

Quality Management Strategy

Participant Access:

An assessment to determine eligibility is conducted by participating Acquired Brain Injury waiver (ABI) providers utilizing the Medicaid Waiver Assessment Form, 351. The Quality Improvement Organization (QIO) reviews the MAP-351 and determines Nursing Facility level of care. DMS staff monitor the QIO contract to ensure compliance with waiver eligibility requirements is met and level of care determinations are made within three (3) days of submission of written request. This monitoring includes a percentage review of all level of care determinations. DMS retains the authority for all level of care determinations. Issues identified through this monitoring results in retraining as appropriate for the QIO staff or corrective actions by the QIO to meet contract requirements.

DMS contracts with the Department for Community Based Services (DCBS) to conduct the technical and financial eligibility determinations for the Medicaid program. This contract is monitored by a full-time position within DMS.

The State offers choice to all individuals. The “Application for Acquired Brain Injury Waiver Services, MAP-26” form is utilized at the time of the initial application for brain injury services to document the member’s choice of community waiver services versus institutional care. The application form includes a statement for the individual’s physician documenting the medical necessity for the waiver services. These applications are reviewed by Admission Committee review staff to ensure the individual meets the eligibility criteria for the waiver program. Upon notification of available funding for the member, the member selects a waiver provider of their choice who is responsible for completing the full admission process for initiation of services for the member.

The ABI Case Managers are required to inform the ABI members regarding choice of waiver services versus institutional services, choice of traditional or consumer directed or blended service options, choice of waiver services, and choice of providers. These choices are documented utilizing the “Long Term Care Facilities and Home and Community Based Program Certification Form, MAP-350” which must be maintained by the ABI providers in each member record. Monitoring of this requirement is accomplished through the initial admission process of prior authorization of services and through on-site certification surveys conducted at least annually by the QIO. DMS staff will also conduct monitoring of a percentage of individual records as second line monitoring of the QIO and the ABI waiver providers.

Participant Centered Service Planning and Delivery:

ABI providers must supply and educate members regarding all services available through the waiver program including the service definitions and any applicable

limitations. All ABI members have a designated case manager who is employed by the ABI provider. The case manager is responsible for the assistance in obtaining and coordination of all identified service needs of the member.

All ABI members are assessed at the time of initial waiver admission and reassessed at least annually, at a minimum (more frequently if a change in the member's condition warrants). These assessments are conducted utilizing the "Medicaid Waiver Assessment Form, MAP-351". This assessment tool utilizes the member's level of functioning in the following areas: activities of daily living, instrumental activities of daily living, mental/emotional health and well-being; behavioral support needs; environmental information to determine if the member meets NF level of care. The member participates in this entire process and this assessment/reassessment is utilized along with the "Individual Support Plan/Support Spending Plan, MAP-072" form to develop the person centered support plan. During this process the member is encouraged and assisted to participate in all areas of decision making. The ABI provider must provide any needed education regarding the waiver program to the member.

Upon receipt of approved level of care ABI waiver provider case managers are required to submit a service packet to the Quality Improvement Organization (QIO) for review, approval and prior authorization of services upon admission of the individual to the waiver program and at least annually thereafter. The packet consists of the MAP-351, MAP-350, the Level of Care certification, an ABI Waiver Services Program Applicant/recipient Memorandum of Understanding form, the MAP-4096, the ABI Recipient's Admission Discharge DCBS Notification form, the MAP-24B, a Freedom of Choice of Home and Community Based Waiver Service Providers form, the MAP-4102, the initial thirty (30) day Individual Support Plan MAP-072. Evaluation of the individual occurs during the first thirty days of service and any necessary revisions to the MAP-072 are to be completed and submitted to the Quality Improvement Organization (QIO) within thirty (30) days of initiation of services for continued prior authorization of services. The individual support plan must provide details of the personal needs identified in the planning process (including any health and safety/risk factors), the type and amount of each waiver service chosen by the individual to meet their support needs, the provider chosen for each service, non-waiver services to be provided, emergency back-up plan, personal outcomes and the specific service and training objectives to be implemented. Addendums to the MAP-072 are to be submitted by the Case Manager or Support Broker within fourteen (14) days of any change in support needs or choice by the individual for review and prior authorization. Based upon review of the MAP-072 additional documentation may be requested to ensure appropriateness of the support plan. Additional information that is requested includes service assessments and documentation of past service provision. QIO tracks and submits monthly summary reports to DMS reflecting total number of MAP-072's reviewed. DMS or designee reviews a percentage of member records on site to ensure appropriate approval and implementation of individual support plans.

DMS provides training and technical assistance to ABI providers regarding the person-centered planning process, completing and modifying the individual support plans.

Monitoring of the support plans includes ensuring all needs of the participants are met by appropriate interventions or services. This includes the coordination of non-waiver services as well. The Case Manager is responsible for facilitating the planning process, education, referral and coordinating community resources to meet the participant's needs by:

- Ensuring all activities documented meet the service definitions of the waiver;
- Ensuring the services are provided in accordance with the approved MAP-072;
- Ensuring participants are involved in the care planning process and have freedom of choice in their service provision.

ABI providers are required to maintain detailed documentation of the decision making process during the planning meeting and to provide a complete listing of providers to allow participant choice of any certified provider. Through on site monitoring of the ABI waiver providers DMS ensures: that an individual assessment is conducted to ensure medical necessity for waiver services; all required eligibility information is completed and maintained in each individual's record; monitors appropriateness and implementation of the individual support plan; and monitors documentation is maintained to ensure the member has been fully educated regarding options available and assisted to have freedom of choice and decision making authority. The monitoring occurs through review of the member's clinical record during on site provider certification surveys conducted at least annually. DMS maintains a database to track all provider certification surveys, all technical assistance provided to providers and all complaints received regarding problems with service providers or service provision. Based on findings of surveys, site visits and the prior authorization review process, DMS facilitates additional planning meetings as needed to ensure revision of plans found to be deficient. Comprehensive trainings focus on person-centered planning, self-determination, values and rights of the member.

Participant Rights and Responsibilities:

All ABI members are informed of their rights and responsibilities at the time of initial assessment and annual reassessment. This information is documented and maintained by the ABI provider in the member clinical record. This information is reviewed at least annually by DMS or designee during certification surveys and also reviewed during investigations related to this area. DMS also monitors on site during reviews.

ABI members are provided written appeal rights anytime there is an adverse

action initiated. These appeals are held timely and fair hearing procedures are exercised through the Administrative Hearings Branch. DMS tracks and trends all appeals to identify criteria or regulatory language requiring modification.

ABI providers are required to implement procedures to address member complaints and grievances. The providers are required to educate all members regarding this procedure and provide adequate resolution in a timely manner. The provider grievance and appeals are monitored by DMS or designee through on site monitoring during surveys, investigations and technical assistance visits. Complaints and grievances received by DMS or designee are tracked for trending and to determine if additional action is needed to resolve the issue.

Provider Capacity and Capabilities:

The ABI program offers statewide coverage to members. ABI providers are required to enroll through DMS provider enrollment and are then certified by DMS or designee prior to DMS final approval to initiate provision of waiver services. If the agency also operates a group home, it is first licensed by the Office of Inspector General (OIG) and then also certified by DMS or designee as an ABI waiver provider to ensure all waiver requirements and staff qualifications for service provision are met.

DMS or designee conducts an initial pre-service survey, a follow up survey within thirty (30) days of initiation of service provision and recertification surveys at least annually thereafter for all ABI providers. Providers are monitored to ensure continued compliance with the regulatory requirements and CMS Quality Protocol. The completed certification tool and notice of length of certification is maintained by DMS. The certification tool is broken down by category based on the CMS protocol.

The length of certification is determined through this analysis of certification survey findings and is based on overall volume of deficiencies cited, historical deficiencies from previous surveys or investigations, and analysis of incident management reports. DMS or designee renders additional sanctions including contingencies with limited timeframes for correction, shortened certification lengths, moratoriums on new admissions and even recommendations for termination of their certification and participation as a provider. DMS conducts monitoring of Plans of Correction submitted by the provider in response to survey or investigation findings to ensure implementation of the approved plan of correction and compliance with the regulatory requirements.

All complaints regarding certification violations are tracked and investigated by DMS or designee. Copies of all investigation reports are forwarded to DMS upon completion as well as any deficiency letters sent to providers as a result of the investigation. The Office of Inspector General has a toll-free telephone number for the "Medicaid Fraud Hotline" to report any complaints or regulatory

violations. These reports are all reviewed for investigation.

DMS has a full time staff person designated to new provider recruitment and orientation for new provider applicants to provide information regarding the waiver regulatory requirements; the certification process; the person centered planning process, rights, values, dignity and respect; and to provide technical assistance throughout the certification process. New provider applicants are provided a Provider Handbook which contains resource material to assist them with enrollment and certification and on-going ability to meet the waiver regulatory requirements.

DMS staff conduct monitoring to ensure surveys and investigations are completed timely and waiver requirements are being met throughout the process.

Participant Safeguards:

The state assures that providers safeguard the health, safety and welfare of participants through multiple activities. The case managers are also responsible to continuously monitor safety and risk factors for the member and to develop and revise the emergency back up plan to address any matters of concern regarding the member's ability to remain in the community setting. The case manager is responsible for ensuring the member has access to him/her and emergency contact information twenty-four hours per day/ seven days per week. The case manager is required to have at least two face to face visits with the member each month and monitor each service the member is receiving. In addition, providers are required to have written plans to address service provision in the event of natural disasters and other public emergencies. These plans are reviewed at least annually through the DMS or designee on-site surveys, and during investigations of incidents and complaints.

ABI providers are required to adhere to state-mandated reporting laws for incident management and reporting of any allegations or suspected abuse, neglect or exploitation. All provider direct care staff are trained in prevention, identification, and reporting of abuse, neglect and exploitation. The state incident management system requires waiver providers to complete and submit the required incident report form and have a process in place for investigation, communication and prevention of incidents within specified timeframes. DMS staff review all Class I incidents involving medication errors, Class II and Class III incident reports within twenty-four hours of receipt. Other Class I incident reports that are not required to be submitted to DMS, are required to be maintained in the record at the provider site. These are reviewed by DMS during certification surveys, monitoring visits and investigations to ensure classification, agency follow-up and reporting requirements are all being met. All incident reports submitted to DMS are logged and tracked in the Incident Management database and quarterly reports are reviewed to identify any trends or patterns that need to be addressed. As staff review incidents submitted, any issues needing

immediate action are assigned for investigation or to a designated DMS person for the particular provider to address through technical assistance with the provider agency within specified timeframes. Priority areas of the analysis include abuse, neglect, exploitation, medication errors and emergency restraint use. Additionally, Kentucky Adult Protective Services staff provides quarterly training for providers regarding the statutory reporting requirements, identification and prevention of abuse, neglect and exploitation. Joint investigations are conducted when possible with the Adult/Child Protective services staff on any allegation or suspicion of abuse, neglect or exploitation. When indicated, management meetings are held with the Kentucky Adult Protective Services and State Guardianship staff to collaboratively address preventive measures for abuse, neglect and exploitation and to monitor effectiveness of the system. Serious incidents are reviewed and utilized for trending and development of Department wide prevention strategies and specific training initiatives for both clinical and non-clinical staff.

ABI waiver providers are required to have a complaint process in place and to educate waiver members, family members, and legal representatives regarding this process and how to utilize the grievance process with the agency. The DMS staff log and track all complaints received regarding the waiver program.

Participant Outcomes and Satisfaction:

DMS or designee conducts participant Satisfaction/Quality surveys through face to face meetings with participants during home visits and provider certification surveys at least annually. Interviews may also be conducted by telephone. If it is not possible to interview the participant, DMS staff interviews the guardian. Findings from these surveys are shared with and addressed through technical assistance with the provider. Providers are required to address any deficiencies identified through Plans of Correction, which are then monitored by DMS staff to ensure implementation of corrective actions.

System Performance

Administrative Authority:

Through analysis of data obtained from the above-mentioned tools, DMS modifies existing systems and trainings to ensure continuing quality and satisfaction. DMS routinely reviews all reports to identify changing trends so that proactive modifications may be implemented to ensure continuing quality care. Based on the continuing analysis of the system, DMS initiates any needed revisions to the governing regulation. DMS provides policy clarifications to the ABI waiver providers to ensure appropriate implementation of program policy and understanding of any programmatic or regulatory revisions as they occur.

Financial Accountability:

The State assures claims are coded and paid in accordance with the reimbursement methodology System (MMIS) and reviewed periodically for program compliance and as policy is revised, to ensure claims are not paid erroneously. DMS staff or designee monitor the fiscal accountability of waiver providers through performing post payment audits of claims. DMS conducts at least annual post payment billing reviews of each provider agency to identify billing errors. Furthermore, such reviews ensure that proper documentation is maintained by the provider and support that services have been provided in accordance with the approved individual support plan and service definition . Additional billing reviews are conducted based on issues identified during certification surveys or investigations.

The DMS Fiscal Agent provides on-going training and technical assistance to waiver providers regarding submission and resolution of claims as requested. This training can include formal training sessions, one-on-one training or technical assistance. The DMS Fiscal Agent also provides training and assistance to providers regarding billing requirements or issues identified related to billing.