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DEPARTMENT FOR MEDICAID SERVICES
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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

July 29, 2014

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

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,

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.