency of the waiver through a contract with the DMS. DMS exercises administrative discretion in the operation of the waiver and issues policies, rules and regulations related to the waiver. A contract exists between the DMS and DDID requiring that DDID notify DMS of the results of findings reports from provider certification surveys within 30 days of completion of the certification, along with recommendations for recertification or decertification with length of provider certifications.

DMS contracts with Hewlett Packard (HP) as the fiscal agent.

The Quality Improvement Organization (QIO), Carewise Health, contracts with the DMS to review and issue Level of Care (LOC) determinations and prior authorization of waiver services.

The state provides one performance measure for this assurance: 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 CYs 2010 through 2013 (Jan. 1 – Oct. 31, 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.)

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 DDID such as the number and percentage of findings reports and notice of length of provider certifications that the DDID sends to the DMS within the DMS required timeframe.

State's Response:

The state noted at the time of the next renewal, the following performance measures will be added to the waiver: the percentage of required reports the QIO provides to DMS within the required timeframes out of the total reports required of the QIO, and the percentage of required reports the DDID provides to DMS within the required timeframes out of the total reports required of DDID.

The state notes that it has rewritten the contract between the state and BHDID to include a number of reports regarding provider certifications, a waiting list report, schedule of reviews, quality improvement data, case manager trainings, and a new provider report. The state also notes the DMS is considering adding performance measures measuring the number of providers that received recoupment out of the number of providers reviewed.

CMS Response:

The CMS thanks the state for the additional information provided. As stated previously, 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.

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 contracts with Hewlett-Packard for the MMIS, and this contract also includes ongoing training and technical assistance to waiver providers regarding billing procedures.

DDID conducts at least annual utilization reviews of each provider agency to ensure claims billed meet the waiver service definition and were provided in accordance with the waiver participant's POC. Additional ad hoc utilization reviews are conducted based on issues identified during provider certification reviews, investigations, and referrals from the Office of Inspector General. Through utilization reviews, claims that have erroneously been paid by DMS are identified for recoupment to DMS. The providers are notified by DMS of the recoupment.

The state has three performance measures for this assurance. The first performance measure captures the number and percentage of providers audited that resulted in an unsatisfactory audit resulting in recoupment. The data source was DDID billing review records. The state reported recoupment for 61.4% of audited providers for WYs 2010 through 2013. While the QAs provided technical assistance in each instance of non-compliance, 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.

The second performance measure is the number and percentage of waiver service claims that were submitted for participants who were enrolled in the waiver on the service delivery date. The data source was HP Enterprise Services. The state reported 100% compliance for CYs 2010 through 2013 (Jan. 1 – Oct. 31, 2013).

The third performance measure in the approved waiver is the number and percentage of system defects identified in the SCL waiver program and corrected on a quarterly basis. The data source was HP Enterprise Services. It is unclear if this measure refers to MMIS defects, systemic policy defects, or other issues. The compliance rate for the reported measure was 100% for CYs 2010 through 2013 (Jan. 1 – Oct. 31, 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.)

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 recommended adding the following performance measure: the percentage of providers who maintain financial records according to the program policy, out of all providers. The state also noted it is considering revising the performance measure measuring the number and percentage of system defects identified in the Supports for Community Living waiver program and corrected on a quarterly basis. The revised performance measure would read as follows: the percentage of system defects identified and corrected in the waiver, out of all system defects identified and submitted for correction.

The state noted that it currently contracts with HP for paying provider claims and with BHDID to complete the billing reviews. BHDID performs billing reviews on 100% of the waiver's 236 providers. An adhoc review 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 ensure 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 provided in 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. 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 state noted that the providers are only obligated to maintain documentation for 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 notes it is currently reviewing 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 notes it is seeking that the performance measures be refitted to the actual program at the time the waiver is renewed.

CMS Response:

The CMS thanks the state for the additional information provided. As stated previously, 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.

Disabled & Elderly Health Programs Group

JUL 30 2015

Lisa D. Lee, Commissioner
Cabinet for Health and Family Services
Department for Medicaid Services
275 East Main Street, 6W-A
Frankfort, KY 40621



Dear Ms. Lee,

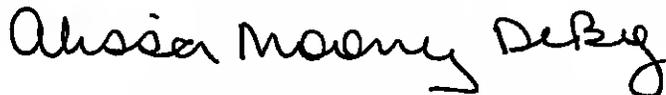
The Centers for Medicare & Medicaid Services (CMS) received your request, dated July 23, 2015 for a temporary extension of Kentucky's Medicaid Managed Care 1915(b) waiver program under CMS control number KY-07. The current temporary waiver authority expires on July 31, 2015.

You have requested this extension to ensure the Kentucky Department for Medicaid Services has adequate time to complete the cost-effectiveness analysis in the waiver.

The CMS is granting a ninety (90) day extension of the KY-07 waiver to operate the managed care program under section 1915(b) of the Social Security Act (the Act). This temporary extension will expire on October 31, 2015. The state must submit a complete managed care renewal waiver application, including the cost effectiveness spreadsheets, the Section D description of the cost effectiveness test, data from the state's monitoring activities, and incorporate the recommendations for improvement from the Independent Assessment into the waiver application by August 10, 2015.

The CMS will continue to work with your staff during the extension period. If you have any questions, please contact Cheryl Brimage, in the Atlanta Regional Office, at (404) 562-7116 or Lovie Davis, of my staff, at (410) 786-1533.

Sincerely,



Alissa Mooney Deboy
Acting Director

cc: Cheryl Brimage, Atlanta Regional Office
Shantrina Roberts, Atlanta Regional Office
Jackie Glaze, Atlanta Regional 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

August 5, 2015

Lisa D. Lee, Commissioner
Cabinet for Health and Family Services
Department for Medicaid Services
275 East Main Street, 6W-A
Frankfort, KY 40621



Dear Ms. Lee,

In accordance with 42 CFR 438.6 the Centers for Medicare & Medicaid Services (CMS) has reviewed and is approving Kentucky's submission of Managed Care Organization (MCO) rates, contracts and amendments. The contracts and several amendments were received by the CMS Regional Office in October 2014. Additional amendments were received on June 25, 2015. The revised rates were received on June 15, 2015. The rates are for the period January 1, 2014 - June 30, 2015.

Specifically, the following contracts and amendments are approved:

- Coventry base contract and amendments 1,2,3
- Humana base contract and amendment 1
- University Health Care, Inc. dba Passport base contract and amendments 1,2
- Wellcare base contract and amendments 1,2,3
- Anthem base contract and amendments 1,2

Kentucky's contracts expired on June 30, 2015. The contracts, amendments and rates are approved for the purpose of federal financial participation effective August 4, 2015. If you have any questions concerning this letter, feel free to contact Cheryl L. Brimage, of my staff, at (404) 562-7116 or email her at cheryl.brimage@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

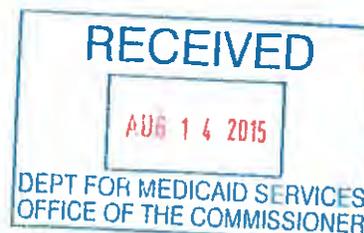
DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303



DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

August 10, 2015

Ms. Lisa Lee, Commissioner
Commonwealth of Kentucky
Cabinet for Health and Family Services
Department of Medicaid Services
275 East Main Street, 6 W-A
Frankfort, KY 40621



Re: Disproportionate Share Hospital Audits and Reports Acknowledgement

Dear Ms. Lee:

The purpose of this letter is to acknowledge receipt of your December 19, 2014 submission of Kentucky's state plan rate year (SPRY) 2011 Disproportionate Share Hospital (DSH) audit and report. After an initial screening to assure basic submission standards, it appears that the minimum elements required by the DSH rule have been included in your submission. This acknowledgement, however, does not constitute notice of a completed review or approval of the content of the state's submission. CMS received the following in your submission package:

- SPRY 2011 Kentucky Department for Medicaid Services Independent Audit of DSH Verifications
- SPRY 2011 Myers and Stauffer, LC Statement of Independence

As you know, CMS promulgated CMS-2198-F on December 19, 2008, with an effective date of January 19, 2009. The final rule implements Section 1001 of the Medicare Drug, Improvement and Modernization Act of 2003, requiring state reports and audits to ensure the appropriate use of Medicaid DSH payments and compliance with the statutorily imposed hospital-specific limits. Statute requires that states submit an annual report and an independent certified audit in order to receive federal financial participation (FFP).

To facilitate the audit and reporting process, CMS issued to states the following guidance relating to the final rule (these materials are available on the CMS website at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Financing-and-Reimbursement.html>):

- General DSH Audit and Reporting Protocol
- DSH Report Format
- Operational Guidance Letter dated July 27, 2009
- Additional Information on the DSH Reporting and Audit Requirements
- Additional Information on the DSH Reporting and Audit Requirements – Part 2

Ms. Lisa Lee

Page 2

CMS has initiated a preliminary review of the state's current submission. This review will be conducted based only on the submitted materials listed above. CMS recognizes that the state may have included in its initial submission only materials that it determined relevant, and encourages the state to submit any additional material or supporting documentation that was not originally included with the initial submission.

Please note that beginning for SPRY 2011, to the extent that audit findings demonstrate the DSH payments exceed the documented hospital-specific limits, these payments will be treated as overpayments to providers that, pursuant to 42 CFR Part 433, Subpart F, trigger the return of the federal share to the federal government. However, if the excess DSH payments are redistributed by the state to other qualifying hospitals as an integral part of the audit process, and in accordance with a federally approved Medicaid state plan provision, the federal share is not required to be returned.

The federal portion of overpayments not subject to redistribution must be returned in accordance with 42 CFR Part 433 Subpart F. The correct accounting for any redistributed DSH payments requires two separate entries on the CMS-64 Quarterly Expenditure Report, an increasing adjustment on line 7 for DSH payments actually redistributed and a decreasing adjustment on line 10 to report the federal portion of any identified overpayments redistributed in accordance with the approved state plan. Both the increasing and decreasing prior period adjustments should specify the year in which the original DSH payments were distributed, which would be fiscal year 2011 in the case of the audits for SPRY 2011. Finally, the state must specify if the redistribution was reflected on the SPRY data elements spreadsheet submitted as part of the annual audit report submission. If the data element report submitted with the audit report did not reflect the redistribution, states should resubmit the data elements spreadsheet to CMS to reflect final DSH payment amounts made to hospitals after redistribution. The revised data elements spreadsheet should be submitted concurrent with the submission of the CMS-64 Report that reflects the redistribution.

We will facilitate further dialogue with your agency and look forward to continued efforts and commitment on behalf of both our agencies in ensuring that the DSH audits and reports comport with section 1923(j) of the Social Security Act, implementing regulations at 42 CFR 447.299 and 42 CFR 447 Subpart D, and related guidance.

CMS remains committed to engaging in open dialogue with the state to discuss this preliminary review and provide technical guidance, as necessary, in an effort to ensure that any adverse financial impact on the Kentucky Medicaid program and its hospitals is averted. Thank you in advance for your willingness to continue working with us. Should the state have any questions regarding the DSH rule requirements or the review process itself, please feel free to contact Stanley Fields at (502) 223-5332.

Sincerely,



Jackie Glaze

Associate Regional Administrator

Division of Medicaid and 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

August 10, 2015

KY-15-016

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 Statement of Work (SOW) with HealthTech Solutions, LLC., to provide consultant services for the SERCH collaborative. The SOW 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. No additional (new) funding is approved for this project in this action.

On site reviews may be conducted to assure the intentions in which federal financial participation was approved, are being accomplished. Specifically, the objective is to validate that automatic data processing equipment or services are being efficiently and effectively utilized to support the approved programs or projects as provided under 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. 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, please contact L. David Hinson at (334) 791-7826 or via email at Lawrence.hinson@cms.hhs.gov.

Sincerely,

Jackie Glaze

Associate Regional Administrator

Division of Medicaid & Children's Health Operations

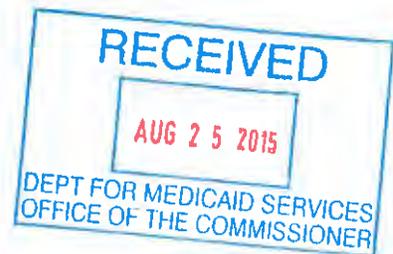
DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303



DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

August 11, 2015

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



Re: Kentucky State Plan Amendment 14-005

Dear Ms. Lee:

We have reviewed the proposed Kentucky state plan amendment, KY 14-005, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on May 14, 2014. This amendment clarifies that foster children, and women receiving treatment through the breast and cervical cancer program, are exempt from certain cost sharing requirements in the state plan.

Based on the information provided, the Medicaid State Plan Amendment KY 14-005 was approved on August 10, 2015. The effective date of this amendment is July 1, 2014. We are enclosing a copy of the new state plan pages. Please incorporate the following approved plan pages within a separate section at the end of Kentucky's approved state plan:

- G1, Pages 1 thru 3
- G2a, Pages 1 thru 3
- G2b, Page 1
- G2c, Page 1
- G3, Pages 1 thru 5

If you have any additional questions or need further assistance, please contact Melanie Benning at (404) 562-7414 or Melanie.Benning@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

Enclosures

State/Territory name: Kentucky

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

KY 14-0005

Proposed Effective Date

07/01/2014 (mm/dd/yyyy)

Federal Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2014	\$ 0.00
Second Year	2015	\$ 0.00

Subject of Amendment

The purpose of this SPA is to clarify who is exempt from cost sharing.

Governor's Office Review

- Governor's office reported no comment
- Comments of Governor's office received

Describe:

- No reply received within 45 days of submittal
- Other, as specified

Describe:

Governor's office has appointed DMS authority

Signature of State Agency Official

Submitted By: Sharley Hughes

Last Revision Date: Jul 14, 2014

Submit Date: Jun 12, 2014



Medicaid Premiums and Cost Sharing

State Name: Kentucky

OMB Control Number 0938-1148

Transmittal Number: KY - 14 - 0005

Expiration date: 10/31/2014

Cost Sharing Requirements G1

1916
1916A
42 CFR 447.50 through 447.57 (excluding 447.55)

The state charges cost sharing (deductibles, co-insurance or co-payments) to individuals covered under Medicaid Yes

- The state assures that it administers cost sharing in accordance with sections 1916 and 1916A of the Social Security Act and 42 CFR 447.50 through 447.57.

General Provisions

- The cost sharing amounts established by the state for services are always less than the amount the agency pays for the service.
- No provider may deny services to an eligible individual on account of the individual's inability to pay cost sharing, except as elected by the state in accordance with 42 CFR 447.52(e)(1).
- The process used by the state to inform providers whether cost sharing for a specific item or service may be imposed on a beneficiary and whether the provider may require the beneficiary to pay the cost sharing charge, as a condition for receiving the item or service, is (check all that apply):
 - The state includes an indicator in the Medicaid Management Information System (MMIS)
 - The state includes an indicator in the Eligibility and Enrollment System
 - The state includes an indicator in the Eligibility Verification System
 - The state includes an indicator on the Medicaid card, which the beneficiary presents to the provider
 - Other process
- Contracts with managed care organizations (MCOs) provide that any cost-sharing charges the MCO imposes on Medicaid enrollees are in accordance with the cost sharing specified in the state plan and the requirements set forth in 42 CFR 447.50 through 447.57.

Cost Sharing for Non-Emergency Services Provided in a Hospital Emergency Department

The state imposes cost sharing for non-emergency services provided in a hospital emergency department. Yes

- The state ensures that before providing non-emergency services and imposing cost sharing for such services, that the hospitals providing care:
 - Conduct an appropriate medical screening under 42 CFR 489.24, subpart G to determine that the individual does not need emergency services;
 - Inform the individual of the amount of his or her cost sharing obligation for non-emergency services provided in the emergency department;
 - Provide the individual with the name and location of an available and accessible alternative non-emergency services provider;



Medicaid Premiums and Cost Sharing

- Determine that the alternative provider can provide services to the individual in a timely manner with the imposition of a lesser cost sharing amount or no cost sharing if the individual is otherwise exempt from cost sharing; and
- Provide a referral to coordinate scheduling for treatment by the alternative provider.
- The state assures that it has a process in place to identify hospital emergency department services as non-emergency for purposes of imposing cost sharing. This process does not limit a hospital's obligations for screening and stabilizing treatment of an emergency medical condition under section 1867 of the Act; or modify any obligations under either state or federal standards relating to the application of a prudent-layperson standard for payment or coverage of emergency medical services by any managed care organization.

The process for identifying emergency department services as non-emergency for purposes of imposing cost sharing is:

Definition of non-emergency care is defined as any health care service provided to evaluate and/or treat any medical condition such that a prudent layperson possessing an average knowledge of medicine and health determines that immediate unscheduled medical care is not required. Hospitals will operationalize this process by performing the required EMTALA screening on the patient and if they determine the condition non-emergent (determined by medical professional at the hospital), the ER staff (either a nurse, doctor or intake staff) will advise the recipient that it is not a condition that required emergency treatment, and that they (the hospital) will assist them in locating another facility (late night clinic, etc), call their primary care physician when they are open, or go to an urgent care clinic that may be available. If the individual still opts to be treated at the ER, they will be required to pay the \$8 co-pay.

Cost Sharing for Drugs

The state charges cost sharing for drugs.

Yes

The state has established differential cost sharing for preferred and non-preferred drugs.

Yes

- The state identifies which drugs are considered to be non-preferred.
- The state assures that it has a timely process in place to limit cost sharing to the amount imposed for a preferred drug in the case of a non-preferred drug within a therapeutically equivalent or similar class of drugs, if the individual's prescribing provider determines that a preferred drug for treatment of the same condition either will be less effective for the individual, will have adverse effects for the individual, or both. In such cases, reimbursement to the pharmacy is based on the appropriate cost sharing amount.

Beneficiary and Public Notice Requirements

- Consistent with 42 CFR 447.57, the state makes available a public schedule describing current cost sharing requirements in a manner that ensures that affected applicants, beneficiaries and providers are likely to have access to the notice. Prior to submitting a SPA which establishes or substantially modifies existing cost sharing amounts or policies, the state provides the public with advance notice of the SPA, specifying the amount of cost sharing and who is subject to the charges, and provides reasonable opportunity for stakeholder comment. Documentation demonstrating that the notice requirements have been met are submitted with the SPA. The state also provides opportunity for additional public notice if cost sharing is substantially modified during the SPA approval process.

Other Relevant Information

Preventive Health Services, including "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines, preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program project; and additional preventive services for women recommended by the Institute of Medicine (IOM) shall not be subject to co-pays



Medicaid Premiums and Cost Sharing

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V 20140415

TN No: 14-005
Kentucky

Approval Date: 08/10/15
G-3

Effective Date 07/01/14



Medicaid Premiums and Cost Sharing

State Name: Kentucky

OMB Control Number: 0938-1148

Transmittal Number: KY - 14 - 0005

Expiration date: 10/31/2014

Cost Sharing Amounts - Categorically Needy Individuals **G2a**

1916
1916A
42 CFR 447.52 through 54

The state charges cost sharing to all categorically needy (Mandatory Coverage and Options for Coverage) individuals. Yes

Services or Items with the Same Cost Sharing Amount for All Incomes

	Service or Item	Amount	Dollars or Percentage	Unit	Explanation	
+	Preferred and non-preferred generic drug	1.00	\$	Prescription	Preferred and non-preferred generic drug or atypical anti-psychotic drug that does not have a generic equivalent	X
+	Preferred brand name drug that does not have a generic equivalent	4.00	\$	Prescription	Preferred brand name drugs that does not have a generic equivalent and is available under the supplemental rebate program	X
+	Non-preferred brand name drug	8.00	\$	Prescription		X
+	Chiropractor	3.00	\$	Visit		X
+	Dental	3.00	\$	Visit		X
+	Podiatry	3.00	\$	Visit		X
+	Optometry	3.00	\$	Visit		X
+	General Ophthalmological services	3.00	\$	Visit		X
+	Office visit for care by a physician	3.00	\$	Visit	Office visit for care by a physician, (CPT codes 99201, 99202, 99203, 99204, 99211, 99212, 99213, and 99214) physician's assistant, advanced registered nurse practitioner, certified pediatric and family nurse practitioner, or nurse midwife or any behavioral health professional	X
+	Physician Service	3.00	\$	Visit		X
+	Visit to a rural health clinic, primary care center, or federally qualified health center	3.00	\$	Visit		X
+	Outpatient hospital service	4.00	\$	Visit		X
+	Emergency Room visit for a non-emergency service	8.00	\$	Visit		X



Medicaid Premiums and Cost Sharing

	Service or Item	Amount	Dollars or Percentage	Unit	Explanation	
+	Inpatient hospital admission	50.00	\$	Entire Stay		X
+	Physical therapy, speech therapy, occupational therapy	3.00	\$	Visit	Physical Therapy, Speech Pathology Services, Speech/Hearing/Language Therapy Services and Occupational Therapy	X
+	Durable medical equipment	4.00	\$	Other	\$4.00 per date of service	X
+	Ambulatory surgical center	4.00	\$	Visit		X
+	Laboratory, diagnostic, or x-ray service	3.00	\$	Visit		X

Services or Items with Cost Sharing Amounts that Vary by Income

Service or Item: Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+							X

Add Service or Item

Cost Sharing for Non-preferred Drugs Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-preferred drugs (entered above), answer the following question:

The state charges cost sharing for non-preferred drugs to otherwise exempt individuals.

Yes

The cost sharing charges for non-preferred drugs imposed on otherwise exempt individuals are the same as the charges imposed on non-exempt individuals.

Yes

Cost Sharing for Non-emergency Services Provided in the Hospital Emergency Department Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-emergency services provided in the hospital emergency department (entered above), answer the following question:

The state charges cost sharing for non-emergency services provided in the hospital emergency department to otherwise exempt individuals.

No



Medicaid Premiums and Cost Sharing

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20140415

TN No: 14-005
Kentucky

Approval Date: 018/10/15
G2a-3

Effective Date: 07/01/14



Medicaid Premiums and Cost Sharing

State Name:

OMB Control Number: 0938-1148

Transmittal Number: KY - 14 - 0005

Expiration date: 10/31/2014

Cost Sharing Amounts - Medically Needy Individuals **G2b**

1916
1916A
42 CFR 447.52 through 54

The state charges cost sharing to all medically needy individuals.

The cost sharing charged to medically needy individuals is the same as that charged to categorically needy individuals.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V 20140415

TN No: 14-005

Approval Date: 08/10/15

Effective Date: 07/01/14

Kentucky

G2b-1



Medicaid Premiums and Cost Sharing

State Name:

OMB Control Number: 0938-1148

Transmittal Number: 14 - - 0005

Expiration date: 10/31/2014

Cost Sharing Amounts - Targeting	G2c
1916 1916A 42 CFR 447.52 through 54	
The state targets cost sharing to a specific group or groups of individuals.	
<input type="text" value="No"/>	

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V 20140415

TN No: 14-005
Kentucky

Approval Date: 08/10/15
G2c-1

Effective Date: 07/01/14



Medicaid Premiums and Cost Sharing

State Name:

OMB Control Number: 0938-1148

Transmittal Number: KY - 14 - 0005

Expiration date: 10/31/2014

Cost Sharing Limitations

G3

42 CFR 447.56
1916
1916A

- The state administers cost sharing in accordance with the limitations described at 42 CFR 447.56, and 1916(a)(2) and (j) and 1916A(b) of the Social Security Act, as follows:

Exemptions

Groups of Individuals - Mandatory Exemptions

The state may not impose cost sharing upon the following groups of individuals:

- Individuals ages 1 and older, and under age 18 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118).
- Infants under age 1 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118), whose income does not exceed the higher of:
 - 133% FPL; and
 - If applicable, the percent FPL described in section 1902(l)(2)(A)(iv) of the Act, up to 185 percent.
- Disabled or blind individuals under age 18 eligible for the following eligibility groups:
 - SSI Beneficiaries (42 CFR 435.120).
 - Blind and Disabled Individuals in 209(b) States (42 CFR 435.121).
 - Individuals Receiving Mandatory State Supplements (42 CFR 435.130).
- Children for whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age.
- Disabled children eligible for Medicaid under the Family Opportunity Act (1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act).
- Pregnant women, during pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends, except for cost sharing for services specified in the state plan as not pregnancy-related.
- Any individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs.
- An individual receiving hospice care, as defined in section 1905(o) of the Act.
- Indians who are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services.
- Individuals who are receiving Medicaid because of the state's election to extend coverage to the Certain Individuals Needing Treatment for Breast or Cervical Cancer eligibility group (42 CFR 435.213).

TN No: 14-005

Approval Date: 08/10/15

Effective Date: 07/01/14

Kentucky

G3-1



Medicaid Premiums and Cost Sharing

Groups of Individuals - Optional Exemptions

The state may elect to exempt the following groups of individuals from cost sharing:

The state elects to exempt individuals under age 19, 20 or 21, or any reasonable category of individuals 18 years of age or over.

Yes

Indicate below the age of the exemption:

- Under age 19
- Under age 20
- Under age 21
- Other reasonable category

Description:

Kentucky exempts all kids under the age of 19. In addition, recipients between the ages of 18-21 who are in state custody and are in foster care or residential treatment are exempted from co-pays.

The state elects to exempt individuals whose medical assistance for services furnished in a home and community-based setting is reduced by amounts reflecting available income other than required for personal needs.

No

Services - Mandatory Exemptions

The state may not impose cost sharing for the following services:

- Emergency services as defined at section 1932(b)(2) of the Act and 42 CFR 438.114(a).
- Family planning services and supplies described in section 1905(a)(4)(C) of the Act, including contraceptives and pharmaceuticals for which the state claims or could claim federal match at the enhanced rate under section 1903(a)(5) of the Act for family planning services and supplies.
- Preventive services, at a minimum the services specified at 42 CFR 457.520, provided to children under 18 years of age regardless of family income, which reflect the well-baby and well child care and immunizations in the Bright Futures guidelines issued by the American Academy of Pediatrics.
- Pregnancy-related services, including those defined at 42 CFR 440.210(a)(2) and 440.250(p), and counseling and drugs for cessation of tobacco use. All services provided to pregnant women will be considered pregnancy-related, except those services specifically identified in the state plan as not being related to pregnancy.
- Provider-preventable services as defined in 42 CFR 447.26(b).

Enforceability of Exemptions

The procedures for implementing and enforcing the exemptions from cost sharing contained in 42 CFR 447.56 are (check all that apply):

- To identify that American Indians/Alaskan Natives (AI/AN) are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services in accordance with 42 CFR 447.56(a)(1)(x), the state uses the following procedures:
 - The state accepts self-attestation



Medicaid Premiums and Cost Sharing

- The state runs periodic claims reviews
- The state obtains an Active or Previous User Letter or other Indian Health Services (IHS) document
- The Eligibility and Enrollment and MMIS systems flag exempt recipients
- Other procedure

Additional description of procedures used is provided below (optional):

If an individual notifies us that they are an American Indian/Alaska Natives (AI/AN) who currently or have previously received services by the Indian Health Service (IHS), and Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U), or through a referral under contract health services in any State, we will use the same "Y/N" indicators switch in the MMIS system, as described below, and set that individual to be exempt from cost-sharing. Additionally, DMS uses a single streamlined applications which asks the following:

Member of a federally recognized tribe, band, nation, community, etc?*

Received services from Indian Health Service, a tribal health program, urban indian health program or through a referral from one of these programs?*

Eligible to receive services from Indian Health Service, a tribal health program, urban indian health program or through a referral from one of these programs?*

Tribe name*

Tribe state*

Federally recognized Tribe Verification*

Federally Recognized Tribe Verification date

- To identify all other individuals exempt from cost sharing, the state uses the following procedures (check all that apply):
 - The MMIS system flags recipients who are exempt
 - The Eligibility and Enrollment System flags recipients who are exempt
 - The Medicaid card indicates if beneficiary is exempt
 - The Eligibility Verification System notifies providers when a beneficiary is exempt
 - Other procedure

Additional description of procedures used is provided below (optional):

KY as a "Y/N" indicator switch in the MMIS system. At the time of enrollment and renewal, if the recipient is exempt from cost sharing the indicator switch is set to indicate that they are exempt from any cost sharing. MMIS has been programmed not to deduct co-payments from claims for Medicaid recipients and services that are exempt from cost sharing as identified in 42 CFR 447.56(a) and 1916(a)(2) and (j) and 1916A(b) of the Social Security Act. MMIS will identify the exempt recipients by age for children under age 18 (or 19 for optional groups), by aid category and recipient status for pregnant women and institutionalized individuals. Additionally, MMIS will identify the exempt demo kids up to age 21 in state custody, foster care or residential treatment. KY uses the same indicator for exempting foster children. Medicaid recipients covered under an approved Waiver program is subject to co-payments for all services except those provided under the waiver program.



Medicaid Premiums and Cost Sharing

Payments to Providers

- The state reduces the payment it makes to a provider by the amount of a beneficiary's cost sharing obligation, regardless of whether the provider has collected the payment or waived the cost sharing, except as provided under 42 CFR 447.56(c).

Payments to Managed Care Organizations

The state contracts with one or more managed care organizations to deliver services under Medicaid.

Yes

- The state calculates its payments to managed care organizations to include cost sharing established under the state plan for beneficiaries not exempt from cost sharing, regardless of whether the organization imposes the cost sharing on its recipient members or the cost sharing is collected.

Aggregate Limits

- Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household do not exceed an aggregate limit of 5 percent of the family's income applied on a quarterly or monthly basis.

- The percentage of family income used for the aggregate limit is:

- 5%
- 4%
- 3%
- 2%
- 1%
- Other: %

- The state calculates family income for the purpose of the aggregate limit on the following basis:

- Quarterly
- Monthly

The state has a process to track each family's incurred premiums and cost sharing through a mechanism that does not rely on beneficiary documentation.

Yes

- Describe the mechanism by which the state tracks each family's incurred premiums and cost sharing (check all that apply):

- As claims are submitted for dates of services within the family's current monthly or quarterly cap period, the state applies the incurred cost sharing for that service to the family's aggregate limit. Once the family reaches the aggregate limit, based on incurred cost sharing and any applicable premiums, the state notifies the family and providers that the family has reached their aggregate limit for the current monthly or quarterly cap period, and are no longer subject to premiums or cost sharing.

- Managed care organization(s) track each family's incurred cost sharing, as follows:

The Department for Medicaid Services passes co-pay indicators to the MCOs. The MMIS houses quarterly family income and passes this to the MCOs along with the co-pay indicator. In the event the family reaches the



Medicaid Premiums and Cost Sharing

quarterly out-of-pocket max, a co-pay indicator in MMIS is turned to "N" to indicate no co-pay

Other process:

- Describe how the state informs beneficiaries and providers of the beneficiaries' aggregate family limit and notifies beneficiaries and providers when a beneficiary has incurred premiums and cost sharing up to the aggregate family limit and individual family members are no longer subject to premiums or cost sharing for the remainder of the family's current monthly or quarterly cap period:

The maximum amount of total cost-sharing shall not exceed 5% of a family's total income for a quarter. Kentucky as a program called co-payment tracking within the MMIS system that will track the member's co-pays to ensure that they are not charged more than the 5% during a quarter. Information regarding the quarterly amount of household income for each case is stored in the MMIS and is updated on a quarterly basis. As claims are processed, the billed services evaluated to determine if a co-payment should have been assessed. If the service was subject to co-payment based on service and member category, the system calculates the amount of the co-payment and maintains that amount in the system. If 5% of the stored income is reached, the co-payment indicator for the member or household is turned off in the system and providers can see the copayment is no longer applicable. Additionally, members will be notified through mail when they have incurred out-of-pocket expenses up to the aggregate family limit and individual family members are no longer subject to cost sharing for the remainder of the family's current quarterly cap period. Current methodology assumes that all copayments are paid by the member. This will be coordinated with the pharmacy benefit manager (PBM) as well.

The state has a documented appeals process for families that believe they have incurred premiums or cost sharing over the aggregate limit for the current monthly or quarterly cap period.

No

- Describe the process used to reimburse beneficiaries and/or providers if the family is identified as paying over the aggregate limit for the month/quarter:

In the event a family believes they have incurred cost sharing over the aggregate limit, the family can call the Member Services toll free line to receive assistance regarding this issue. In the event cost sharing was incurred incorrectly, claims would be processed for the provider and the provider would be responsible for reimbursing the member.

- Describe the process for beneficiaries to request a reassessment of their family aggregate limit if they have a change in circumstances or if they are being terminated for failure to pay a premium:

Members must report changes in income to the Department within 30 days of the change. Changes are recorded in the system immediately upon notification and cost sharing aggregate limits are changed as well.

The state imposes additional aggregate limits, consistent with 42 CFR 447.56(f)(5).

No

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V 20140415

TN No: 14-005
Kentucky

Approval Date: 08/10/15
G3-5

Effective Date: 07/01/14

State: Kentucky

Citation

4.18 Recipient Cost Sharing and Similar Charges (Continued)

42 CFR 447.51
through 447.58

(c) Individuals are covered as medically needy under the plan.

- (1) An enrollment fee, premium or similar charge is imposed. ATTACHMENT 4.18-B specifies the amount of and liability period for such charges subject to the maximum allowable charges in 42 CFR 447.52(b) and defines the State's policy regarding the effect on recipients of non-payment of the enrollment fee, premium, or similar charge.

Revision: HCFA-PM-91 -.4 (BPD)
August 1991

Page 56d

State: Kentucky

RESERVED

TN No. 14-005

Supersedes
TN No. 02/05

Approval Date: 08/10/15

Effective Date: 07/01/2014

Revision: HCFA-PM-91 -4 (BPD)
August 1991

State: Kentucky

RESERVED

TN No. 14-005

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August 1991

Page 56f

State: Kentucky

RESERVED

TN No. 14-005
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Approval Date: 08/10/15

Effective Date: 07/01/2014

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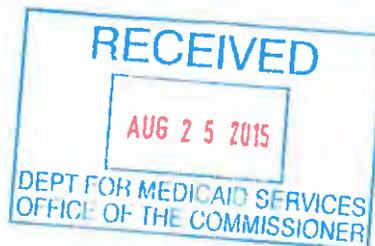
DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303



DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

August 21, 2015

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



Re: Renewal of Kentucky's HCBS Waiver # 0144

Dear Ms. Lee:

This formal Request for Additional Information (RAI) is in response to the state's request to renew Kentucky's Home and Community Based Waiver for individuals with disabilities or aged 65 and older who would otherwise require placement in a nursing facility. Our review of the request (control # 0144.R06) found that it did not conform fully to statutory and regulatory requirements. Please note additional information requested includes how the state intends to proceed with the implementation of occupational, physical, and speech therapy services for waiver participants.

Please provide clarification necessary to responds to the following issues:

Appendix B

1. Quality Improvement, Level of Care, Sub-assurance(c): We remain concerned that the denominator of the state's revised performance measure, "Number of applicants whose Assessment was completed," is only measuring the number of applicants whose assessments were completed, which does not take into account applicants whose assessments were not completed. The state should consider a second performance measure that examines applicants whose assessments were not completed in accordance with the waiver.

Appendix C

2. **Occupational Therapy, Physical Therapy and Speech Therapy Services:** Please advise how the state intends to proceed with the implementation of occupational, physical, and speech therapy services for waiver participants. In this context, please note the following information:
 - If the state continues to cover habilitative services under the therapies' portion of the state plan, then in order for the state to offer services in this waiver, the state will need to designate the service as either an "Extended State Plan Service" or "Other Service" that is different from what is already covered in the state plan. This difference would not be based on the fact that the same services covered in the state plan are habilitative, because habilitative services are already covered in the state plan. It would be based on making the physical therapy, occupational therapy, and speech therapy, different services, or perhaps covering services that are not physical therapy, occupational therapy, or speech therapy that are habilitative in nature.
 - The physical therapy, occupational therapy, and speech therapy services could only be included as extended state plan services in the waiver if the state had a limit on these services in the state plan.
 - Different rates based on the level of need of the beneficiary or skills/training of the provider is permitted under the state plan. Under the state plan, Kentucky's current payment methodology for physical therapy, occupational therapy and speech therapy services does not include differential payment rates based on acuity. The state will need to submit a state plan amendment, which proposes this new rate, if the state chooses this option.
 - If the services are included in the waiver renewal, then the state would have to indicate under the limits section below the service definition that the service is not available for children as it would be covered under Early and Periodic Screening, Diagnostic and Treatment in the state plan.
3. **Quality Improvement, Qualified Providers, Sub-assurance (a):** Regarding the state's revised performance measure, "Number and percent of Home Health and Adult Day providers that meet OIG licensing requirement at review," please confirm that Home Health and Adult Day providers are the only providers under the waiver that have Office of Inspector General (OIG) licensing requirements. If there are others, we suggest that the state expand the proposed performance measures to cover all OIG licensed providers under the waiver.

Appendix E

4. Appendix E-1-f: The state indicates that, "If the issues [with a participant's legal or non-legal representative] continue, or the participant's health, safety and welfare are at risk, the service advisor shall transition the participant to traditional services and a 10-day notice to a fair hearing will be provided." Please clarify whether waiver participants would be given the opportunity to choose another representative before being transitioned to traditional services.

Appendix G

5. Appendix G-1-d: Please describe the process and timeframes for informing the participant and other relevant parties (i.e. the participant's legal representative, waiver provider(s), waiver operating agency and licensing and regulatory authorities) of the investigation results.

Appendix H

6. Appendix H-1: The state indicates that the QIS will be "evaluated quarterly, one quarter in arrears." Please clarify the meaning of the state's use of the term, "arrears."

Appendix I

7. Appendix I-2-a: The state indicates that, "The 5 years of data, along with trends are included in an attached excel spreadsheet." We request a copy of this spreadsheet so that we can review the state's trends and rate development.

Appendix J

8. Appendix J-2-a and J-2-b: In response to why the total number of participants is expected to increase 56 percent from the third year of the current waiver to the first year of the renewal when the participant numbers are declining, the state responded that "Unduplicated program participants are a fixed number in the waiver portal. The portal will not allow it to be changed..." We recommend the state contact technical support through the Waiver Management System to obtain assistance with this issue.
9. Appendix J-2-c: The state indicates that, "The data used for forecasting...was claims data and did not include prescription claims. Data for forecasting items D', G, and G' were taken directly from the 372 reports." Please note that estimates of Factor D' must not include the costs of prescribed drugs that will be furnished to Medicare/Medicaid dual eligibles under the provisions of Part D. If the costs of these drugs are present in the baseline 372 figures, please remove them, and please confirm that costs for these drugs were removed from the derivation of Factor D'.

Ms. Lisa Lee
Page 4

10. Appendix J-2-d: In the state's explanation regarding why there is a the projected decrease in factor D for the first year of the renewal despite an increase in the number of participants, the state indicated that "This is due to the fact that the waiver portal froze the unduplicated participants at 17,050 and would not allow any changes." We recommend the state contact technical support through the Waiver Management System to obtain assistance with this issue.

Under section 1915(f) of the Social Security Act, a waiver request must be approved, denied or additional information requested within 90 days of receipt or the request will be deemed approved. The 90-day review period of this request ends November 19, 2015. This request for additional information will, however, stop the 90 day clock. Once the additional information is submitted, the 90-day clock will restart at day one.

If you have questions related to this request, or would like to schedule a time to discuss these questions, please contact Melanie Benning at (404) 562-7414 at melanie.benning@cms.hhs.gov.

Sincerely,



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

cc: Amanda Hill, Central Office

✓ to
LH

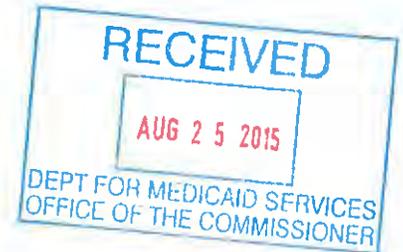
DEPARTMENT OF HEALTH & HUMAN SERVICES
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DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

August 21, 2015

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



Re: Renewal of Kentucky's HCBS Waiver # 0314

Dear Ms. Lee:

This formal Request for Additional Information (RAI) is in response to the state's request to renew Kentucky's Home and Community Based Waiver for individuals who are developmentally and/or intellectually disabled who meet the intermediate care facility for individuals with intellectual disabilities' level of care. Our review of the request (control # 0314.R04) found that it did not conform fully to statutory and regulatory requirements. Please note additional information requested includes how the state intends to proceed with the implementation of occupational, physical, and speech therapy services for waiver participants.

Main Module

1. Item 1, Major Changes: Please explain why the major changes section does not include the removal of occupational therapy (OT), physical therapy (PT) and speech therapy (ST) from the waiver.
2. Attachment #1, Transition Plan: Please provide information regarding the transition for individuals receiving OT/PT/ST who will now be receiving those services through the state plan.
 - Please describe in the transition plan the similarities and differences between the services covered in the approved waiver and those covered in the renewed waiver.
 - Please provide information regarding how the health and welfare of persons who receive services through the approved waiver will be assured during the transition of the services offered in the state plan.
 - Please include a description of how the participant is informed of the opportunity to request a Fair Hearing.

3. Attachment #2, Home and Community-Based Settings Waiver Transition Plan: Please include the following language in this section of the application: “Kentucky assures that the settings transition plan included with this waiver renewal will be subject to any provisions or requirements included in Kentucky’s approved Statewide Transition Plan. Kentucky will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.”
4. Public Input, 6-I:
 - Please include in your public input section, a summary of how a non-electronic copy of the waiver renewal was made available. For example, what information was included in the public notice to inform participants about how to access the hard copy?
 - Please include in this section the methods and details of how people were able to make public comment (for example, to where could they write in, call, or send emails to provide comment).
 - Please include the URL for the waiver renewal that was posted.
 - Please include in the public input section a summary of the changes that were made as a result of public input. If no changes were made, please indicate this as well.

Appendix B

5. B-5-a: The state checked the box to indicate that the operating agency executes Medicaid provider agreements. Please explain if this is accurate, or if the operating agency only recommends providers for enrollment.
 - The state has not indicated that it is applying spousal impoverishment rules for the special home and community based waiver group under 42 CFR 435.217. However, Section 2404 of the Affordable Care Act requires that for a 5-year period beginning on 1/1/2014, states must apply the spousal impoverishment protections for individuals with a community spouse who are eligible for section 1915(c), (d), (i) or (k) services, as well as those receiving home and community-based services under an 1115 waiver.
 - For the 217 category, to which application of spousal eligibility and post-eligibility rules has historically been an option for states, the amendment makes the option a mandate; spousal impoverishment eligibility and post eligibility treatment of income rules apply for individuals determined eligible under the special home and community-based waiver eligibility group specified at 42 CFR 435.217.
 - The state should check the first check box, that for the 5-year time period beginning January 1, 2104, the following instructions are mandatory: that the state is using the spousal impoverishment eligibility and post eligibility rules under section 1924 of the Act for individuals that have a community spouse.

6. **Quality Improvement, Level of Care, Sub-assurance(a):**
 - Please explain how the state identifies a waiver applicant for whom there is a reasonable indication that services may be needed, if there is no Level of Care (LOC) evaluation for that individual? Where would such data/files be kept? For purposes of this performance measure, how are cases treated when there is a waiver applicant for whom there is a reasonable indication that services may be needed, but the LOC evaluation is scheduled or has begun, but is not completed?
 - Please provide remediation information for this performance measure for all instances of non-compliance that arise during the term of the waiver.
 - Please clarify the respective roles of the State Medicaid Agency and Quality Improvement Organization (QIO) for the collection and generation, and aggregation and analysis, of data to be used in determining whether performance complies with the sub-assurance.
7. **Quality Improvement, Level of Care, Sub-assurance(c):**
 - The performance measure (PM) indicates the numerator will be randomly selected LOCs, but the table beneath it indicates 100% Review. Please clarify how the PM will be implemented, and make any correction to the application that is needed.
 - Please clarify what constitutes a “level of care...done appropriately.”
 - Does the denominator (i.e. number of LOCs reviewed) mean that 100% of LOCs will be reviewed (given that the Sampling Approach is “100% Review”)? If not, please clarify what the denominator represents.
8. **Methods for Remediation/Fixing Individual Problems:** We suggest the state provide a more robust and detailed method for remediation and fixing individual problems, in light of concerns expressed by CMS in the Final Evidentiary Report. We would suggest, for example, that (i) utilization management reports should be generated by the fiscal agent and QIO every two to four weeks depending on the number of applicants for whom LOC evaluations are needed; (ii) exception reports showing applicants who are at risk of not receiving timely LOC evaluations are provided to those individuals responsible for ensuring that timely LOC evaluations are performed; and (iii) exception reports be provided every two to four weeks to DMS listed individuals who did not receive timely LOC evaluations and the reason(s) for that problem, as well as steps taken to remediate the problem. These short-term lists should be compiled and analyzed on a quarterly basis, and corrective actions taken on a systemic basis whenever possible and practicable.

Appendix C

9. Occupational Therapy, Physical Therapy and Speech Therapy Services: Please advise how the state intends to proceed with the implementation of occupational, physical, and speech therapy services for waiver participants. In this context, please note the following information:
- If the state continues to cover habilitative services under the therapies' portion of the state plan, then in order for the state to offer services in this waiver, the state will need to designate the service as either an "Extended State Plan Service" or "Other Service" that is different from what is already covered in the state plan. This difference would not be based on the fact that the same services covered in the state plan are habilitative, because habilitative services are already covered in the state plan. It would be based on making the physical therapy, occupational therapy, and speech therapy, different services, or perhaps covering services that are not physical therapy, occupational therapy, or speech therapy that are habilitative in nature.
 - The physical therapy, occupational therapy, and speech therapy services could only be included as extended state plan services in the waiver if the state had a limit on these services in the state plan.
 - Different rates based on the level of need of the beneficiary or skills/training of the provider is permitted under the state plan. Under the state plan, Kentucky's current payment methodology for physical therapy, occupational therapy and speech therapy services does not include differential payment rates based on acuity. The state will need to submit a state plan amendment, which proposes this new rate, if the state chooses this option.
 - If the services are included in the waiver renewal, then the state would have to indicate under the limits section below the service definition that the service is not available for children as it would be covered under Early and Periodic Screening, Diagnostic and Treatment in the state plan.
10. C-1/C-3, General Comment: Please list provider license and certificates under corresponding headings. If a license is issued by state law, please provide the citation of the applicable state law governing the issuance of the license. If a certificate is issued by a state agency, cite the applicable state regulation or policies that serve as the basis for the certification.
11. C-1/C-3, Community Guide: Previously a standard for community guide services included, "Has a valid Social Security number or a valid work permit if not a citizen of the U.S." Please clarify whether the latter is still a requirement.
12. C-1/C-3: Case Management: Please only include in the service definition the actual service definition. Move the provider qualifications and standards to the Provider Qualifications section.
13. C-1/C-3: Community Access Services: A change in limits for this service is noted. Please mark that "Service is included in approved waiver. The service specifications have been modified." Before the service was limited to 160 units per week but now this is not included in the limits section. A change in the "Other Standards" is also noted.

14. C-1/C-3: Community Transition: There is now one provider type instead of the previous three. Please indicate "Service is included in approved waiver. The service specifications have been modified."
15. C-1/C-3: Environmental Accessibility Adaptation Services: There is now one provider type instead of the previous two. Please indicate "Service is included in approved waiver. The service specifications have been modified."
16. C-1/C-3: Goods and Services: This service has both changed Service Type and had two previous provider types and now has one. Please indicate "Service is included in approved waiver. The service specifications have been modified."
17. C-1/C-3: Positive Behavior Supports: There is now one provider type instead of the previous three. There are also additional "Other Standards" listed. Please indicate "Service is included in approved waiver. The service specifications have been modified."
18. C-1/C-3: Specialized Medical Equipment and Supplies: There is now one provider type instead of the previous three. Please indicate "Service is included in approved waiver. The service specifications have been modified."
19. C-1/C-3: Transportation: There is now one provider type instead of the previous three. Please indicate "Service is included in approved waiver. The service specifications have been modified."
20. C-1/C-3: Vehicle Adaptations: There is now one provider type instead of the previous two. Please indicate "Service is included in approved waiver. The service specifications have been modified."
21. C-5: Only one sentence is needed in this section to refer to the transition plan in Attachment #2.
22. Quality Improvement, Qualified Providers, Sub-assurance (a):
 - For the first PM, please verify that the denominator counts only providers who have certification requirements to be met and clarify how the operating agency confirms that a provider satisfies all applicable certification requirements. We suggest that information for this PM be monitored at least quarterly, rather than annually.
 - Please clarify whether the background checks will be completed successfully before each and every new provider provides any waiver services.
 - Please describe how successful completion of the tasks in third performance measure be documented.
 - We suggest an additional PM measuring whether each provider that has not made timely correction of his or her credentials or other requirements is terminated as an eligible provider.
23. Quality Improvement, Qualified Providers, Sub-assurance (b):
 - Please describe the processes in place to assure the non-licensed/non-certified providers adhere to the waiver's eligibility requirements prior to their rendering waiver services.
 - Given issues identified in the Evidentiary Report, we recommend that the state evaluate its achievement of this PM at least quarterly.

- Please describe what steps will be taken if the representative sample fails the PM (e.g. Will the sample be expanded? Will 100% of the records be reviewed?).
24. Quality Improvement, Qualified Providers, Sub-assurance (c):
- Please describe how the state verifies that the provider training is conducted in accordance with state requirements.
 - Please clarify what is meant by “reviewed providers” in both the numerator and denominator.
25. Methods for Remediation/Fixing Individual Problems: The proposed methods of remediation and fixing individual problems do not seem adequate to address failures as they arise. We recommend the state develop a new set of methods for correcting each incident of non-compliance by an individual or organization. We suggest the state set forth separate methods for each PM, which includes (a) who specifically is accountable for identifying non-compliance; (b) who is responsible for issuing the remediation requirements; (c) what are the remediation requirements for each PM where non-compliance is noted; (d) who is responsible for monitoring that the remediation has been completed within the time specified; and (e) what are the consequences (or range of consequences) if the non-compliance is not rectified within the specified timeframe.

Appendix D

26. D-1-d:
- The state indicates that the Person Centered Service Plan (PCSP) is developed utilizing the Supports Intensity Scale (SIS). By the state’s proposed effective date for this renewal, will the state be fully ready to implement use of the SIS tool throughout this waiver, and will the state discontinue use of its MAP form assessment tool? Note: The state has indicated in the past that full implementation of the SIS tool was not a certainty due to various challenges.
 - Service Plan Development Process: Please describe how planning meetings are scheduled at times and locations convenient to the individual.
27. D-1-g: Please further clarify how the Medicaid agency exercises oversight of service plans on a routine and periodic basis.
28. Quality Improvement, Service Plan, Sub-assurance (a):
- Regarding the first PM:
 - Please confirm that the “total number of service plans reviewed” means 100% of all service plans that are complete as of the measuring date.
 - Please explain how a service plan is determined to “reflect assessed needs.”
 - Regarding the third PM: Please clarify what is the sampling approach since “Less than 100% Review” is checked.
 - Regarding the fifth PM: Please clarify what is the sampling approach since “Less than 100% Review” is checked.

- Regarding the sixth PM: Please clarify what is the sampling approach since “Less than 100% Review” is checked.
29. Quality Improvement, Service Plan, Sub-assurance (c):
- How soon after a participant's needs change will his/her service plan be updated?
 - Please clarify whether the service plan update will be completed by the participant's anniversary date, and that any service plan that is not 100% complete by the participant's anniversary date will not be counted in the numerator.
 - How will the state identify service plans that were revised during the year?
 - How will the state identify which participants need their service plans changed?
30. Quality Improvement, Service Plan, Sub-assurance (d):
- Please clarify what the state means by “Continuously and Ongoing” under “Frequency of data collection/generation.”
 - Please confirm that if any service listed in the service plan is not delivered precisely in the corresponding type, amount, scope, duration and frequency, the record will not be included in the numerator.
31. Quality Improvement, Service Plan, Sub-assurance (d): Pursuant to the Waiver Quality Review Report dated July 29, 2014, the state must add a performance measure demonstrating participants are offered a choice between waiver services and institutional care.
32. Methods for Remediation/Fixing Individual Problems: We suggest that the state develop a more detailed and robust set of remediation methods for correcting each incident of a failing performance by an individual or organization. We suggest the state set forth separate methods for each PM, which includes (i) who specifically is accountable for identifying a failing performance; (ii) who is responsible for issuing the remediation requirements; (iii) what are the remediation requirements for each failing PM; (iv) who is responsible for monitoring that the remediation has been completed within the time specified; and (v) what are the consequences (or range of consequences) if the performance is not rectified within the specified timeframe.

Appendix E

33. E-1-e: Please further clarify that participants are given information about the benefits and potential liabilities associated with participant direction as well as their responsibilities when they elect to direct their services.
34. E-1-f: Please clarify the extent of the decision-making authority exercised by the non-legal representative and what safeguards are present so that the representative functions in the best interest of the participant.
35. E-1-m: Please indicate in this section the right to a fair hearing is provided at least 10 days in advance of the termination per 42 CFR 431.211.
- Please indicate in this section, if a fair hearing is requested before the termination date, services will be maintained until a decision is rendered after the hearing per 42 CFR 431.230.

- Please indicate in the second scenario for termination that if terminated from the waiver, the individual has a right to a fair hearing.
 - Please revise the beginning of paragraph three to indicate that if an employee or representative has exhibited abusive, intimidating, or threatening behavior, immediate action will be taken instead of a corrective action plan.
 - Please provide more information regarding the safeguards that will be in place to ensure continuity of services during the transition plan.
 - What supports will the individual receive in selecting a provider?
 - Please provide justification for disenrollment from the waiver in 30 days if a provider is not located within that timeframe.
36. E-2-a-ii: The state has indicated participants are responsible for the cost of obtaining criminal background checks, drug testing and all cost associated with training. This is not something an individual can be required to pay for potential hires. The potential hire is required to demonstrate that he/she meets the qualifications. Accordingly, please delete the sentence, “The participant, as the employer, is responsible for the cost of obtaining criminal background checks, drug testing and all cost associated with training.”
37. E-2-b-ii:
- Please clarify when a budget varies based on additional factors, the factors that are used and how they affect the budget.
 - Describe how information about the budget methodology is made available to the public.
38. E-2-b-iii:
- Please clarify how a participant can request an adjustment in the budget.
 - Describe how participants are afforded the opportunity to request a Fair Hearing when the participant's request for a budget adjustment is denied or the amount of the budget is reduced.
39. E-2-b-v:
- Describe how the safeguards allow for identification of potential budget problems on a timely basis.
 - Describe the safeguards that include flagging potential over expenditures or budget underutilization.

Appendix F

40. F-1:
- Please specify how individuals are informed about the Fair Hearing process during entrance to the waiver, including how, when, and by whom this information is provided.
 - Please specify where notices of adverse actions and the opportunity to request a Fair Hearing are kept.

- Please address all instances when a notice must be made to an individual of an adverse action regarding choice of home and community based services versus institutional services, choice of provider or service, and denial, reduction, suspension or termination of service.
 - Please specify how the notice is made, the entity responsible for issuing the notice, and assistance provided to an individual with pursuing a fair hearing.
 - Please specify the right to a fair hearing must be provided at least 10 days prior to the taken action.
41. F-2-b: Please describe how the state informs the participant who elects to make use of the dispute mechanism (i.e. files a grievance or makes a complaint) that the dispute resolution mechanism is not a pre-requisite or substitute for a Fair Hearing.
42. F-3-c: Please describe how the participant is informed that filing a grievance or making a complaint is not a pre-requisite or substitute for a Fair Hearing.

Appendix G

43. G-1-b:
- Please identify the individuals/entities that must report critical events and incidents.
 - Please include a timeline in which a critical event or incident must be reported and the method of reporting.
44. G-1-c: Please describe how training and/or information is furnished to participants or their informal caregivers concerning protections from abuse, neglect and exploitation, including how to notify the appropriate authorities?
45. G-1-d: Please describe the process and timeframes for informing the participant, including the participant (or the participant's family or legal representative as appropriate) and other relevant parties (e.g., the waiver providers, licensing and regulatory authorities, the waiver operating agency) of the investigation results.
46. G-2-b-i: Please describe the required education and training of personnel involved in the administration of the psychotropic PRN?
47. G-2-b-ii: Please describe how data are analyzed to identify trends and patterns to support improvement strategies, how data are collected, compiled, and used to prevent re-occurrence, and the frequency of oversight activities.
48. G-3-b-ii: Please describe how frequently the state monitors medication management administration and potentially harmful practices regarding such administration.
49. Quality Improvement, Health and Welfare, Sub-assurance (a):
- Regarding the first PM, please confirm that the numerator is the “Number of deaths reviewed by a clinical committee.”
 - While it may be helpful to measure the percentage of timely critical incident reports that have been submitted, either or both PMs do not appear sufficient to prove the sub-assurance because measuring timely critical incident reports presupposes that all critical incident reports that should be filed are indeed filed.

50. Quality Improvement, Health and Welfare, Sub-assurance (b):
- What constitutes an “incident?”
 - Would the state consider a PM that measures survey results of participants or their family members, as providers, which included questions about whether they feel that the organization encourages reporting of incidents when they arise?
51. Quality Improvement, Health and Welfare, Sub-assurance (c): How will the number of participants with restrictive interventions, including restraints and seclusions, be accurately measured?
52. Quality Improvement, Health and Welfare, Sub-assurance (d): Although the state has proposed three PMs for this sub-assurance, we are concerned that without specific health care standards against which physicians, dentists, and those who monitor residential supports can evaluate and monitor the health care of each participant, the mere examination or screening is not sufficient to evaluate whether all participants’ health care needs are being met. Moreover, a formal checklist that is filled out by the provider would greatly simplify the state’s monitoring and measuring of this performance measure.
53. Methods for Remediation/Fixing Individual Problems: We suggest that the state develop a more detailed and robust set of remediation methods for correcting each incident of non-compliance by an individual or organization. We suggest the state set forth separate methods for each PM, which includes (i) who specifically is accountable for identifying non-compliance; (ii) who is responsible for issuing the remediation requirements; (iii) what are the remediation requirements for each instance of non-compliance with a PM; (iv) who is responsible for monitoring that the remediation has been completed within the time specified; and (v) what are the consequences (or range of consequences) if the performance is not rectified within the specified timeframe.

Appendix H

54. Please provide control numbers of the other waivers for which the Medicaid Waiver Management system will be used.

Appendix I

55. I-1:
- Please identify the entity responsible for conducting the periodic independent audit of the waiver program under the provisions of the Single Audit Act.
 - For claims with payments issued without appropriate documentation or not in accordance with approved PCSP, are more paid claims reviewed for appropriateness? What criteria are used to review additional claims (e.g., are they stratified by provider or agency; types of claims; geography)?
 - What are, if any, the penalties imposed on providers who have payments with inappropriate documentation?

- Please describe the audit method used for personal care services in detail, including how claims are selected to be reviewed. Which documents are examined and what components of those documents are examined? What is the audit methodology detail? Which services are deemed personal care services for purposes of the audit?
- Please explain, in detail, the systems and procedures in place to assure that (i) personal care services are provided only by qualified individuals; (ii) such individuals only provide the services to eligible participants with the frequency, amount, and duration specified in the POC; and (iii) that such individuals are only paid for the services they actually perform that are in accordance with the POC.
- Please explain, in detail, how the systems and procedures described check for and detect: (i) services that are billed for but not actually rendered; (ii) duplicative billing (i.e., either billing more than once for the same service or billing by more than one individual or agency for the same service); and (iii) services provided by an unauthorized individual and either billed by the unauthorized individual or by an authorized individual.
- Please explain, in detail, what monitoring systems and procedures are used to detect and prevent participants from being coerced into approving services that were not provided in accordance with his or her POC, or were not provided by an authorized provider
- Who specifically is the employing organization accountable for the proper administration of the systems and procedures described in D, and how is the state Medicaid agency monitoring the organization accountable for fiscal integrity?

56. I-2-a:

- Please clarify the methods used to trend the claims data forward.
- How often is the fee-for-service rate schedule updated and when was the last time the rates were updated? When was the last time the rates were re-based?
- Please describe if there is a schedule for annual cost of living increase (or other reason for increase) for the rates. If so, please provide the annual schedule for increase and describe how it is determined. If there is no cost of living increase or similar schedule for periodic rate adjustments, describe why a cost increase is not built into the rates.
- Please describe how public comments are solicited during promulgation.
- Please describe how and when information about payment rates is made available to waiver participants.

57. I-2-d:

- Please describe how verification occurs that the service billed is in the recipient's service plan.
- Please describe the mechanisms in place to assure that the POC-authorized services were actually provided.

58. Quality Improvement, Financial Accountability, Sub-assurances (a) and (b):

- How does the state assure claims are paid in accordance with the waiver's reimbursement methodology and only for services rendered?

- How are claim codes correlated to the service plan?
 - How does the state ensure that 100% of the claims are for services that are in fact rendered and that those services are limited to those authorized by the participant's service plan?
 - Please clarify what type of "system defects" are identified and measured.
59. **Methods for Remediation/Fixing Individual Problems:** We suggest that the state develop a more detailed and robust set of remediation methods for correcting each incident of a non-compliance by an individual or organization. We suggest the state set forth separate methods for each PM, which includes (i) who specifically is accountable for identifying non-compliance; (ii) who is responsible for issuing the remediation requirements; (iii) what are the remediation requirements for each instance of non-compliance; (iv) who is responsible for monitoring that the remediation has been completed within the time specified; and (v) what are the consequences (or range of consequences) if the non-compliance is not rectified within the specified timeframe.

Appendix J

60. J-2a and J-2b:

- The three most recent 372 reports show the population served increased in each year, from 3,546 in year 1, to 3,724 in year 2, to 4,147 in year 3. Please explain why the unduplicated number of participants who will be served is expected to remain constant at 4,941 in each year of the renewal waiver. Also, please explain how the state contrived the number of 4,941 unduplicated participants.
- The three most recent 372 reports show the average length of stay (ALOS) decreased in each year, from 351 in year 1, to 348 in year 2, to 341 in year 3. The state indicated that the estimated ALOS for the renewal waiver is based on data from the CMS 372 Lag Report for the period 09/01/2013 through 08/31/2014. For that period, total days of waiver coverage was 1,169,813, and total unduplicated waiver participants was 4,050, which yields an average days per waiver participant of 289. However, the ALOS in each year of the renewal waiver as reported in Appendix J, is 11. Conversion of the ALOS from days to months would result in an ALOS of 9.5. Please clarify whether the ALOS is expressed in months, why the ALOS is 11, and why the ALOS is expected to remain constant in each year of the renewal waiver given the expected increase in participants.

61. J-2-c:

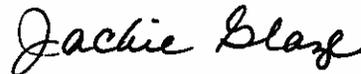
- Please confirm that the state has accounted for and removed the costs of prescribed drugs in the development of Factor D'.
- Please explain why Factor D' is less than Factor G' in all years of the waiver renewal.

- Regarding the development of Factor D', please clarify the following:
 - In the absence of a full year of representative claims data, the state used claims paid data under "SCL 2." Please provide information on the process used to derive Factor D' using this population.
 - For new services with low utilization, DMS assumed 10% annual utilization growth. Please explain how DMS arrived at this estimate.

Under section 1915(f) of the Social Security Act, a waiver request must be approved, denied or additional information requested within 90 days of receipt or the request will be deemed approved. The 90-day review period of this request ends November 19, 2015. This request for additional information will, however, stop the 90 day clock. Once the additional information is submitted, the 90-day clock will restart at day one.

If you have questions related to this request, or would like to schedule a time to discuss these questions, please contact Melanie Benning at (404) 562-7414 at melanie.benning@cms.hhs.gov.

Sincerely,



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

cc: Amanda Hill, Central Office

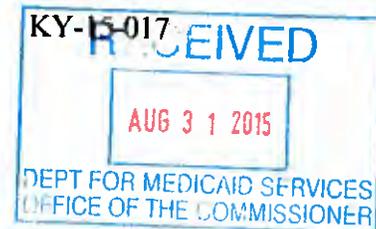
DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303



DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

August 27, 2015

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 Implementation Advance Planning Document Update (IAPDU #5) for the International Classification of Diseases, Version 10 (ICD-10) dated August 11, 2015, in accordance with 45 CFR Part 95, Subpart F, and the State Medicaid Manual (SMM), Part 11. You are hereby authorized to add a post-implementation phase from October 1, 2015, until March 31, 2016, and carry forward approved funding in the amount of \$598,620 (\$496,922 at 90 percent federal financial participation [FFP]; \$23,242 at 50 percent FFP; \$520,164 total FFP). No additional (new) funding is approved for this project.

Onsite reviews may be conducted to assure that the intentions for which FFP was approved are being accomplished. Specifically, the objective is to validate that automated data processing (ADP) equipment or services are being efficiently and effectively utilized to support the approved programs or projects as provided under 45 CFR 95.621 and the SMM. As provided by the SMM, Section 11200, and by 45 CFR 95.611, all subsequent revisions and amendments to the IAPD will require CMS prior written approval to qualify for FFP.

Allowable costs are determined by 45 CFR Part 95, Subpart F, Section 631 and the SMM, Part 11. Only actual costs incurred are reimbursable. The Commonwealth must provide adequate support for all costs claimed in addition to providing detailed records and proper audit trails.

If there are any questions concerning this approval, please contact John Allison at (828) 513-1323 or via e-mail at John.Allison@cms.hhs.gov.

Sincerely,

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

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