CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

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September 20, 2018

Greetings –

The Department for Medicaid Services (the Department) is excited to present Navigant Consulting's assessment report of Kentucky's 1915(c) Home and Community Based Waiver Redesign. This report includes Navigant's recommendations for improving the Waiver program based on months of evaluation, extensive stakeholder input, and a thorough assessment of the Department's processes and data. Please also know that the report contains a brief Executive Summary for your review and consideration.

The Department will use this report to help determine which program changes to implement. Prior to making final decisions, we are seeking and greatly value input from our stakeholders. You can share your comments on Navigant's full report by emailing medicaidpubliccomment@ky.gov, by calling Misty Peach with the Division of Community Alternatives at (502) 564-7540, or by sending a letter to the following address:

Department for Medicaid Services
Division of Community Alternatives
275 E. Main Street 6W-B
Frankfort, Kentucky 40621

The Department will have additional opportunities for stakeholders to ask questions and have their comments heard. We will provide more information on those opportunities in our response to the report, which we expect to release very soon.

Once again, thank you for your continued involvement in this process. We look forward to your feedback and in working together to create improved 1915(c) Home and Community Based Waiver programs in Kentucky.

Most sincerely,

Jill R. Hunter

Jill R. Hunter
Senior Deputy Commissioner

NAVIGANT

1915(c) Home and Community-Based Services Waiver Redesign Assessment

Recommendations Report

Commonwealth of Kentucky

Cabinet for Health and Family Services

August 20, 2018

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Table of Contents

Executive Summary 1

Chapter 1: Assessment Background and Methodology 15

1.1 The Cabinet's Charge and Navigant's Role 15

1.2 Assessment Goals 16

1.3 Establishing Assessment Methodology 16

1.4 Program and Policy Assessment Method 18

1.5 Organizational and Operational Assessments Method 21

1.6 Stakeholder Engagement Method 27

Chapter 2: Overview of HCBS Programs Nationwide 32

2.1 National Profile of HCBS Waiver Programs 32

2.2 Waiver Authorities, Application, and CMS Approval Process 36

2.3 Growth in HCBS Programs and Rebalancing LTSS 39

Chapter 3: Profile of Kentucky's 1915(c) Waiver Programs 51

3.1 Kentucky Demographics 51

3.2 Profile of Kentucky's Medicaid Program 55

3.3 Profile of Kentucky's 1915(c) Waivers 58

3.4 Cabinet Organizational Structure for Administration and Oversight of 1915(c) Waiver Programs 62

Chapter 4: Summary of High-Impact Policies and Considerations for HCBS Programs 65

4.1 The Olmstead Ruling of 1999 65

4.2 HCBS Settings Rule of 2014 67

4.3 Expansion of the Participant-directed Service Model 73

4.4 Conflict Free Case Management (CFCM) Regulations 77

4.5 Provider and Direct Service Provider Shortages 78
4.6 Increased Focus on HCBS Assessment Tools and Practices 80
4.7 Increased Focus on HCBS Quality 82
Chapter 5: Assessment Findings 84
5.1 Listing of Assessment Findings 84
5.2 Assessment Limitations 118
Chapter 6: Recommendations 122
6.1 Introduction to Recommendations 122
6.2 Recommendations 125
Recommendation 1 – Standardize and Revise Waiver Applications and Waiver Related KAR 125
Recommendation 2 – Adopt a Universal Assessment Tool 131
Recommendation 3 – Implement an Individual Budgeting Methodology 141
Recommendation 4 – Update the Rate Setting Methodology Across Waiver Programs 151
Recommendation 5 – Develop Standard Operating Procedures 160
Recommendation 6 – Strengthen Case Management Systems 165
Recommendation 7 – Streamline Participant-directed Service Delivery 176
Recommendation 8 – Centralize Operation and Oversight within DMS 185
Recommendation 9 – Improve Stakeholder Engagement 191
Recommendation 10 – Implement a Quality Improvement Strategy ... 200
Recommendation 11 – Conduct Waiver Reconfiguration Analysis 209
Chapter 7: Next Steps 218

7.1 Immediate Action Steps for the Cabinet 218

7.2 Sequencing and Timing Considerations Related to Phase I and Phase II Recommendations 218

Appendix A Summary of Key Interview Themes

Appendix B Workflow Solution Summaries

Appendix C Focus Group Themes Report

Appendix D DMS Organizational Chart

Appendix E Current 1915(c) Waiver Service Limitations

Appendix F Payment and Rate Study Provider Letter

Appendix G Recommendation Implementation Activities

Appendix H Matrix of Findings Supportive of Navigant Recommendations

Executive Summary

Kentucky currently operates six Home and Community-Based (HCBS) waivers to support over 33,000 individuals in the Commonwealth receiving services in home and community-based settings. However, there is a growing demand in Kentucky for these waivers services with more than 8,800 individuals on waiting lists. In an effort to more effectively utilize state resources and address the growing demand for these services, the Cabinet realized the need to carefully examine its options and plan for the future delivery of Long-Term Services and Supports (LTSS) needs of those in the 1915(c) waiver programs adopting strategies to further promote and support improved outcomes for those served. In addition to the internal drive to focus on efficiency and effectiveness of the HCBS programs, current federal oversight and rules impacting the HCBS environment amidst ongoing Medicaid reform also point to the need to examine current program infrastructure.

Recognizing these pressures and the need for reform, the Cabinet for Health and Family Services (CHFS or "the Cabinet"), Department for Medicaid Services (DMS), engaged Navigant Consulting, Inc. ("Navigant") to assess existing program operations and identify options for innovative redesign of the Commonwealth's six 1915(c) waivers. After concluding its assessment of the waiver programs, Navigant is providing this Recommendations Report, in which Navigant provides actionable recommendations to address each of the Cabinet's stated priorities and goals for this engagement.

Cabinet Priorities and Goals

The Cabinet adopted ten goals for this assessment which became the guiding principles throughout Navigant's process. The Cabinet prioritized those goals in the following order of importance:

Priority	Goal
Must Have	Be feasible to implement within timeline and budget
1	Enhance quality of care to participants
2	Maximize consistency in definitions and requirements across waivers
3	Implement a universal participant assessment and individualized budgeting methodology
4	Curb preventable increases in total spend for HCBS programs
5	Establish procedures for all waiver management administration activities
6	Diversify and grow provider network
7	Design services that address participants' community-based needs, including populations who are under-served or not served by today's waivers

Priority	Goal
8	Make provider funding consistent with reasonable and necessary HCBS program costs
9	Optimize case management to support person-centered planning and abide by conflict free case management regulation

Recommendations

To develop its recommendations, Navigant interviewed over 30 Cabinet staff members, reviewed multiple Cabinet workflows, conducted 40 focus groups, and participated in ten town hall forums throughout the Commonwealth to gain a comprehensive understanding of the most challenging issues facing participants, providers, and the Cabinet. Navigant offers the following recommendations:

No.	Navigant Recommendation
1	Standardize provider qualifications, service definitions and waiver operations across 1915(c) waivers when appropriate, including waiver-specific regulations to be promulgated in KAR.
2	Move to needs-based care planning with a universal assessment tool, completed by an independent entity using a uniform operational approach across waivers, with electronic capture and data management of assessment information.
3	Implement a prospective, data-driven individualized budget process, using an algorithm that quantifies participant needs based on information obtained through assessment, establishing a budget the participant can use on a monthly or annual basis to obtain waiver services.
4	Develop a sound rate-setting methodology, informed by a study of the reasonable and necessary costs incurred by providers to serve waiver participants.
5	Develop standard operating procedures using a standardized template across the Cabinet, to include as part of a training program for Cabinet staff responsible for administration and oversight of the 1915(c) waivers.
6	Update and enhance the case management approach for HCBS waivers, implementing updated tools, strengthened performance standards and training that better reinforces and supports case managers.
7	Streamline participant-directed service (PDS) delivery by reducing operational disparity between fiscal management agency (FMA) operations and strengthening program policies and procedures.

No.	Navigant Recommendation
8	Consolidate HCBS waiver operations and oversight under one quality management business unit within DMS to centralize decision-making authority and responsibility.
9	Implement an ongoing, formal stakeholder engagement process to engage all types of stakeholders who may be affected by the Cabinet's HCBS policy and operations and to improve the use of advisory committees, including but not limited to the Technical Assistance Committees (TACs) and Medicaid Advisory Committee (MAC).
10	Implement a quality improvement strategy (QIS) for the 1915(c) waivers to increase emphasis on improving service outcomes and participant experience.
11	Conduct a future assessment of the need for waiver reconfiguration, once aforementioned recommendations are implemented and reviewed for effectiveness.

Overview of Recommendations

Below is a brief description of each recommendation, the anticipated results should the Cabinet implement, and the related Cabinet goals the recommendation addresses. Chapter 6: *Recommendations* includes more detailed information regarding each recommendation.

No.	Recommendation Description	Anticipated Results	Related Cabinet Goals Addressed
1	Navigant recommends ***revising language contained in the 1915(c) waiver applications to streamline and improve waiver operations***. Navigant recommends a coordinated approach between DMS and sister agency teams to develop the content of waiver amendments to maximize consistency in language and content across waivers. This process should incorporate best practice revisions proposed during policy review assessment activities. To the extent the waiver language serves unique disability groups with specialized needs, Navigant recommends retaining and leveraging waiver language tailored to respective populations and services within each waiver.	This recommendation would result in administrative efficiencies through alignment of terminology, provider qualifications, and service definitions across the 1915(c) waivers. This recommendation would also result in streamlined KAR, by reducing the emphasis within the regulations on operational protocols and regulatory interpretations, and by moving operational requirements into provider manuals and operating procedures to be referenced in the KAR – thus allowing the Cabinet to operate more nimbly.	• Maximize consistency in definitions and requirements across waivers • Establish standardized procedures for all waiver management administration activities • Design services that address participants' community-based needs, including populations who are under-served or not served by today's waivers • Optimize case management to support person-centered planning and abide by conflict free case management regulation
2	Navigant recommends the Cabinet ***implement a validated universal assessment tool that contains sub-sections to assess the unique needs of specific populations with disabilities*** (e.g., individuals who have ABI, individuals who have ID/DD, individuals under 18, etc.) In addition,	This recommendation would result in more consistent and comprehensive collection of needed information that would better inform service planning and allow for a better overall understanding of the 1915(c) waiver	• Enhance quality of care to participants • Implement a universal participant assessment and individualized budgeting methodology

No.	Recommendation Description	Anticipated Results	Related Cabinet Goals Addressed
	the Cabinet should adopt a standard approach to independently assess participants, using conflict-free entities. To support the selection and implementation of a universal assessment tool, Navigant recommends appointing an advisory panel of external stakeholders to recommend which tool may be the best fit for the Commonwealth's needs.	participant's needs. Further, this exercise is a building block for evaluation and development of improved budgeting of PDS care plans.	• Curb preventable increases in total spend for HCBS programs • Design services that address participants' community-based needs, including populations who are under-served or not served by today's waivers • Make provider funding consistent with reasonable and necessary HCBS program costs
3	Navigant recommends the Commonwealth's ***individualized budgeting method be based upon algorithms that produce a budget based upon a set of characteristics known to influence service utilization*** (e.g., age, medical conditions, ambulatory status, ADL status, cognitive impairment, etc.). The methodology would account for these variables *and* factor in historical costs.	This recommendation would result in a data-driven, objective approach to assigning waiver resources to a participant based on their individually assessed needs. This data-driven approach would promote transparency in how the Commonwealth establishes budgets and how changes in a participant's needs may prompt changes to a participant's budget. An improved budgeting methodology could lead to more efficient and effective allocation of resources.	• Enhance quality of care to participants • Curb preventable increases in total spend for HCBS programs • Design services that address participants' community-based needs, including populations who are under-served or not served by today's waivers • Implement a universal participant assessment and individualized budgeting methodology
4	Navigant recommends the Cabinet ***conduct a comprehensive rate study for all HCBS waiver***	This recommendation would result in a more transparent rate setting and	• Enhance quality of care to participants

No.	Recommendation Description	Anticipated Results	Related Cabinet Goals Addressed
	services. The study would focus on developing rates that are consistent with the efficiency, accessibility and the quality of care standards federally required by U.S.C. Section 1396a (a)(30)(A) and updating payment practices to align with the reasonable and necessary costs to provide HCBS services. The study should include a provider cost and wage survey, opportunities for further provider engagement, provider and program data analysis, and financial modeling to establish a rate-setting methodology for CMS review. This study would need to consider the funding of any newly developed rates including state budget constraints.	payment methodology. The study would provide the Cabinet with a foundation with which to conduct ongoing analyses to determine if rates warrant future adjustments. This would also potentially result in diversification and growth in the HCBS provider network, along with enhanced quality of care.	• Diversify and grow provider network • Make provider funding consistent with reasonable and necessary HCBS program costs
5	Navigant recommends for all operational responsibilities pertaining to HCBS waiver oversight, ***establishing standard operating procedures (SOPs) to be owned, maintained and operated by the Division of Community Alternatives.*** SOPs should contain clear, actionable steps for responsible parties to undertake, as well as timelines for accomplishing each step. SOPs should also include any documentation or associated resources that responsible parties would consider useful in performing tasks. For processes requiring coordination between DMS, DBHDID, and DAIL, Navigant recommends that procedures include	This recommendation would result enhanced efficiency and customer service to internal and external stakeholders, and would establish more consistent, transparent approaches to waiver administration. If included as part of future Cabinet staff training, SOPs will support onboarding of new staff and reduce “ramp-up” time when staff transition to new positions.	• Enhance quality of care to participants • Establish procedures for all waiver management administration activities

No.	Recommendation Description	Anticipated Results	Related Cabinet Goals Addressed
	clear delineation of responsibilities by Department and individual, to promote alignment and avoid duplication of tasks. Once developed, the Cabinet should leverage SOPs as part of a broad training program that would solidify and strengthen workflows across the Cabinet and assist with onboarding of new staff.		
6	Navigant recommends ***improving case management services offered to wraparound participants on 1915(c) waivers, by applying performance standards that drive how services are delivered.*** These performance standards, coupled with requirements set forth for person-centered planning defined in CMS' HCBS Settings Rule of 2014, would drive a foundational restructuring of case management support and oversight for both traditional, blended, and participant-directed case management services.	Navigant anticipates clearer requirements to govern case load sizes that the Cabinet can monitor to assure that case managers have an appropriately sized case load. Additionally, Navigant anticipates clearer performance standards and objectives for case management delivery, including for the Cabinet, for case management providers and for participants, their natural supports and other external stakeholders.	• Enhance quality of care to participants • Maximize consistency in definitions and requirements across waivers • Optimize case management to support person-centered planning and abide by conflict free case management regulation
7	Navigant ***recommends strengthening Kentucky's PDS program through a blend of policy clarifications.*** Navigant recommends the Cabinet better define several program elements, including: who is eligible to self-direct, who is eligible to be a PDS employee, updating employee background checks, implementing a PDS employee	This recommendation would result in support of the Cabinet's commitment to PDS and the participants they serve by providing more guidance to participants, natural supports and FMAs that may streamline the PDS program. Navigant's recommendation	• Enhance quality of care to participants • Maximize consistency in definitions and requirements across waivers • Design services that address participants' community-based

No.	Recommendation Description	Anticipated Results	Related Cabinet Goals Addressed
	registry, and strengthening FMA contracts and oversight.	emphasizes the balance between flexibility intended for self-direction and oversight by the Commonwealth to monitor appropriate use of the PDS option, as heard by stakeholders.	needs, including populations who are under-served or not served by today's waivers
8	Navigant recommends the Cabinet ***consolidate leadership of waiver operations and administration currently spread across DMS, DBHDID, and DAIL, by creating a single business unit within DMS that is responsible for decision-making related to provider and service monitoring and oversight***. The business unit should focus on overall quality management, accountabilities for delivering quality care, and creation of consistent and accurate processes for HCBS waiver administration, while reducing duplication of effort.	This recommendation would result in a single, accountable business unit within the Cabinet with operational responsibility and allow leadership to more effectively promote consistent, effective initiatives across all waivers. This would also result in establishing unified procedures for all waiver management administration activities.	• Enhance quality of care to participants • Establish procedures for all waiver management administration activities
9	Navigant recommends the Cabinet ***develop a long-term strategy for ongoing, meaningful stakeholder engagement*** including a full range of stakeholders. External stakeholders should be involved, informed, and encouraged to provide their insights and recommendations to DMS and the Cabinet. Navigant recommends implementing strategies, including improved communications via written and in-person engagement, along with	This recommendation would result in improved ongoing communication and stronger relationships between the Cabinet and waiver stakeholders. This would help engage under-represented or disengaged stakeholders and offer ongoing opportunities to provide input into and receive education about HCBS design and delivery.	• All 10 of the Cabinet's goals would advance through implementation of this recommendation

No.	Recommendation Description	Anticipated Results	Related Cabinet Goals Addressed
	optimization of how the Cabinet engages MAC, TACs, and other boards and organizations in program design, evaluation, and decision-making. Finally, Navigant encourages the Cabinet to improve the representation of waiver participants, their natural supports, and other stakeholder types beyond providers into TACs, to further assure diversity in stakeholder input and engagement.	Participants' input would be essential to educate and guide the Cabinet to drive long-term improvements in participant outcomes.	
10	Navigant recommends that the ***Cabinet develop and execute a comprehensive HCBS quality improvement strategy*** that sets forth a plan for achieving the Cabinet's goals.	This recommendation would result in implementation of a comprehensive HCBS quality improvement strategy that would drive cultural change within the Cabinet, as well as in the way the Cabinet interacts with external stakeholders. The Cabinet's quality management activities would focus on systems improvement as opposed to solely on compliance. Ultimately, these quality management activities would improve the participant experience through improved quality of care and quality of life.	• Enhance quality of care to participants • Maximize consistency in definitions and requirements across waivers • Curb preventable increases in total spend for HCBS programs
11	Navigant recommends that the Cabinet ***conduct future analysis of the Commonwealth's waiver configuration***. Navigant recommends the Cabinet first implement Recommendations 1 through 10,	This analysis would determine the reconfiguration options most likely to achieve redesign goals while	• Enhance quality of care to participants • Diversify and grow the provider network

No.	Recommendation Description	Anticipated Results	Related Cabinet Goals Addressed
	which are referred to as the Phase I recommendations. Upon completion of Phase I recommendation implementation, the Cabinet should initiate work on the Phase II recommendation.	considering the unintended negative outcomes and minimizing risk.	• Curb preventable increases in total spend for HCBS programs • Design services that address participants' community-based needs, including for populations who are under-served or not served by today's waivers

Assessment Focus Areas

The Cabinet outlined the following considerations for Navigant as part of this assessment and as intended outcomes of LTSS redesign:

1. Better serve waiver participants
2. Better support providers in delivering quality care
3. Improve the overall administration of the 1915(c) waivers

These three considerations continue to serve as the foundation for Navigant's assessment and remain at the forefront of all of Navigant's underlying recommendations. To deliver on these considerations, the Cabinet charged Navigant with three focus areas for this assessment:

Operational Redesign | **Waiver Redesign** | **Stakeholder Engagement**

Operational Redesign

Navigant's focus on operational redesign included assessing areas for improvement *within* the Cabinet, i.e., the business processes and overall administration of the 1915(c) waivers. Assessment focuses in this area included:

- Organizational structure of DMS and its sister agencies, the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID), and the Department for Aging and Independent Living (DAIL)
- Workflows and communications between DMS, DBHDID, and DAIL and with program stakeholders
- Existing policies and procedures to govern how Cabinet staff perform their work
- Compliance and quality improvement oversight
- Tools and resources available to Cabinet staff to conduct administration activities

Waiver Redesign

Navigant's focus on waiver redesign included assessing areas for improvement within the Cabinet's waiver application for each of the six 1915(c) waivers. The assessment included an appendix-by-appendix examination across each of the waiver applications to evaluate:

- Consistency of waiver terminology, including provider and service definitions
- Similarities (and differences) of services offered across HCBS waivers
- Program administration and monitoring process descriptions

Stakeholder Engagement

Navigant's focus on stakeholder engagement included assessing areas for improvement in how the Cabinet promotes transparency and engages both internal and external stakeholders in program design and administration. Assessment focuses in this area included:

- Compliance with federal requirements on stakeholder engagement
- Frequency and type of stakeholder engagement opportunities the Cabinet offers stakeholders
- Ways in which the Cabinet incorporates stakeholder feedback into waiver design and program operations

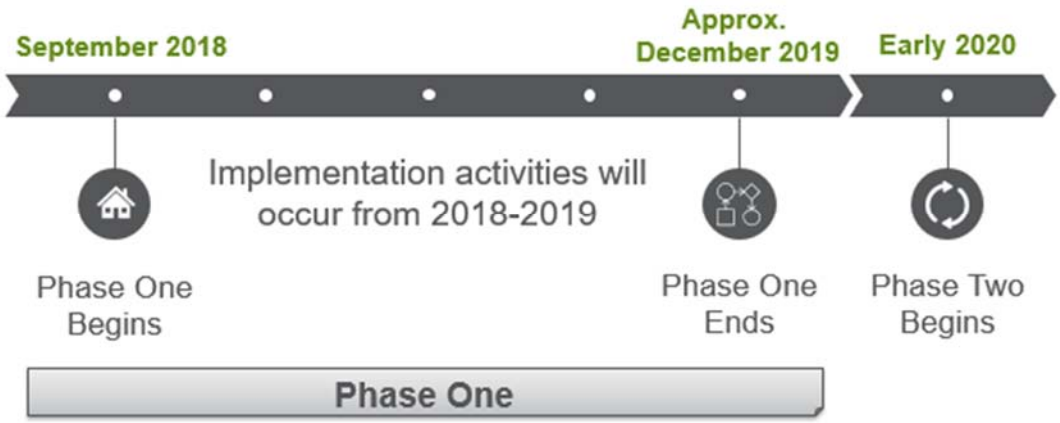
Collectively, these three focus areas constitute Phase I of Navigant's assessment of the 1915(c) waivers.

Timeline for Implementation

Navigant recommends the Cabinet first implement Recommendations 1 through 10, which are referred to as the Phase I Recommendations. These Phase I Recommendations address areas for improvement in design, administration, and operation of the existing 1915(c) waivers and does not suggest any change to the number of waivers or the populations served.

Upon completing implementation of selected Phase I recommendations, the Cabinet should then consider initiating Phase II to assess the need for waiver reconfiguration and/or a change in delivery models from the existing fee-for-service approach, which would include consideration of transition to a managed long-term services and supports (MLTSS) model. Navigant recommends the proposed timeline below for this two-phased approach to implement Navigant's recommendations. Navigant proposes the Cabinet complete implementation of selected Phase I recommendations by approximately the end of calendar year 2019, so the Cabinet can initiate Phase II in early 2020. The Cabinet may have competing priorities and resource constraints that pose challenges to implementing all ten Phase I recommendations within the timeline proposed. As such, the Cabinet should carefully consider which recommendations are most feasible to complete and will have the greatest impact on their goals, as outlined in Chapter 1.2: *Assessment Goals*.

Timeline for Implementation



Whether the Cabinet accepts all ten Phase I recommendations, or a subset of the recommendations, the Cabinet must carefully sequence implementation in way that recognizes the interdependencies that exist among recommended changes. For example:

- Many Phase I activities will need to be documented in waiver applications that must be submitted to CMS for review and approval, which may take up to six months for approval.
- Development of a universal assessment tool would impact the development of the individualized budgeting methodology.
- Changes to payment and rate methodology would impact the development of an individualized budgeting methodology reflective of utilization costs.
- Improved functional assessment data obtained via electronic storage would help inform the selection of quality improvement strategy measures and would vastly improve the Cabinet's ability to measure outcomes.

This is only a small sample of identified inter-dependencies that will need to be considered by the Cabinet when selecting Phase I recommendations for improvement and planning a coordinated implementation. Many recommendations are interdependent, and the Cabinet will need to consider whether any recommendations partially implemented or not selected may in turn influence the ability to advance those recommendations that are selected.

Navigant recognizes there are existing resource constraints within the Cabinet and specifically DMS, which is actively undertaking additional initiatives outside of improving 1915(c) waiver programs. These initiatives include work related to implementing the 1115 Kentucky Health waiver program, updating DMS' Medicaid Management Information Systems (MMIS), all while managing the demands of day-to-day operations on existing staff and program resources. Given these constraints, the Cabinet can modify the extent to which it implements recommendations, including a longer timeline with phased improvements, or piloting significant changes on a smaller, more focused scale as needed to promote success with whatever changes are selected

for implementation going forward.

Navigant would highlight certain recommendation components that offer early opportunities for improvement that can be feasibly implemented with minimal interdependency, including:

- Standardizing terms and definitions within 1915(c) waivers, and training internal and external stakeholders on updated terms, definitions and new more consistent approaches across waivers.
- Centralizing quality management of current program operations to better align responsibilities across DMS, DAIL and DBHDID using standard operating procedures to ease operational processes and overall organization.
- Updating quality management practices across services and waivers related to annual certification, desk reviews, critical incident investigation and the development, issuance and monitoring of corrective action plans all monitored using defined performance standards that can be shared with internal staff, Cabinet leadership and the Legislature to monitor operational outcomes.
- Optimizing case management by improving Cabinet oversight of person-centered tools and templates, while offering improved technical assistance and training to case management providers.
- Clarifying PDS-related policy and implementing new PDS tools and participant supports to improve the PDS delivery model.
- Completing a study to develop a rate methodology informed by providers' reported costs.
- Begin the process of incorporating ongoing quality improvement processes into the Cabinet's management and oversight approach.
- Enhancing stakeholder engagement practices through a thoughtful engagement strategy to obtain meaningful stakeholder input into program design and decision-making.

Chapter 1: Assessment Background and Methodology

This chapter describes the background of the 1915(c) Home and Community-Based Waiver (HCBS) Redesign assessment, along with Navigant's methodology to meet the Cabinet's goals for the assessment.

1.1 The Cabinet's Charge and Navigant's Role

The Cabinet's Charge

Kentucky operates six 1915(c) waiver programs designed to offer long-term services and supports (LTSS) to individuals in Kentucky Medicaid who qualify to receive these services in a home or community-based setting. As is common in other states, Kentucky developed each HCBS waiver individually as the HCBS program evolved and has never formally assessed the effectiveness and efficiency of the Medicaid agency's holistic administration and oversight of these HCBS waiver programs. As such, DMS sought an outside consultant to assess the Commonwealth's six 1915(c) waivers, including DMS's internal structure and administration, operating efficiencies, statutory timelines, reimbursement rates and opportunities for cost containment. The Cabinet released a competitive Request for Proposals (RFP) in February 2017, with an anticipated contractor start date of April 2017.

Navigant's Role

Through the Commonwealth's competitive procurement process, Navigant successfully bid to complete the following scope of work as defined in the RFP:

1. Evaluate the processes in place in the area of 1915(c) waivers and work to:
    a. Improve in service;
    b. Improve efficiency, including but not limited to, potential changes in internal structure and administration; and
    c. Improve cost effectiveness.
2. Provide support that includes the analysis, development, and implementation of fiscal/financial management processes, procedures and controls with focus on cost containment in the area of 1915(c) waivers.

To meet this scope of work, Navigant was charged with presenting recommendations to optimize the Kentucky 1915(c) waiver programs; including evaluating program oversight and administration, maintaining (or enhancing) quality of care, improving service delivery and participant and provider experience. This Recommendations Report outlines Navigant's assessment findings and recommendations for the Cabinet's consideration. The Cabinet retains all decision-making authority regarding Navigant's recommendations and, as outlined in Chapter 6: *Recommendations* and Chapter 7: *Next Steps*, will be responsible for determining whether and how to implement each recommendation.

1.2 Assessment Goals

At the start of the engagement, the Cabinet established goals for the 1915(c) waiver programs and prioritized that list of goals as shown in Figure 1.1. Navigant used this list of prioritized goals to guide its assessment and development of recommendations.

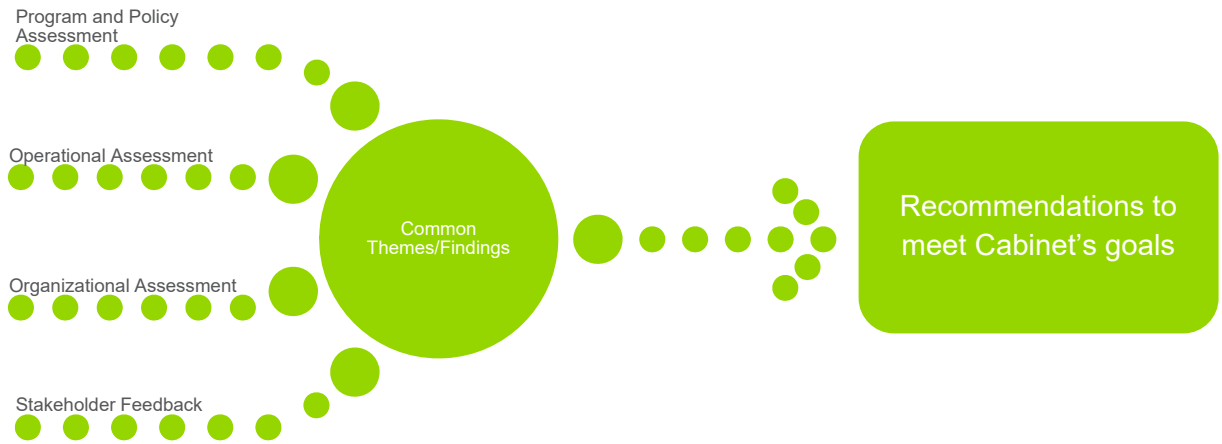
Figure 1.1 Cabinet of Health and Family Services' Goals for 1915(c) Waiver Programs

Priority	Goal
Must Have	Be feasible to implement within timeline and budget
1	Enhance quality of care to participants
2	Maximize consistency in definitions and requirements across waivers
3	Implement a universal participant assessment and individualized budgeting methodology
4	Curb preventable increases in total spend for HCBS programs
5	Establish procedures for all waiver management administration activities
6	Diversify and grow provider network
7	Design services that address participants' community-based needs, including populations who are under-served or not served by today's waivers
8	Make provider funding consistent with reasonable and necessary HCBS program costs
9	Optimize case management to support person-centered planning and abide by conflict free case management regulation

1.3 Establishing Assessment Methodology

Once the Cabinet established goals, DMS and the Navigant engagement team identified anticipated barriers to achieving those goals, followed by a development of a methodology to comprehensively assess the Commonwealth's current 1915(c) waiver programs. As depicted in Figure 1.2, Navigant identified four needed methodology components within the overall assessment, all of which have informed Navigant's recommendations in comprehensively understanding Kentucky's HCBS system, the challenges within it, and the opportunities for improvement.

Figure 1.2 Navigant Assessment Components and Recommendations



The four assessment components include:

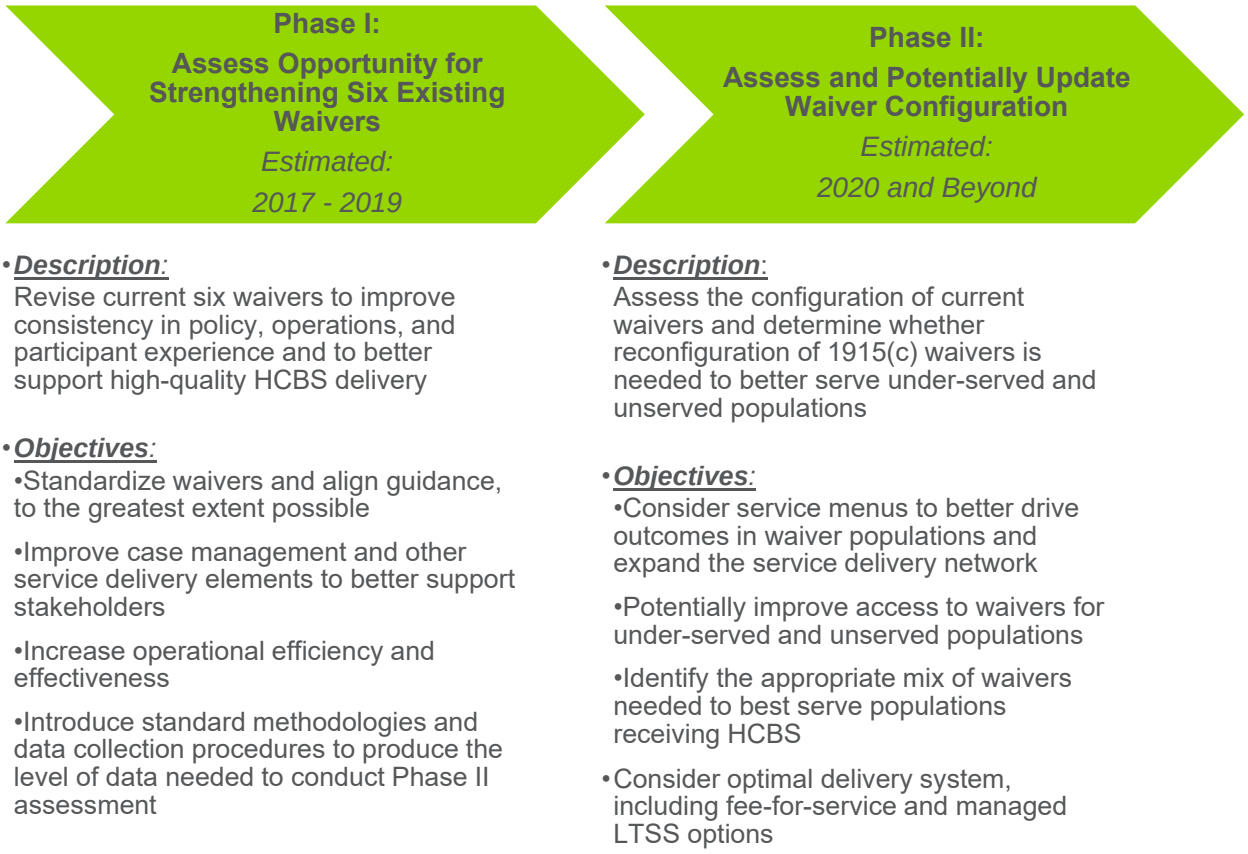
1. Program and policy assessment: Navigant identified early in the process that the contents of existing 1915(c) waiver applications and waiver-specific regulations are inconsistent, difficult to understand, and cumbersome for readers to navigate. Additionally, Navigant reviewed associated waiver assurances to determine if measures and data collection efforts reflected Cabinet goals and overall program direction. Navigant identified the need for a comprehensive review, including a line-by-line review of 1915(c) waiver applications, to examine how to streamline programs and improve the Cabinet's respective policies and Kentucky Administrative Regulation (KAR).
2. Operational assessment: Navigant identified the need to review existing procedural documentation that staff use to guide the monitoring and administration of the 1915(c) waivers. Navigant worked with Cabinet staff to collect and analyze existing standard operating procedures, handbooks, guides, and templates staff use to govern work and any inconsistencies in this documentation.
3. Organizational assessment: Navigant found that in many cases, the Cabinet departments operated in distinct siloes, independently overseeing the various HCBS waivers and operational responsibilities. These siloes and resulting disparity in approaches necessitated a review of existing Cabinet administration and organizational structure to oversee the waivers.

4. Stakeholder engagement: External stakeholders made clear to Cabinet leadership, DMS, and the Navigant team that substantial stakeholder engagement would be essential to any assessment the 1915(c) waivers and important to understand and reflect the experiences and perspectives of a wide array of stakeholders in Navigant's review and findings.

Establishing Assessment Phases

For the 1915(c) assessment, Navigant recommends a two-phased approach, illustrated in Figure 1.3, which lays out a logical sequence to optimize use of Cabinet resources, available data, and operational information. This approach also promotes a focused review of program progress, done in parts, as opposed to an overly comprehensive approach that may reduce the ability of the Cabinet to identify targeted changes and advance the goals established.

Figure 1.3 Overview of Assessment Phases: Description and Goals



1.4 Program and Policy Assessment Method

The 1915(c) waiver application requires states to describe how they will structure, implement and monitor HCBS programs. The CMS *Version 3.5 HCBS Waiver Application* has ten appendices (A – J), each of which addresses specific dimensions of waiver operations. Figure 1.4 includes a brief description of the waiver application design and appendices.

Figure 1.4 1915(c) Waiver Application Appendices[1]

Appendix Title	Description
Appendix A: Waiver Administration and Operations	Addresses the state agency responsible for the day-to-day waiver administration and operation, other contracted entities that perform waiver operational functions, and if applicable, local/regional entities that have waiver administrative responsibilities
Appendix B: Participant Access and Eligibility	Addresses the target group(s) of Medicaid participants that the waiver serves, its scope (i.e., how many individuals the waiver serves), and processes associated with entry into the waiver
Appendix C: Participant Services	Addresses the services provided in the waiver including: summary listing of services, general service specifications, specifications of *each* waiver service, and limitations (if any) which apply to the overall amount of waiver services specified
Appendix D: Participant-Centered Planning and Service Delivery	Addresses service plan development, implementation, and monitoring, including responsibility for service plan development, service plan development safeguards, supporting participants in the service plan development process, risk assessment and mitigation, etc.
Appendix E: Participant Direction of Services	Addresses how the waiver affords participants the opportunity to direct some or all of their waiver services
Appendix F: Participant Rights	Addresses how participants are afforded the opportunity to request a Fair Hearing, whether there is an alternate dispute resolution process available for participants to appeal decisions, and the system available to register grievances and complaints about their services
Appendix G: Participant Safeguards	Addresses safeguards to assure the health and welfare of waiver participants, including: response to critical events or incidents, safeguards concerning restraints and restrictive interventions, and medication management
Appendix H: Systems Improvement	Addresses the state's quality improvement strategy, waiver assurances, and measures and processes employed to correct identified problems
Appendix I: Financial Accountability	Addresses financial elements of HCBS waiver operations including: financial integrity, accountability, rates, billings, claims, payments, etc.
Appendix J: Cost Neutrality Demonstration	Addresses how the waiver will remain "cost neutral" each year the waiver is in effect and the basis for the estimates used in the cost neutrality calculation

[1]Application for a 1915(c) Home and Community Based Waiver. Version 3.5. January 2015. Available at: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/downloads/technical-guidance.pdf

To assess the Commonwealth's HCBS program and policy environment, Navigant reviewed Kentucky's current 1915(c) waivers, focusing on four areas:

- Inconsistency in waiver language across the six current HCBS waivers in Kentucky
- Incorporation of state and federal best practice approaches for waiver policy and program design, administration, and service design and delivery into waiver applications
- Review of HCBS waiver assurances to identify inconsistencies in measures across waivers
- Review of the KAR to examine opportunities to streamline contents, including comparative review of other states' regulations and waiver-related tools as referenced to Kentucky

Navigant began this assessment by comparing Kentucky's 1915(c) waiver applications appendix by appendix through comparison matrices. Figure 1.5 depicts a snapshot of an Appendix E comparison across waiver programs.

Figure 1.5 Example: Appendix E Policy and Program Assessment Comparison Matrix[2]

Kentucky HCBS Waiver Comparison Matrix – Appendix E: Participant Direction of Services

	ABI Acute	ABI Long Term	HCB	Michelle P	SCL
Applicability	**Yes. This waiver provides participant direction opportunities.**	**Yes. This waiver provides participant direction opportunities.**	**Yes. This waiver provides participant direction opportunities.**	**Yes. This waiver provides participant direction opportunities.**	**Yes. This waiver provides participant direction opportunities.**
Indicate whether Independence Plus designation is requested	No. Independence Plus designation is not requested.	No. Independence Plus designation is not requested.	No. Independence Plus designation is not requested.	No. Independence Plus designation is not requested.	No. Independence Plus designation is not requested.
E-1: Overview					
a. Description of Participant Direction.	Certain supports available within the ABI Waiver facilitate independence while decreasing the need for human assistance for individuals residing in their own home or the home of their family member. The supports include assistance, support (including reminding, observing, and/or guiding)	Certain supports available within the ABI Long Term Waiver facilitate independence while decreasing the need for human assistance for individuals residing in their own home or the home of their family member. The supports include assistance, support (including reminding	The Home and Community Based Services Transitions (HCBST) waiver program promotes personal choice and control over the delivery of waiver services by affording opportunities for participant direction. HCBST participants have the opportunity to direct some or all of their non-residential	The Michelle P. waiver (MPW) program promotes personal choice and control over the delivery of waiver services by affording opportunities for participant direction. MPW participants have the opportunity to direct some or all of their non-medical	The Supports for Community Living (SCL) waiver program promotes personal choice and control over the delivery of waiver services by affording opportunities for participant direction. SCL participants have the opportunity to direct some or all of their non-residential, non-medical waiver services

Using the comparison matrices, Navigant highlighted inconsistent language, gaps or opportunities for clarification across the six 1915(c) waiver applications. Navigant then identified opportunities for improvement based on comparison to policy design in other states. Navigant conducted this exercise for all the appendices listed in Figure 1.4 and compiled comments and questions for the Cabinet's consideration.

[2] Note that Model II Waiver is not included in the comparison matrix example because it does not offer PDS services. Model II Waiver was included in all other appendices that are applicable to the waiver.

Once Navigant reviewed for inconsistencies across waivers, Navigant reviewed the KAR regulations associated with each waiver. Navigant compared the applicable regulations to the language in each 1915(c) waiver application to identify inconsistencies between the KAR regulations and 1915(c) waiver applications and provided the Cabinet with a summary of its findings.

Navigant compiled the waiver assurances and accompanying waiver measures included in the 1915(c) waiver applications to identify ways to standardize measures across waivers and how to structure the measures support broader Cabinet goals for the HCBS programs. By grouping these measures, Navigant determined the degree of variation among measures and identified opportunities to streamline and standardize measures across waivers to ease the reporting burden for providers. Navigant also considered how standardizing measures could potentially support a Quality Improvement Strategy for the 1915(c) waiver programs.

1.5 Organizational and Operational Assessments Method

While the 1915(c) waiver applications and related regulations provide an HCBS framework, Navigant also needed to fully understand how the operationalization of this framework occurs. The assessment included an in-depth assessment of Cabinet operations, including assessment of the organizational structure of both DMS and waiver-designated operating agencies DAIL and DBHDID, also referred to as sister agencies.

To begin the organizational and operational assessments of operations and program administration, Navigant interviewed leadership and program staff in May and June 2017. Navigant conducted more than 30 interviews with individuals from the following departments to obtain an understanding of staff perspectives related to Kentucky's HCBS waivers:

- Department for Medicaid Services (DMS)
- Department for Behavioral Health, Developmental Disabilities and Intellectual Disabilities (DBHDID)
- Department for Aging and Independent Living (DAIL)
- The Cabinet's Office of the Ombudsman
- Kentucky Protection and Advocacy (P&A)

As a part of each interview, Navigant asked about staff roles and responsibilities and tasks associated with each operational area. Navigant sought to accomplish six overarching objectives as a part of the interview process, as described in Figure 1.6.

Figure 1.6 Objectives of Staff Interviews

Understand day-to-day operations and documented process work flows	Understand perceived operational strengths and weaknesses	Identify gaps in tools and resources available to staff
Review communication channels and practices	Gain staff perspective into key HCBS subject matter areas	Engage staff in solution development and collaboration

Navigant focused interview questions to better understand the efficiency and effectiveness of program administration (e.g., issue identification, chain of command, issue resolution) as well as program operations (e.g., the tools and resources staff have at their disposal to support monitoring and oversight). A sampling of interview topics covered include:

- Organizational structure for operations
- Standard operating procedures and current work flows
- Tools and technologies used or needed
- Internal and external communication patterns
- Staff training and development needs
- Best practices and opportunities for improvement
- Objectives for the future of HCBS waivers

As requested in the RFP scope of work, the Navigant interviews focused on the actionable steps the Cabinet can take to:

- Improve HCBS service design and delivery
- Improve efficiency, including but not limited to potential changes in internal structure and administration, as well as operational effectiveness within the Cabinet
- Improve cost effectiveness

Summary of Key Interview Themes

Navigant summarized key themes across all interviews in a report issued to engagement leadership and shared with the governance team in July 2017. This report can be found in Appendix A. Additionally, Navigant presented findings in-person to staff during an inter-departmental team meeting of Cabinet staff from DMS, DAIL, and DBHDID.

Workflow Identification, Prioritization and Selection

Cabinet leadership and Navigant identified 79 workflows for assessment based on staff feedback. Navigant and DMS organized workflows into 18 domains that address the major operational and administrative concerns of Cabinet leadership, depicted in Figure 1.7.

Figure 1.7 Cabinet's Current HCBS Waiver Workflow Domains

Critical Incident/ Escalation Management	Participant-directed Services Oversight	Auditing and Issuance of Penalties	Waiting List Management	Prior Authorization/ Service Authorization	Handling Consumer/ Provider Inquiries
Provider Training and Technical Assistance	Develop and Release of External Notices	Data Management and Reporting	Operating Agency Contract Monitoring	Preparing for Dispute Resolutions and Hearings	Future Staffing Projections
Conducting Conflict-Free Assessment	Staff Meetings and Departmental Communication	Billing Reviews	Annual Operating Agency Contract Development	CMS Required Waiver Reporting	Provider Enrollment/ Certification

Navigant developed three priority levels for the 18 domains (high, moderate, and low) based on the domain's risk for CMS corrective action or sanctions, associated negative impacts for participants, and impacts on Cabinet staff and/or stakeholders, as outlined in Figure 1.8.

Figure 1.8 Criteria for Prioritization of Work Domains for Subsequent Assessment

High Priority

- Poses immediate jeopardy to participants
- Places agency at risk for CMS corrective action or sanction
- Increased risk for state government leadership intervention

Moderate Priority

- High-frequency point of frustration for external stakeholders
- High-frequency point of frustration for staff
- Current state of operation negatively impacts program integrity

Low Priority

- Process occurs infrequently, or has limited impact on participants
- Low-frequency point of frustration for stakeholders
- Low-frequency point of frustration for staff
- Low risk of negative impacts to program integrity

Using the priority level definitions from Figure 1.8, Cabinet leadership prioritized the 18 domains and underlying workflows into priority groups as shown in Figure 1.9.

Figure 1.9 Listing of Domains (and Counts of Workflows) by Prioritization

High Priority	Moderate Priority	Low Priority
• Critical Incident/Escalation Management (8) • Participant-Directed Services Oversight (9) • Auditing and Issuance of Penalties (6) • Waiting List Management (4) • Prior Authorization/Service Authorization (5) • CMS Required Reporting (2)	• Provider Enrollment and Certification (5) • Provider Training and Technical Assistance (7) • Develop and Release of External Notices (3) • Data Management and Reporting (4) • Operating Agency Contract Monitoring (2) • Handling Participant and Provider Inquires (8) • Preparing for Dispute Resolutions and Hearings (5) • Sun-setting Staff (1) • Conducting Conflict-Free Assessment (3)	• Staff Meetings and Departmental Communication (2) • Billing Reviews (3) • Annual Operating Agency Contract Development (2)

For a subset of the workflows in Figure 1.9 considered to be high priority, Cabinet leadership opted to conduct further assessment to address operational tasks that could greatly improve daily operations of the Commonwealth's 1915(c) waivers and mitigate the risk of corrective action or CMS sanctions. The Cabinet selected seven of the highest priority individual workflows for Navigant to holistically assess, as described in Figure 1.10.

Figure 1.10 Selected Work Domains and Workflows for First Round Assessment

Work Domain	Cabinet-Selected Workflows
Critical Incident/ Escalation Management	1. Prioritization of incoming escalations across 1915(c) waivers including staff assignments for providing a response
	2. Communicating progress and resolution to frequent referrers of escalations, including: Executive office, Legislative inquiries, Office of the Ombudsman, Kentucky Protection and Advocacy, etc.
	3. Application sanctions for adverse findings of critical incidents
Participant-Directed Services Oversight	4. Reviewing requests and approving/denying requested participant-directed services employees based on regulatory standards

Work Domain	Cabinet-Selected Workflows
	5. Developing and implementing a standardized tool for approval of participant-directed services employees
Auditing and Issuance of Sanctions[3]	6. Conducting first line monitoring across all waivers
	7. Determining when to provide technical assistance to a provider vs. sanctioning or recouping payment due to adverse findings or provider error

Workflow Assessment

For each of the seven workflows, DMS designated a Cabinet staff member to serve as a *Workflow Navigator* – who was responsible for co-managing the workflow assessment process with Navigant. DMS designated Workflow Navigators based on their in-depth knowledge of the existing process, coupled with their ability to identify issues and support development of solutions.

Navigant met with each Workflow Navigator to:

- Obtain an overview of the existing workflow, including assessing issues and strengths
- Identify appropriate additional Cabinet staff for Navigant to interview
- Identify and share any relevant workflow documentation

Upon completion of the initial meeting with the Workflow Navigator, Navigant and identified staff discussed the following three topics:

1. Current workflow operations, including:
    a. Review of the end-to-end workflow
    b. Parties who participate in the workflow (internal and external)
    c. Individual staff roles and responsibilities within the workflow
    d. Associated tools and technology leveraged to complete tasks
2. Issues associated with a workflow, including:
    a. Current bottlenecks and staff frustration
    b. Overly time-consuming aspects of individual tasks
    c. Inconsistencies in how departments approached similar tasks
    d. Duplicative efforts throughout the end-to-end workflow

[3] Workflow summaries and recommendations under the "Auditing and Issuing of Sanctions" domain are not included in Appendix B. While conducting the workflow assessment, it was concluded that auditing and issuing of sanctions would be impacted by 1915(c) waiver assessment and potential redesign. It was concluded that these workflows would be better addressed after the waiver assessment was complete and is not included in this preliminary report.

3. Observed opportunities for improvement

Once Navigant conducted interviews, analyzed all available information, and reviewed existing tools and technologies, targeted recommendations and solutions were developed, designed to improve the effectiveness of the workflow. Navigant presented findings, recommendations and proposed solutions to an *Advisory Council* comprised of Cabinet staff familiar with the workflow, for review. Navigant submitted three final summaries for implementation consideration, depicted in Figure 1.11. Full summaries are in Appendix B.

Figure 1.11 Summaries of Workflows Selected for First Round Assessment

Summary One: Punitive Actions and Sanctions for Founded Critical Incidents

- Develop policy and standards for application of punitive actions and sanctions for founded critical incidents

Summary Two: Compliants, Escalation Response and Prioritization

- Develop a standardized method for prioritization of incoming escalations across 1915(c) waivers including staff assignments for providing a response
- Define operating procedures and standard response timeframes for communicating progress and resolution to frequent referrers of escalations, including: Executive office, Legislative inquiries, Office of the Ombudsman, Kentucky Protection and Advocacy, etc.

Summary Three: Participant-Directed Services

- Develop policy and train staff on definition of eligibility for participant-directed services employees
- Develop and implement a standardized tool for approval of participant-directed services employees

Organizational Assessment

Navigant also reviewed the 1915(c) waiver organizational structure, primarily within the Department of Medicaid Services' Division of Community Alternatives, to understand how the current organizational construct contributes to operational inefficiencies. The goal of this assessment was to identify how DMS can potentially consider restructuring or otherwise modifying its delegated waiver administration model to improve 1915(c) waiver administration and oversight activities across DMS and the other departments within the Cabinet. Navigant conducted this review primarily through interviews with managers and key staff across DMS, DBDHDID and DAIL, who assisted Navigant to confirm current staffing levels and organizational structures across waivers.

1.6 Stakeholder Engagement Method

Given that HCBS include highly personalized services that support vulnerable individuals in key areas of their lives, there is a heightened need for transparent communication with all types of stakeholders, including participants, caregivers, advocates and providers. Navigant also recognized that to truly understand the current state of the HCBS waivers, Navigant would need to listen to the perspectives of those who engage with the HCBS system regularly. Thus, as part of the assessment, Cabinet leadership and staff embraced an increased focus on stakeholder engagement, allowing Navigant to facilitate stakeholder engagement activities, including focus groups, town halls, and other methods described below.

The term *stakeholder* applies to a wide variety of individuals with differing interests and roles in the Commonwealth's HCBS programs. To be as clear as possible for readers, Navigant will refer to stakeholders with as much detail as possible, differentiating stakeholder types with the following terms:

- **Internal stakeholders** – this term refers to stakeholders within the Cabinet, including executive leadership, management across the departments who contribute to or interact with 1915(c) waiver programs, and their staff.
- **External stakeholders** – this term refers to stakeholders who do not work within the Cabinet, but are part of the HCBS delivery system, including:
    - 1915(c) waiver participants
    - Legal guardians/representatives, parents, relatives and other caregivers of 1915(c) waiver participants
    - Prospective participants on a waitlist for 1915(c) waivers
    - Legal guardians. representatives, parents, relatives and other caregivers of prospective participants on a 1915(c) waiver waitlist
    - Provider leadership and employees who deliver services within HCBS waivers
    - Advocates for individuals who need HCBS
- **The Legislature** – Navigant considers members of the Kentucky Legislature as a separate stakeholder group because of their dual roles as policymakers with influence over the Cabinet, who are also accountable to their constituents who include external stakeholders.

Focus Groups

In September and October 2017, Navigant facilitated 40 focus group meetings across the Western, Eastern, and Central regions of the Commonwealth. Figure 1.12 highlights the ten focus groups locations across Kentucky. Navigant, in coordination with the Cabinet, selected these locations to engage as many individuals as possible resulting in a diverse range of stakeholder viewpoints.

Navigant facilitated four focus groups at each of these ten locations, one for each of four key categories of external stakeholders:

- Participants (including individuals on a waiting list)
- Caregivers (including caregivers of individuals on a waiting list)
- Provider managers and executives
- Direct support professionals (DSP) – individuals who directly deliver services to participants, including case managers, personal care aides, participant-directed service employees, etc.

Attendance was capped at 20 attendees per focus group to allow sufficient time for individual participation. The focus group facilitators followed a focus group guide targeted to each stakeholder group's perspective and experiences.

Figure 1.12 Focus Group Weeks, by Geography

Focus groups sought stakeholder input on 16 topics overall. Each focus group addressed two topics. Navigant assigned focus group topics randomly to each focus group location, stratifying by urban/rural location so that each topic was addressed in at least one rural (e.g. Paducah, Somerset, Prestonsburg) and one urban (e.g. Louisville, Lexington, Florence) area, since HCBS systems and service delivery can be quite different in various regions of the Commonwealth. Figure 1.13 lists the focus group topics addressed by stakeholder type and Appendix C contains a summary of focus group comments.

Figure 1.13 Sampling of Focus Group Topics, by Stakeholder Type

Focus Group Attendance

In total, 488 individuals participated across the forty focus groups, as shown in Figure 1.14.

Figure 1.14 Focus Group Attendance, by Stakeholder Type

Category	# of Attendees
Participants	67
Caregivers	128
Provider Managers and Executives	156
Direct Support Professionals	137
TOTAL	**488**

Stakeholder representation spanned all six HCBS waivers and additional details on the diversity within each stakeholder type are listed below:

1. **Participants** – Participant attendees included individuals from all HCBS waivers except for the Model II waiver. Navigant invited individuals on a waiting list for any waiver and several attended. Participant attendees included individuals who required adaptive technology to participate.

2. **Caregivers** - Caregivers often included family members, guardians or other persons providing unpaid support to participants. Many parents of participants attended, with the age of the participant spanning from children through adults. Additionally, in multiple locations several attendees were caregivers who provide care for individuals on waiting lists, particularly for the Michelle P. and SCL waivers.
3. **Provider Managers and Executives** – This group included individuals responsible to manage or lead their HCBS provider organization and oversee the delivery of services to high volumes individuals in the waiver programs. Attendees in this category spanned all of the waivers, included a mix of residential and non-residential service providers, and included both small, medium and large-sized provider organizations.
4. **Direct Support Professionals (DSP)** - DSPs are individuals providing hands-on care or assistance to waiver participants. Common attendees included: personal care aides, participant-directed service workers, residential support staff and case managers/support brokers.

Public Comment Inbox

DMS established a public comment inbox as an additional method for the public to provide comments and concerns. The Cabinet advertised the public comment inbox on the Cabinet's website, highlighted the inbox in all public presentation materials and handouts, and documented the inbox in a business card format that meeting attendees could easily take with them. The inbox allowed stakeholders unable to attend the focus group to participate in the process and provide their input. Additionally, stakeholders who participated in the town halls submitted their testimonies to the comment inbox for consideration during the recommendation process along with any other concerns that were not addressed during the town halls. DMS received 205 submissions to the public comment inbox.

Inbox Review Process

Navigant catalogued all comments into a tracking table, which enabled Navigant to identify and highlight recurring themes from inbox feedback.[4] Upon receiving an email, the intake team logged the name and affiliated organization (if applicable) of the submitting party along with the specific waiver addressed in the email. Navigant also coded topics addressed and recorded a summary of comments or questions within the email. For the town hall public testimonies, Navigant documented the participant's testimony along with the corresponding recommendations addressed in their testimony. Navigant considered the information gathered from the public inbox as it developed its recommendations.

[4] Navigant forwarded all case-specific issues raised by commenters to DMS, so that DMS could address each case directly.

Town Halls

In May 2018, Navigant and DMS held town halls in the same ten cities as the focus groups. The purpose of the town halls was to gather external stakeholder feedback in response to Navigant's preliminary recommendations for HCBS waiver program improvements.

Prior to the town halls, Navigant issued its preliminary recommendations in both a traditional report format and a user-friendly report format. The Cabinet released these reports to the public via the DMS website. DMS also notified stakeholders about the preliminary Recommendations Report release via email using list-serve of individuals and organizations who has previously submitted comment to the inbox, attended a public meeting related to the project, or otherwise advised the Cabinet of their desire to receive project notifications. DMS encouraged stakeholders to provide feedback about the recommendations, either at the town halls and/or via the public inbox.

During the town halls, DMS staff presented high-level information about the assessment process, and Navigant presented its preliminary recommendations. The town hall format allowed external stakeholders to provide their feedback via formal public testimony. Each testifier was allotted three minutes to provide their input and feedback. Navigant and DMS encouraged town hall attendees to submit their comments and feedback to the public inbox if they did not wish to publicly testify and encouraged attendees to document their written testimony and submit this to the Cabinet for future reference. Navigant considered all received stakeholder input before finalizing the recommendations.

Chapter 2: Overview of HCBS Programs Nationwide

This chapter profiles HCBS programs nationally, details the waiver authorities available to states, and describes the types of applications that CMS requires states to submit to obtain approval.

2.1 National Profile of HCBS Waiver Programs

Section 1915(c) of the Social Security Act permits states the authority to submit waivers for federal approval to provide a variety of home and community-based services to assist Medicaid participants to live in the community and avoid institutionalization. The nature of waiver programs vary depending on the state, specific needs of the population served, resources and funding available, service delivery system, state goals and objectives, and other factors.[5] Each waiver typically serves a targeted population group, such as individuals with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses.[6] The US Census Bureau defines a person as having a disability based on positive responses to any one of six questions asked regarding vision, hearing, cognitive, ambulation, self-care, and independent living.[7,8]

Along with an aging United States population, the percentage of people meeting the US Census Bureau definition of having a disability is also increasing. For example, in 2016, approximately 40 million people in the United States (12.8 percent) had a disability, representing an increase from 11.9 percent in 2010.[9] Coupled with this growth, more individuals who have disabilities are living in community settings, with many individuals receiving home and community-based Long-Term Services and Supports (LTSS). According to the National Committee for Quality Assurance (NCQA), in 2015, "Medicaid spent $158 billion in state and federal funds on LTSS, with expenditures on HCBS representing more than 55% of all Medicaid spending for LTSS. In addition, 28 states reported that HCBS accounted for the majority of Medicaid LTSS spending." [10]

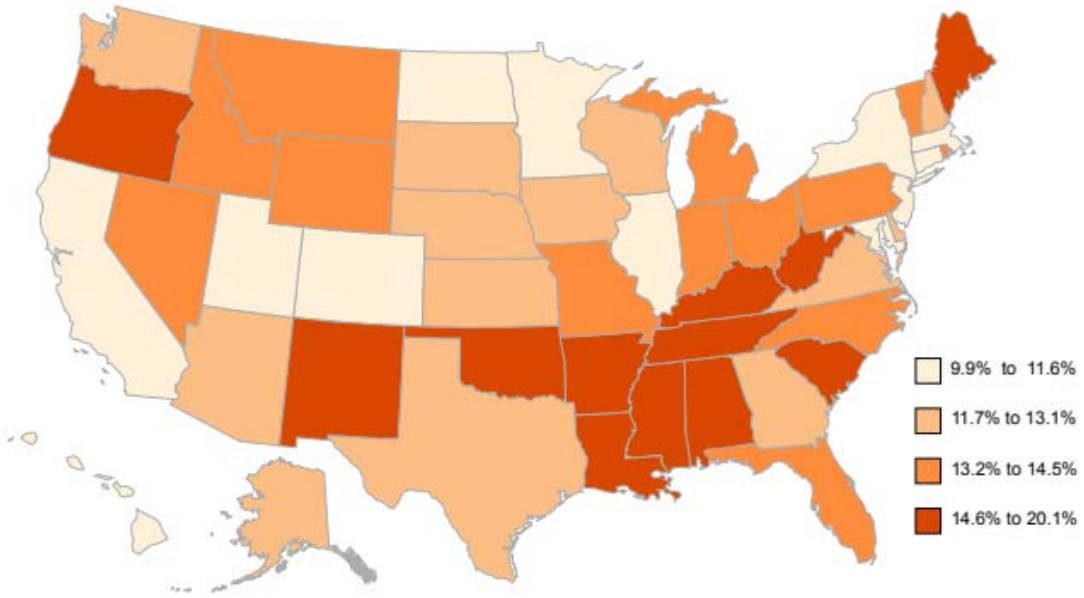
The shift of the majority of LTSS spending from institutional settings to home and community-based services reflects consumer preference for community-integrated living and aging in place. It also reflects the impact of the Olmstead Supreme Court decision of 1999, which ruled that the

[5] Medicaid.gov. Application for a 1915(c) Waiver. Available at: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/downloads/hcbs-waivers-application.pdf
[6] Medicaid.gov. Home and Community Based Services. 2018 Available at: https://www.medicaid.gov/medicaid/hcbs/index.html
[7] Institute on Disability. University of New Hampshire. 2017 Disability Statistics Annual Report, January 2018. Available at: https://disabilitycompendium.org/sites/default/files/user-uploads/AnnualReport_2017_FINAL.pdf
[8] Questions related to cognitive, ambulatory, self-care, and independent living are not used to identify disability in individuals less than five years old, and the question related to independent living is not used to identify disability in individuals less than 18 years old.
[9] Institute on Disability. University of New Hampshire. 2017 Disability Statistics Annual Report; Figure, January 2018. Available at: https://disabilitycompendium.org/sites/default/files/user-uploads/AnnualReport_2017_FINAL.pdf
[10] National Committee for Quality Assurance in collaboration with Health Management Associates. Trends in Medicaid Long-Term Services and Supports: A move to Accountable Managed Care, 2017. Available at: https://www.ncqa.org/Portals/0/Programs/Accreditation/NCQA1086-0917_LTSSWhitePaper_Web.pdf?ver=2017-12-12-085014-077

Americans with Disabilities Act requires states to offer publicly financed services in the most integrated setting appropriate to the needs of qualified individuals with disabilities.[11] By 2029, all baby boomers will be aged 65 or older, with the leading edge of the generation being older than 80 – the age group most likely to need LTSS."[12]

States need to continuously consider how to build HCBS programs to account for this anticipated growth and critically evaluate HCBS packages for people who are aging and who have disabilities. Figure 2.1 outlines the percentage of each state's population who have disabilities and are living in the community in 2016. Kentucky falls in the stratum with the highest percentage of people who have disabilities and are living in community settings (14.6 percent to 20.1 percent).

Figure 2.1 People with Disabilities Living in the Community as a Percent of the State's Population, 2016[13]



History of 1915(c) Waiver Programs

Home and Community-Based Services (HCBS) first became available in 1983 after Congress added 1915(c) to the Social Security Act, giving states the option to receive a waiver of

[11] Kaiser Family Foundation. The Olmstead Decision: Implications for Medicaid. March 2000. Available at: https://kaiserfamilyfoundation.files.wordpress.com/2000/03/2185-the-olmstead-decision-implications-for-medicaid.pdf
[12] National Committee for Quality Assurance in collaboration with Health Management Associates. Trends in Medicaid Long-Term Services and Supports: A move to Accountable Managed Care, 2017. Available at: https://www.ncqa.org/Portals/0/Programs/Accreditation/NCQA1086-0917_LTSSWhitePaper_Web.pdf?ver=2017-12-12-085014-077
[13] Institute on Disability. University of New Hampshire. 2017 Disability Statistics Annual Report; Figure. January 2018. Available at: https://disabilitycompendium.org/sites/default/files/user-uploads/AnnualReport_2017_FINAL.pdf

Medicaid rules governing institutional care.[14] Prior to the enactment of Section 1915(c), the Medicaid program provided for little in the way of coverage for LTSS in non-institutional settings but offered full or partial coverage of institutional care. The 1915(c) waiver concept allows states broad discretion to design programs tailored to address the needs of the waiver's target population(s). Waiver services often complement and/or supplement the services available to participants through the state's Medicaid State Plan and other federal, state and local public programs, as well as the supports that families and communities provide.

The 1915(c) waiver authority permits a state to offer HCBS to individuals who: (a) are found to require a level of institutional care (hospital, nursing facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)) under the State plan; (b) are members of a target group that is included in the waiver (c) meet applicable Medicaid financial eligibility criteria; (d) require one or more waiver services in order to function in the community; and (e) exercise freedom of choice by choosing to enter the waiver in lieu of receiving institutional care.[15]

Since the inception of 1915(c) waivers in 1983, several milestone policies have continued to encourage states' participation in HCBS waiver programs and supported the concept of shifting care delivery away from institutional settings and into home and community-based settings. This concept is generally known as "rebalancing," discussed further in this chapter and in Chapter 4 of this report. Figure 2.2 summarizes selected milestones related to the growth of HCBS waiver programs and other community options.

Figure 2.2 Selected HCBS-Related Milestones

Milestone	Relevance
Americans with Disabilities Act – *1990*	• Requires public entities to administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities
Olmstead Decision – *1999*	• Landmark decision – Ruled that unnecessary institutionalization of individuals with disabilities was a violation of the Americans with Disabilities Act • Ruled that states have an obligation to provide integrated community-based services to individuals with disabilities to the fullest extent possible

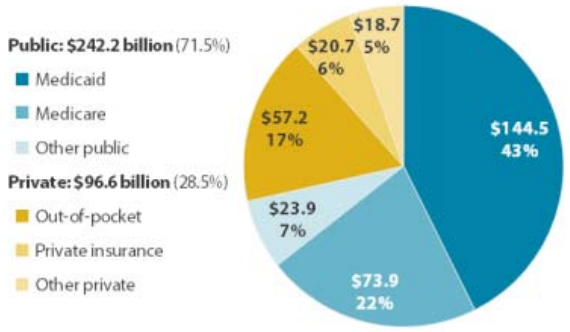
[14] Medicaid.gov. Home & Community Based Services Authorities. Available at: https://www.medicaid.gov/medicaid/hcbs/authorities/index.html
[15] Application for a 1915(c) Home and Community Based Waiver. Version 3.5. January 2015. Available at: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/downloads/technical-guidance.pdf

Milestone	Relevance
Deficit Reduction Act – *2005*	• Authorized the Money Follows the Person (MFP) program to encourage rebalancing and community-based placements • Allowed states to cover home and community-based services through the state plan
Affordable Care Act – *2010*	• Provided enhanced federal matching rates as an incentive to increase HCBS
Final HCBS Setting Rule – *2014*	• Required all home and community-based settings to meet certain qualifications such as demonstrating that the setting is integrated in the greater community and is selected by individuals among setting options

Medicaid's Role as a Payer of LTSS

Medicaid LTSS spending covers two primary types of care: (1) institutional LTSS, including nursing home services and intermediate care facility (ICF) services for individuals with intellectual and developmental disabilities and (2) HCBS.[16] Medicaid is the nation's primary payer of LTSS today – and, as illustrated in Figure 2.3, Medicaid accounted for 43 percent of national LTSS spending in 2013.

Figure 2.3 LTSS Spending by Payer, 2013[17]



In Fiscal Year (FY) 2015, HCBS accounted for approximately 55 percent of the total Medicaid LTSS expenditures; and has increased by one to three percentage points nearly every year since FY 1992.[18] Furthermore, 1915(c) waivers continue to be a common option for offering HCBS. As of May 2018, 296 1915(c) waivers existed across 47 States and the District of Columbia.[19]

[16] Medicaid.gov. 2016 Actuarial Report on the Financial Outlook for Medicaid. Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2016.pdf
[17] Center for Health Strategies. Strengthening Long Term Services and Supports Reform Strategies. February 2018. Available at: http://www.allhealthpolicy.org/wp-content/uploads/2018/02/5.-Mann-and-Herman-Soper-Presentation.pdf
[18] Truven Health Analytics. Medicaid Expenditures for Long-Term services and Supports (LTSS in FY 2015. April 2017. Available at: https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf.
[19] Centers for Medicare and Medicaid Services. State Waivers List. May 2018. Available at: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html

The average LTSS cost-per-participant varies among states due to eligibility levels, benefits offered, provider reimbursement rates, program design, and differences in the overall health care market across states.[20] In 2015, aged beneficiaries received an estimated $14,323 in benefits on average—a decrease of 2.1 percent from 2014 driven by a large shift in long-term care delivery from generally more expensive institutional care into home and community-based care, typically through 1915(c) waivers.[21]

Nationally, the number of individuals participating in 1915(c) waiver programs has increased from approximately 240,000 in 1992 to over 1.5 million in 2013.[22] Most individuals and expenditures are associated with 1915(c) waivers that serve people with complex needs, particularly people who live with intellectual or developmental disabilities. These individuals account for approximately 40 percent of the 1915(c) waiver participants and approximately 70 percent of 1915(c) waiver expenditure. Beneficiaries who have disabilities are estimated to have received an average of $19,478 a year in benefits, a 4.4-percent increase from 2014.[23]

2.2 Waiver Authorities, Application, and CMS Approval Process

States can use 1915(c) waivers to provide services that are not traditionally covered within a Medicaid's state plan services (e.g., adult day health, personal care, respite care) but are needed to support and enhance an individual's ability to live outside of institutional settings.[24] For CMS to approve a waiver, states must demonstrate that waiver services will be less costly than providing LTSS in an institution and must indicate how they will comply with waiver assurances across six waiver assurance areas, including health and welfare and service planning.[25] CMS provides states with uniform applications with appendices and technical guidance for submitting these elements within a proposed or revised 1915(c) waiver for subsequent approval. Figure 2.4 demonstrates the types of applications a state may use to apply for a HCBS waiver and applicable scenarios for submission.

[20] Medicaid.gov. 2016 Actuarial Report on the Financial Outlook for Medicaid. Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2016.pdf
[21] Medicaid.gov. 2016 Actuarial Report on the Financial Outlook for Medicaid. Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2016.pdf
[22] Office of the Assistant Secretary for Planning and Evaluation. Understanding Home and Community Services: A Primer. October 2000. Available at: https://aspe.hhs.gov/basic-report/understanding-medicaid-home-and-community-services-primer#Chap1
[23] Medicaid.gov. 2016 Actuarial Report on the Financial Outlook for Medicaid. Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2016.pdf
[24] Office of the Assistant Secretary for Planning and Evaluation. Understanding Home and Community Services: A Primer. October 2000. Available at: https://aspe.hhs.gov/basic-report/understanding-medicaid-home-and-community-services-primer#Chap1.
[25] Medicaid.gov. Application for a 1915(c) Waiver. Available at: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/downloads/hcbs-waivers-application.pdf

Figure 2.4 Types of HCBS waiver Applications Available to States[26]

Application Type	Applicable Scenario
New waiver applications	A state must submit an initial waiver application to seek approval for a new waiver not yet operationalized
New waiver to replace an approved waiver	A state must submit a new waiver to replace an approved waiver in either of the following circumstances: • *State Election*: A state may decide to submit a new waiver rather than renew an approved waiver because the state wants to redesign the waiver • *CMS Requires the Submission of a New Application*: When CMS determines that there are serious operational problems within an approved waiver, CMS may require that the state replace the approved waiver with a new waiver
Renewal applications	A state must submit a waiver renewal application to seek approval for an extension of an existing waiver program. *Note: The SSA does not provide for the automatic extension of an approved waiver, and waivers that have not been formally renewed by the end of the waiver period automatically expire. To ensure the continuous operation of a waiver, a state should submit a waiver renewal application to CMS at least 90, but preferably 180 calendar days prior to the end of the waiver period.*
1915(b) / 1915(c) **Concurrent waiver applications**	A state may submit concurrent waivers to combine the delivery of HCBS waiver services with the provision of other state plan services through a managed-care service delivery system. The Section 1915(b) waiver authority permits a state to waive provisions of the Act beyond the waivers that may be requested under the Section 1915(c) waiver authority.
1915(a) Authority concurrent with a 1915(c) waiver	A state may operate a Section 1915(a) authority in conjunction with a Section 1915(c) waiver, which permits a state to waive statewideness, comparability, or free choice of provider under certain circumstances. Typically, states have used Section 1915(a) authority to provide for voluntary managed care for all or some HCBS waiver participants.
Other changes to approved waivers	A state may exercise other options to seek approval for the design of their waiver programs, including: • *Splitting a Waiver:* A state may divide an approved waiver into separate waivers

[26]Application for a 1915(c) Home and Community Based Waiver. Version 3.5. January 2015. Available at: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/downloads/technical-guidance.pdf

Application Type	Applicable Scenario
	• *Combining Waivers*: A state may combine two approved waivers that serve the same or very similar target populations. • *Converting a **Model** Waiver to a **Regular** Waiver*: A state may convert a *model* waiver to a *regular* waiver when the state decides to serve more than 200 individuals at any point in time. • *Participant Limit Reductions:* A state may renew an approved waiver or amend an approved waiver to reduce the number of unduplicated individuals served in the waiver.

Within the application for a 1915(c) waiver, CMS outlines ten appendices (Appendix A through Appendix J), each of which requires a state to describe in detail specific elements of waiver operations. Refer to Figure 1.4 in Chapter 1 for a brief description of the waiver application organization and its appendices.

Timeline for CMS Approval

In accordance with *42 CFR Section 430.25(f)(3)*, CMS has 90 calendar days to approve or deny an initial waiver application, a waiver renewal or an amendment request, or alternatively issue a written request for additional information (RAI). CMS attempts to identify any serious problems in an application within 45 days of its receipt. CMS requires states to employ the web-based application to submit new waivers, waiver renewals, and amendments.[27]

Other timeline considerations include:

- For initial or new waiver applications, the application must be submitted at least 90 calendar days in advance of the proposed waiver *effective* date
- For waiver renewal applications, the application must be submitted at least 90 calendar days in advance of the approved waiver's *expiration* date

Figure 2.5 depicts the high-level waiver approval process.

[27]Application for a 1915(c) Home and Community Based Waiver. Version 3.5. January 2015. Available at: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/downloads/technical-guidance.pdf

Figure 2.5 HCBS Waiver Approval Process*

**Note: This timeline is approximate. Overall timeframes are subject to the state's timing in response to requests for additional information (RAIs), as well as CMS backlogs in 1915 waiver and Medicaid State Plan Amendment (SPA) submissions.*

2.3 Growth in HCBS Programs and Rebalancing LTSS

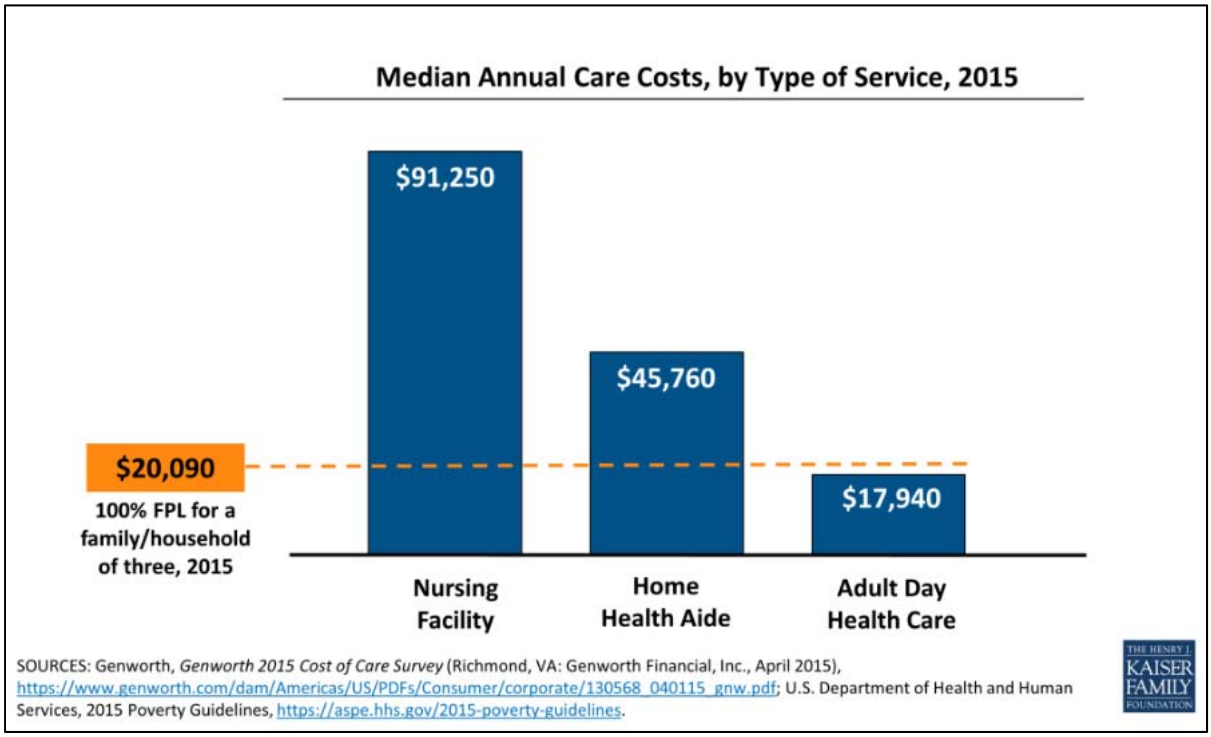
As LTSS programs have grown over the past several decades, states have implemented strategies to rebalance their long-term care systems to spend more on HCBS compared to institutional care. States' efforts to rebalance LTSS programs are typically driven by three factors:[28]

- Participants tend to prefer HCBS over institutional care
- HCBS are typically less costly compared to institutional care
- States' are required to meet community integration mandates under the Americans with Disabilities Act and the Supreme Court's *Olmstead* decision

Figure 2.6 illustrates the difference in average annual costs between institutional services (ex. nursing facility) and HCBS (ex. home health aide and adult day health care) as compared to the federal poverty level (FPL), which has been a main reason for the shift away from institutional care.

[28] Kaiser Family Foundation. Measuring Long-Term Services and Supports Rebalancing. February 2015. Available at: http://files.kff.org/attachment/fact-sheet-measuring-long-term-services-and-supports-rebalancing

Figure 2.6 Difference in Costs between Institutional Care and HCBS, 2015[29]



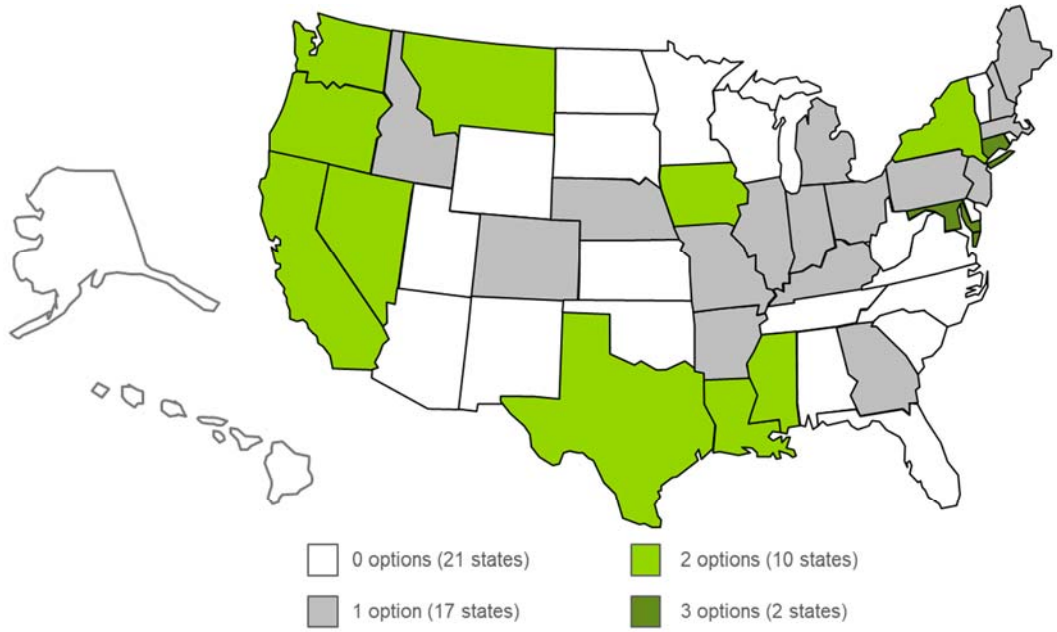
The Affordable Care Act (ACA) included several provisions designed to improve the availability of HCBS options, including but by no means limited to:[30]

- **Balancing Incentive Program (BIP)** – BIP authorized an enhanced federal matching rate for states spending less than 25 percent (five percent enhanced match) or less than 50 percent (two percent enhanced match) of all LTSS expenditures in home and community-based care settings.
- **Community First Choice state plan option** – The Community First Choice state plan option authorizes a six percent enhanced federal matching rate for states to provide a community attendant or other support services for individuals who would otherwise require institutional services.
- **1915(i) Medicaid State Plan Option** – Originally enacted in 2006, this initiative offered states the ability to provide HCBS to individuals not yet at an institutional level of care.

In turn, states have been very active in pursuing the available options and assistance offered by the Federal government. Figure 2.7 shows states' participation in rebalancing efforts.

[29] Kaiser Family Foundation. Medicaid and Long-Term Services and Supports: A Primer. December 2015. Available at: https://www.kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/
[30] Robert Wood Johnson Foundation. Rebalancing Medicaid Long-Term Services And Supports. Shifting away from primarily financing institutional care, Medicaid is supporting more flexible community-based long-term services and supports. September 17, 2015. Available at: https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf423379

Figure 2.7 State Participation in Rebalancing Initiatives[31]

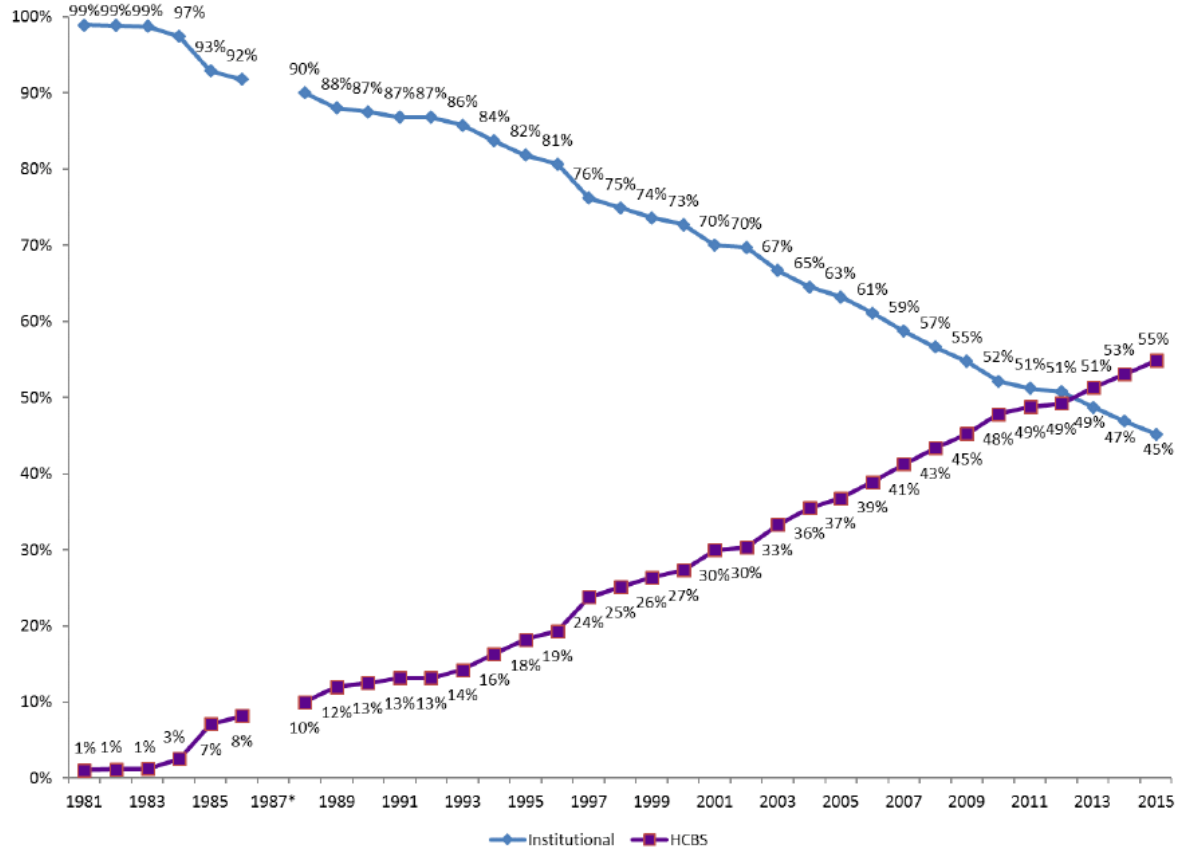


Note: Included options – Balancing Incentive Program, Medicaid State Plan Amendments under 1915 (i), and Community First Choice option under 1915 (k)
Source: Nasuad.org

Efforts to rebalance Medicaid spending in LTSS have significantly affected the national HCBS landscape. 2013 was the first year that the majority of national Medicaid LTSS spending was devoted to HCBS settings instead of institutional care. This trend is expected to grow. CMS projects that Medicaid HCBS spending will reach 63 percent of total Medicaid LTSS spending by 2020.[32] Figure 2.8 illustrates the shifting trend of Medicaid LTSS spending over the past three decades, which includes a pattern of one to three percentage point increases in HCBS expenditures almost every year since FY 1993.

[31] NASUAD. State Medicaid Integration Tracker. June 1, 2018. Available at: http://www.nasuad.org/sites/nasuad/files/State%20Medicaid%20Integration%20Tracker%20June%202018.pdf
[32] Robert Wood Johnson Foundation. Rebalancing Medicaid Long-Term Services And Supports. Shifting away from primarily financing institutional care, Medicaid is supporting more flexible community-based long-term services and supports. September 17, 2015. Available at: https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf423379

Figure 2.8 National Medicaid HCBS and Institutional LTSS Expenditures as a Percentage of Total Medicaid LTSS Expenditures, FY 1981-2015[33]

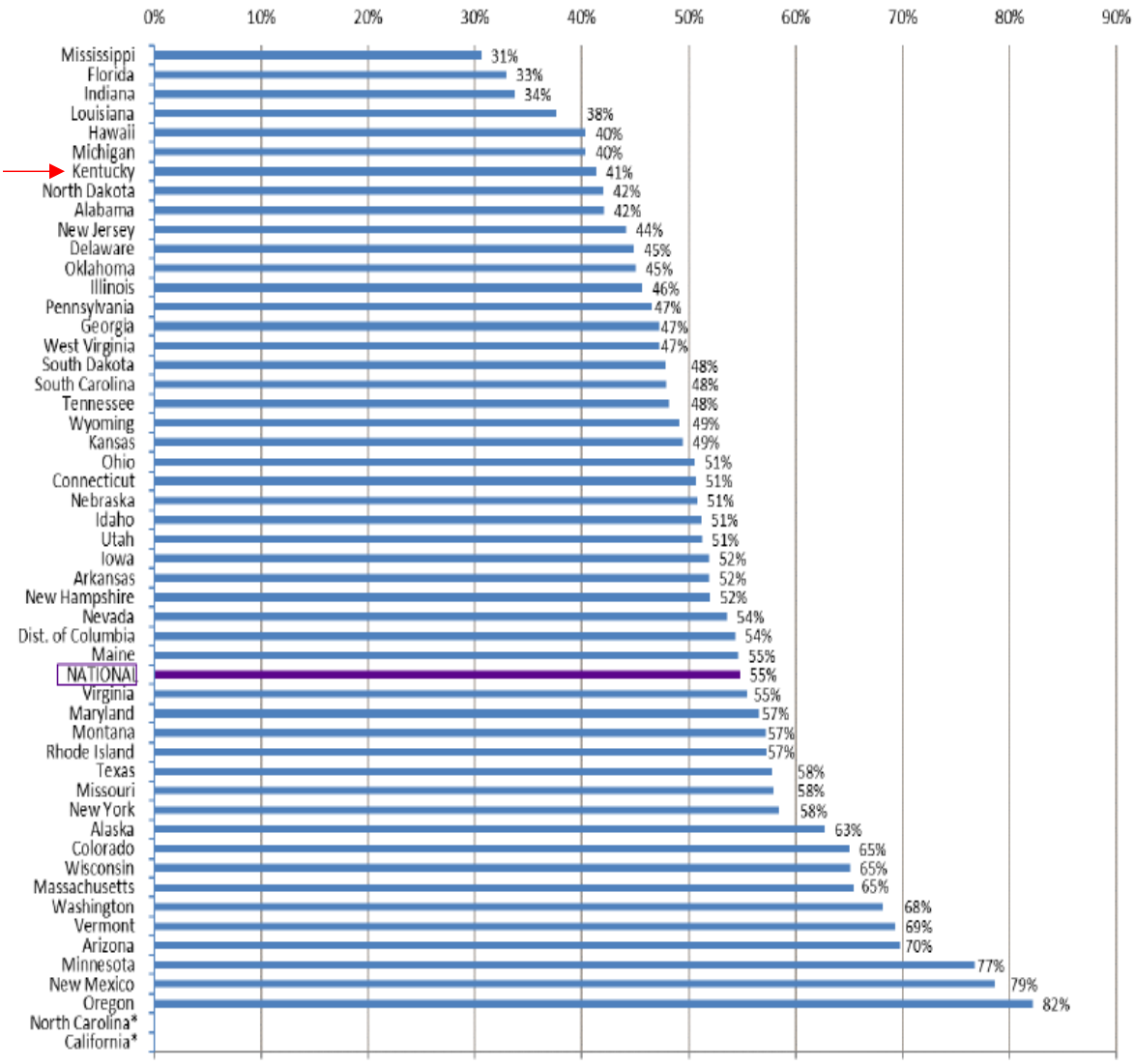


Despite overall Medicaid LTSS spend shifting from institutional care to HCBS, large disparities remain across states in this shift. States spend between 31 and 82 percent of their total Medicaid LTSS dollars on HCBS, as depicted in Figure 2.9.[34] Kentucky's HCBS expenditures accounted for 41 percent of its total Medicaid LTSS spend in State Fiscal Year 2015.

[33] Truven Health Analytics. Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015. April 14, 2017. Available at: https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf

[34] Truven Health Analytics. Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015. April 14, 2017. Available at: https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf

Figure 2.9 Medicaid HCBS Expenditures as a Percentage of Total Medicaid LTSS Expenditures, by State, FY 2015[35]



Populations covered under 1915(c) waivers

Many early HCBS waivers targeted people who were elderly or who lived with developmental disabilities. More recently, waiver programs evolved to target Medicaid-eligible individuals with a variety of conditions and chronic disorders, such as physical disabilities, HIV/AIDS, acquired

[35] Truven Health Analytics. Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015. April 14, 2017. Available at: https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf

brain injuries, and in a more limited manner, mental illness.[36] Of the hundreds of approved waivers, most states have waivers for:

1. Aged adults (and may be combined with adults with physical disabilities)
2. Individuals with I/DD (typically with separated programs for children and adults)[37]

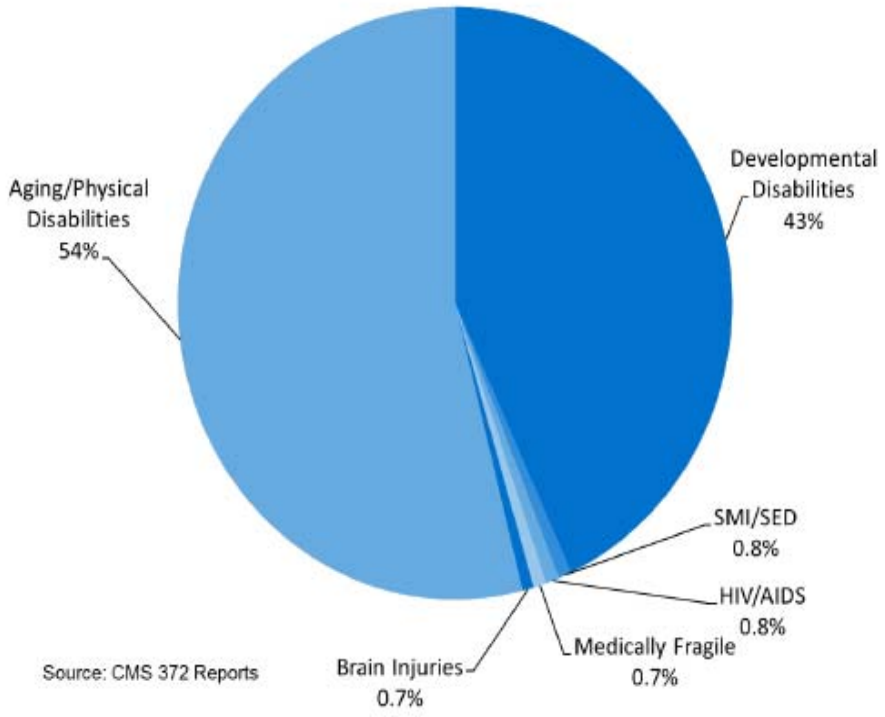
Generally, 1915(c) waivers allow states the flexibility to offer services to a diverse range of populations. States vary in the populations covered under HCBS waivers, but typical populations include:

- Individuals who are aged (65 years of age or greater) or physically disabled, or both, including the following recognized sub-categories:
    - Individuals with brain injury
    - Individuals with HIV/AIDS
    - Individuals considered medically fragile
    - Individuals who are technology dependent
- Individuals with developmental or intellectual disabilities, including the following recognized sub-categories:
    - Individuals with autism
    - Individuals with developmental disabilities
    - Individuals with intellectual disability
- Individuals with mental illness, including the following recognized sub-categories:
    - Individuals with severe mental illness (18 years and older)
    - Individuals with severe emotional disturbance (under 18 years)

Figure 2.10 illustrates various HCBS subpopulations as a percentage of total HCBS enrollment, with individuals with developmental disabilities or aging/physical disabilities comprising approximately 97 percent of waiver populations in 2014.

[36] LeBlanc AJ, Tonner MC, Harrington C. Medicaid 1915(c) Home and Community-Based Services Waivers Across the States. *Health Care Financing Review*. 2000;22(2):159-174.
[37] Kaiser Family Foundation. "Medicaid Home and Community-Based Services: Results From a 50-State Survey of Enrollment, Spending, and Program Policies." January 19, 2018. Available at: https://www.kff.org/report-section/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies-report/

Figure 2.10 National Distribution of 1915(c) Waiver Participants by Target Population, Waiver Year Ending in 2014[38]



As states continue to pursue LTSS programs to provide services to these populations, it is critical for policy-makers to understand approaches and design options available, identify national trends in practice, and identify models that have addressed program design and implementation challenges.

Range of services covered under HCBS waivers

Federal regulation does not dictate or restrict the quantity or types of services a state can offer under an HCBS waiver program; therefore, Medicaid LTSS service offerings vary greatly by state and even across waivers within a single state. HCBS programs can offer a combination of standard medical services and non-medical services but always must include care coordination or planning. States may include the following additional services, among others: homemaker/home health aide/personal care, adult day health, habilitation, respite, day treatment/partial hospitalization, psychosocial rehabilitation, transportation, extended home health, supported housing, supported employment, shared living and more.[39]

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[38] Truven Health Analytics. Medicaid Section 1915(c) Waiver Data based on the CMS 372 Report, 2013 – 2014. September 6, 2017. Available at: https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/cms-372-report-2014.pdf

[39] National Committee for Quality Assurance in Collaboration with Health Management Associates. Trends in Medicaid Long-Term Services and Supports: A Move to Accountable Managed Care. Available at:

Figure 2.11 illustrates the number of waiver participants nationally receiving each type of service, with over a million individuals receiving home-based services (e.g., personal care services, homemaker, respite, etc).

Figure 2.11 National Landscape of Medicaid 1915(c) Waiver Participants by Service, 2014[40]

HCBS Waiver Service	# of HCBS Waiver Participants Using Service
Home-Based Services	1,095,719
Day Services	707,173
Case Management	588,701
Equipment, Technology and Modifications	429,338
Round-the-Clock Services	345,872
Nursing / Therapy / Other Health and Therapeutic	267,413
Other Mental Health and Behavioral Services	159,740
Supported Employment	145,337
Other Services (e.g., transportation, housing assistance, goods and services, pest control, etc.)	528,045
Total*	**4,267,338**

** Note that the total does not reflect unduplicated 1915(c) waiver participants, as participants in some instances may receive more than one type of service.*

In 2014, approximately 1.1 million individuals of 1915(c) waiver participants received home-based services. The most common type of home-based service provided to waiver participants was personal care (approximately 457,000 individuals), followed by respite (approximately 191,000 individuals), and chore/homemaker (approximately 173,000 individuals).

Growth in HCBS Waiver Expenditures and Participants

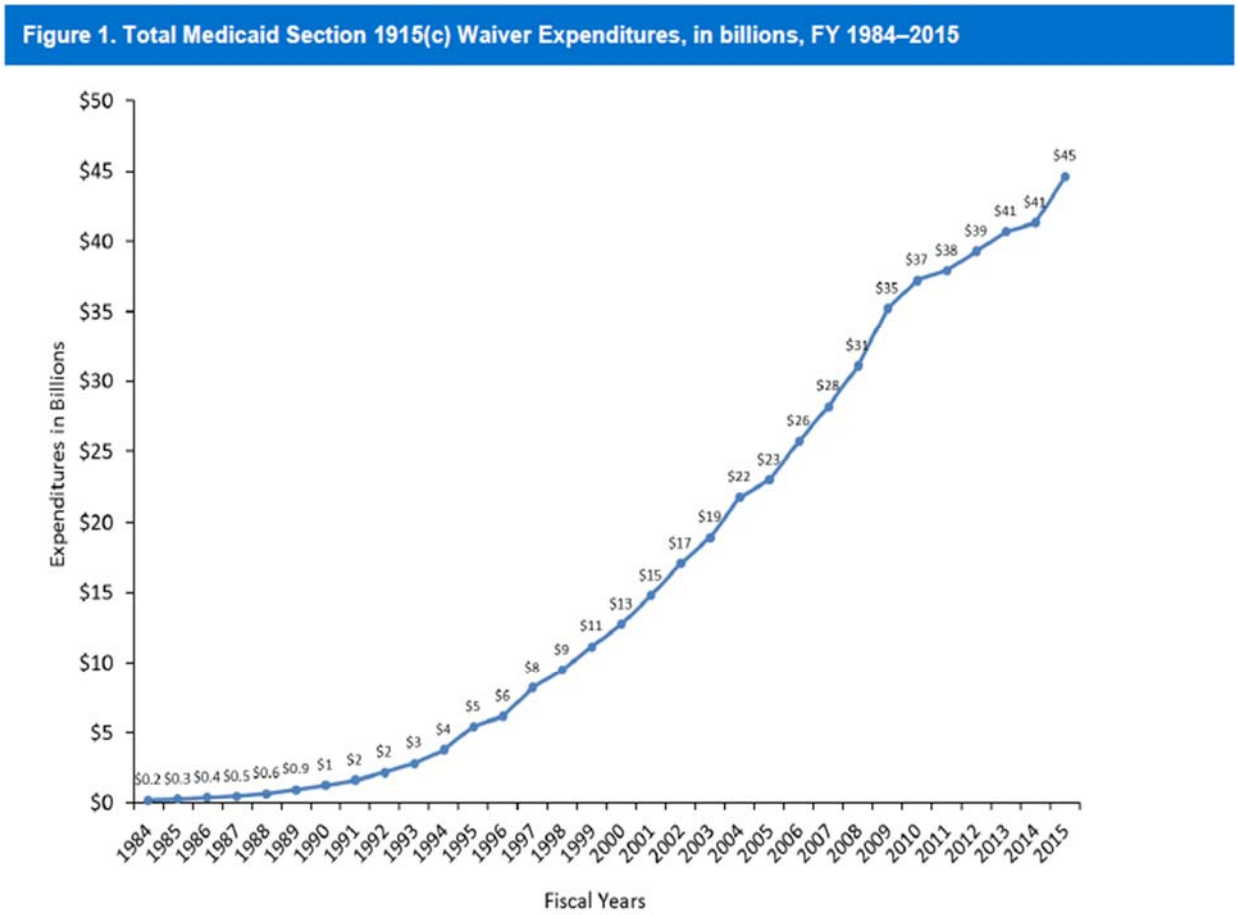
Nationwide, total state and federal expenditures for 1915(c) waivers were $45 billion in federal fiscal year (FY) 2015, an eight percent increase from $41 billion in FY 2014. FY 2015 was the

https://www.ncqa.org/Portals/0/Programs/Accreditation/NCQA1086-0917_LTSSWhitePaper_Web.pdf?ver=2017-12-12-085014-077

[40] Kaiser Family Foundation. Medicaid Home and Community-Based Services: Results From a 50-State Survey of Enrollment, Spending, and Program Policies. January 2018. Available at: http://files.kff.org/attachment/Report-Medicaid-Home-and-Community-Based-Services

first year since FY 2010 that waiver spending increased by more than five percent. Figure 2.12 illustrates the total 1915(c) waiver expenditure growth from FY 1984 – 2015.[41]

Figure 2.12 Total National 1915(c) Waiver Expenditures, in Billions, FY 1984 – 2015[42]



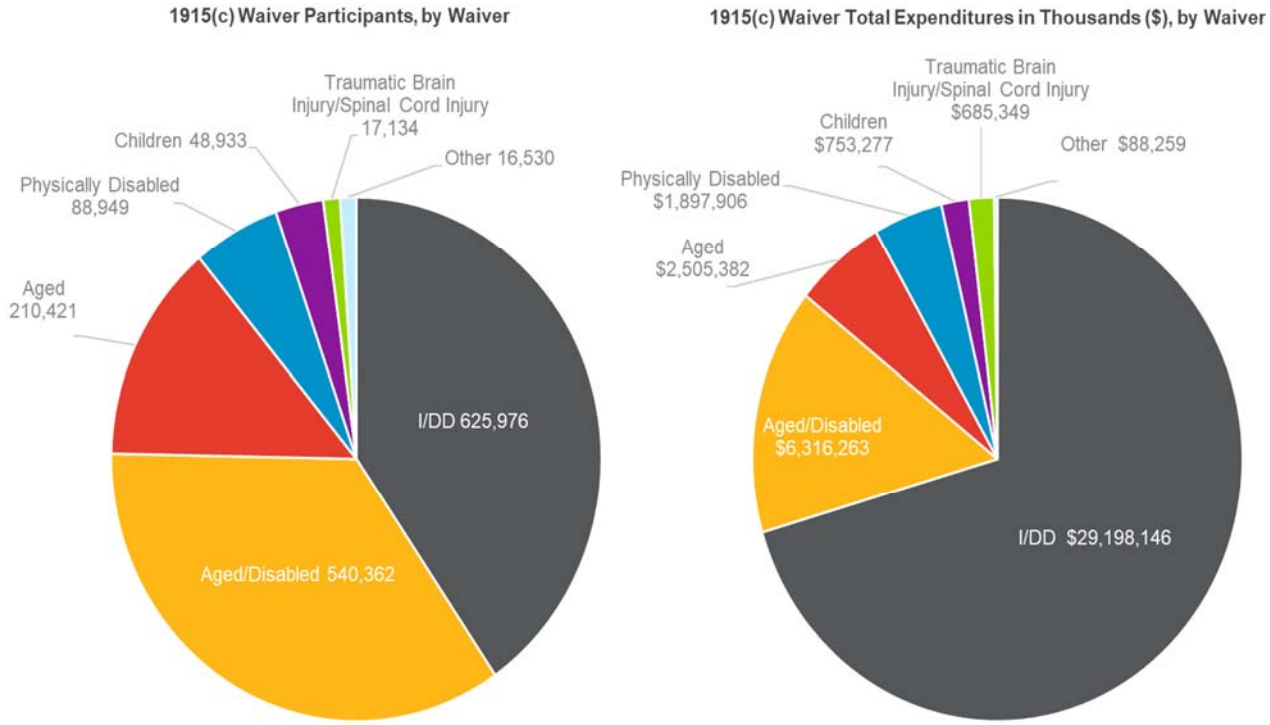
Nationally, the number of individuals participating in 1915(c) waiver programs has increased over time, from approximately 240,000 in 1992 to over 1.5 million in 2013.[43] While HCBS, and specifically the 1915(c) waiver authority, has experienced tremendous growth in the past 35 years, the average LTSS spend per participant varies greatly among states due to program

[41] Truven Health Analytics. Medicaid Section 1915(c) Waiver Data based on the CMS 372 Report, 2013 – 2014. September 6, 2017. Available at: https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/cms-372-report-2014.pdf
[42] Truven Health Analytics. Medicaid Section 1915(c) Waiver Data based on the CMS 372 Report, 2013 – 2014. September 6, 2017. Available at: https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/cms-372-report-2014.pdf
[43] Office of the Assistant Secretary for Planning and Evaluation. Understanding Home and Community Services: A Primer. October 2000. Available at: https://aspe.hhs.gov/basic-report/understanding-medicaid-home-and-community-services-primer#Chap1

design, eligibility levels, benefits offered, provider reimbursement rates, and because of differences in the overall healthcare markets across states.[44]

Most HCBS waiver participants and expenditures are associated with waivers for people who have complex needs, such as those who live with intellectual or developmental disabilities(I/DD), as illustrated by Figure 2.13. I/DD waiver services account for approximately 40 percent of the 1915(c) waiver participants and approximately 70 percent of the 1915(c) waiver expenditures.

Figure 2.13 1915(c) Waiver Participants and Total Expenditures Nationally, 2013[45]



Note: "Other" category includes 1915(c) waivers for mental health and HIV/AIDS.

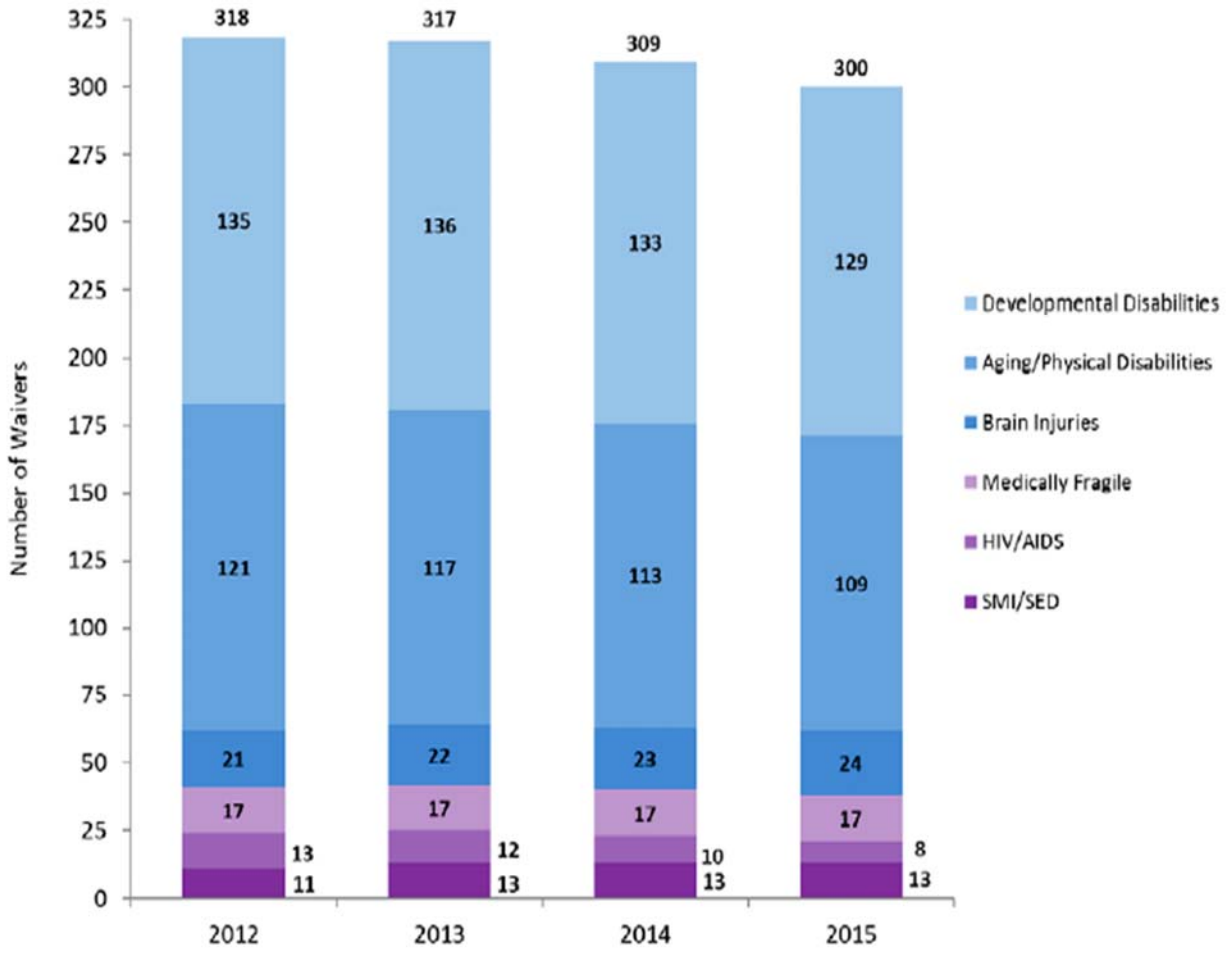
In summary, 1915(c) waivers continue to play a significant role in Medicaid LTSS, and while these waivers have grown in volume in the past 35 years, it is important to note that between FY 2012 and 2015, the number of 1915(c) waivers actually decreased six percent, from 318 to 300, as depicted in Figure 2.14. This decrease may be due to states that opted to transition services from 1915(c) waivers to 1115 demonstrations, consolidate multiple waivers or transition to

[44] Medicaid.gov. 2016 Actuarial Report on the Financial Outlook for Medicaid. Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2016.pdf

[45] Kaiser Family Foundation. Medicaid Section 1915(c) Home and Community-Based Services Waivers Participants. 2013. Available at: https://www.kff.org/medicaid/state-indicator/medicaid-section-1915c-home-and-community-based-services-waivers-participants/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

managed LTSS. Reviewing the number of waivers by population, the only waiver type that grew in number during this four-year period were those targeting people with brain injury.

Figure 2.14 Number of 1915(c) waivers by Target Population Nationally, FY 2012 – 2015[46]



Role of Responsible State Agency and Sister Agencies

CMS stipulates that for each HCBS waiver, the *Single State Medicaid Agency* (SSMA) is the party responsible for making policy decisions, setting eligibility criteria, managing provider oversight, and ensuring participants' health, safety, and welfare, among other program administration duties required by CMS. The SSMA must manage programs to operate cost-effectively while complying with Federal regulations and waiver terms and conditions. Within the 1915(c) waiver authority, the SSMA may delegate administration and operational elements of HCBS waiver programs to another state agency. Regardless of whether and how the SSMA

[46] Truven Health Analytics. "Medicaid Expenditures for Section 1915(c) Waiver Programs in FY 2014." September 9, 2016. Available at: https://www.medicaid.gov/medicaid/ltss/downloads/1915c-expenditures-fy2014.pdf

delegates duties, the SSMA still retains overall authority and responsibility to CMS for the HCBS waivers.

Chapter 3: Profile of Kentucky's 1915(c) Waiver Program

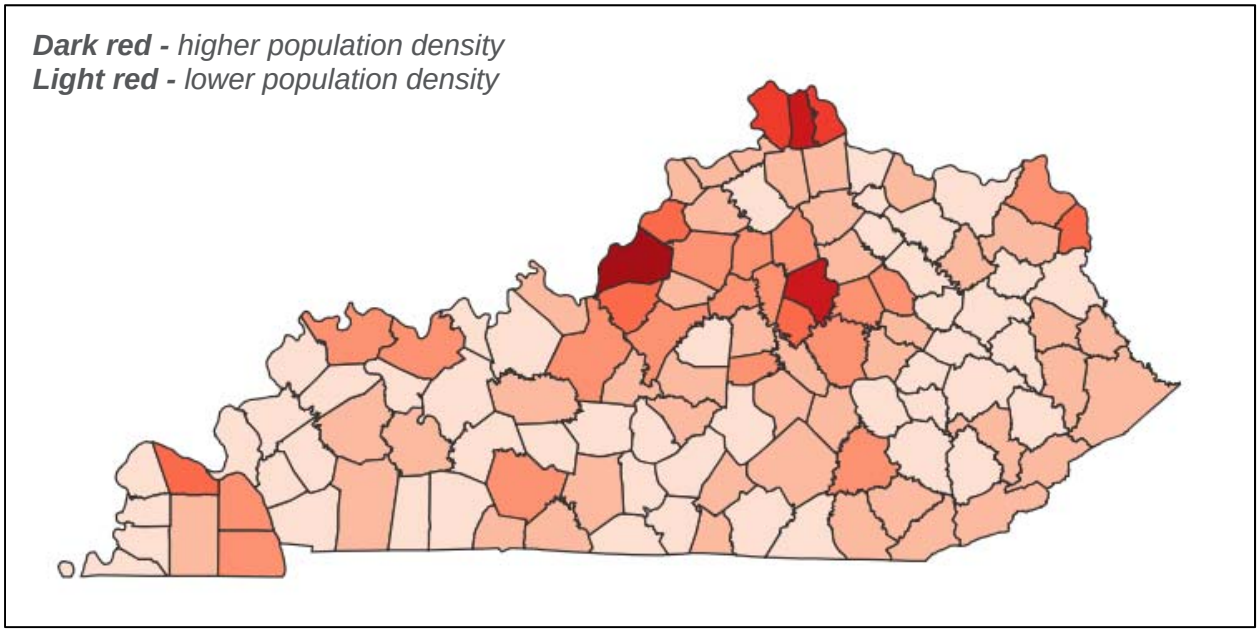
This chapter profiles relevant Kentucky demographics and the Commonwealth's Medicaid program, and reviews the history of Kentucky's 1915(c) waivers, describing how those waivers operate today.

3.1 Kentucky Demographics

Population

The Commonwealth of Kentucky is diverse in many ways including demographics, economic factors and geography. Regional differences show this diversity, with clear differences between the Commonwealth's urban and rural areas. Figure 3.1 illustrates, in dark red, the population clusters in the Louisville (Jefferson County), Lexington (Fayette County) and greater-Cincinnati region (Kenton County). A significant portion of the Commonwealth's 4.4 million residents live in these three counties.[47]

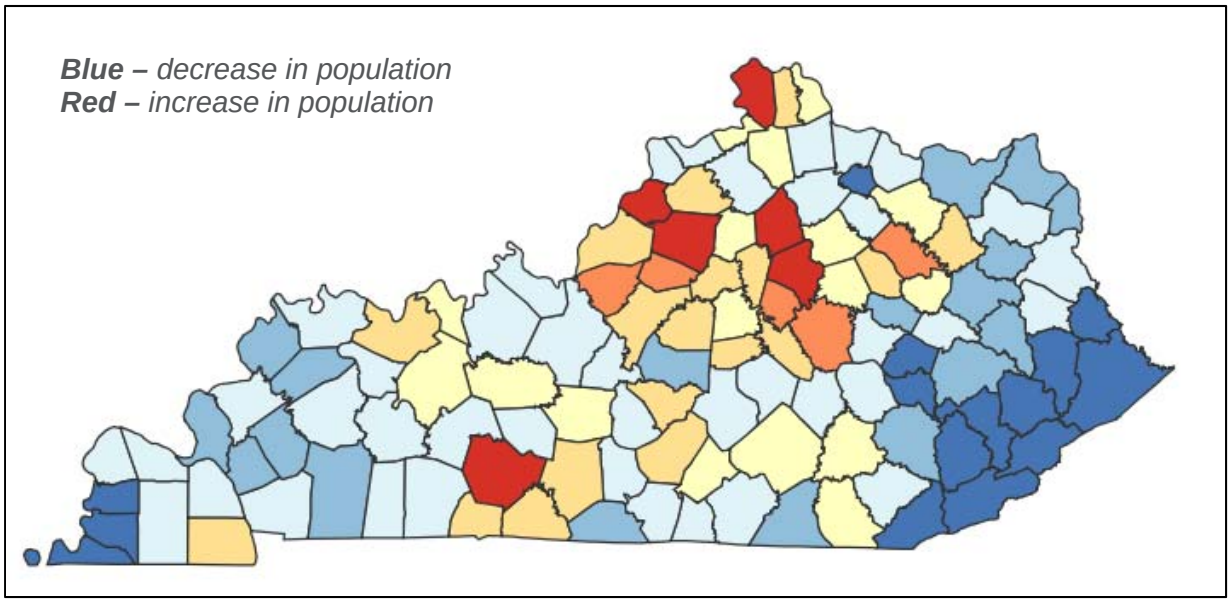
Figure 3.1 Kentucky Population Density by County, 2018[48]



In recent years, rural counties, particularly in the eastern part of the Commonwealth, have experienced a decrease in population while urban counties have experienced population growth, as illustrated in Figure 3.2.

[47] Kentucky Population. (2018-01-19). Retrieved 2018-05-25. Available at: http://worldpopulationreview.com/states/kentucky-population/
[48] Kentucky Population. (2018-01-19). Retrieved 2018-05-25. Available at: http://worldpopulationreview.com/states/kentucky-population/

Figure 3.2 Kentucky Population Growth Rate by County, 2018[49]

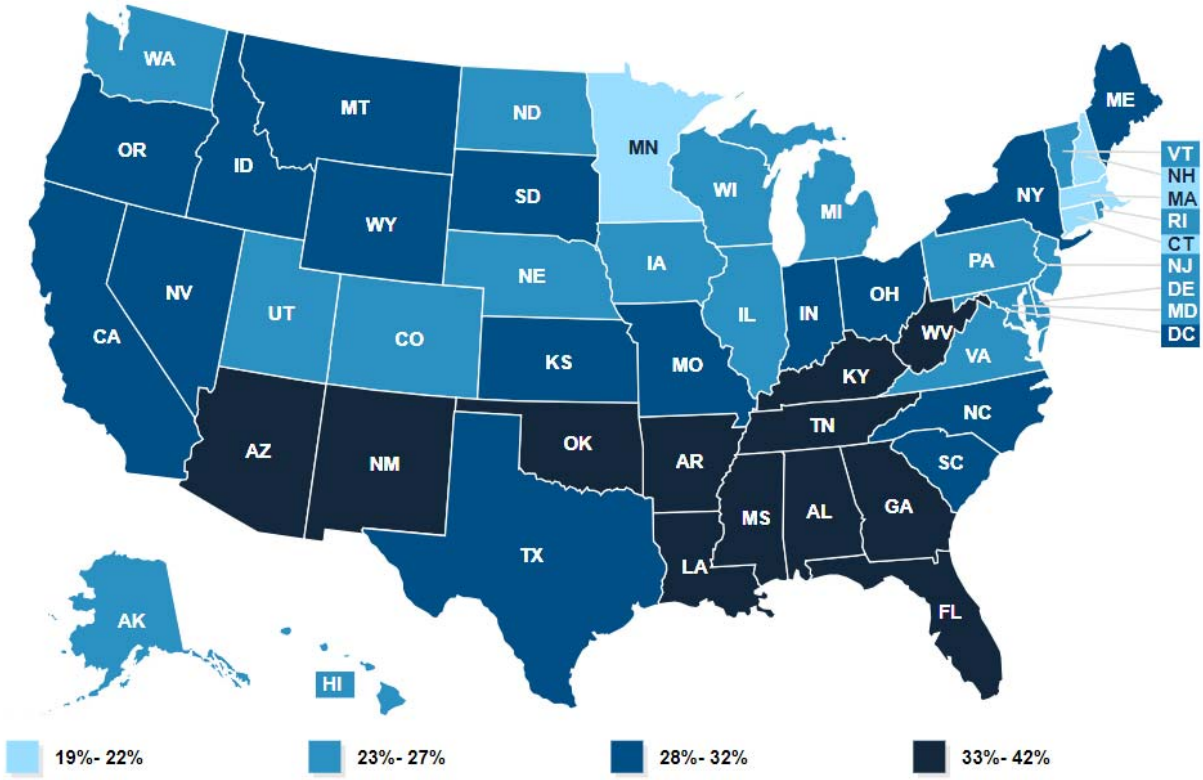


Poverty Rates in Kentucky

With a median household income of $44,811, Kentucky has the fifth highest percentage nationally (37 percent) of individuals living under 200 percent of the Federal Poverty Level (FPL).[50] Figure 3.3 illustrates how Kentucky compares to other states and the United States as a whole, with respect to FPL.

[49] Kentucky Population. (2018-01-19). Retrieved 2018-05-25, Available at: http://worldpopulationreview.com/states/kentucky-population/
[50] United States Census Bureau. Quick Facts, Kentucky, 2016. Available at: https://www.census.gov/quickfacts/fact/table/ky/INC110216

Figure 3.3 Percent of the Total Population under the Federal Poverty Level (below 200% FPL), in 2016[51]



Location	Under 200%
1. Kentucky	37%
United States	**30%**

Health Outcomes in Kentucky

In addition to high poverty rates compared to other states, citizens of the Commonwealth experience higher rates of several chronic health conditions when compared to other states. This trend impacts HCBS delivery, as many waiver participants often struggle to manage multiple chronic conditions and cope with a high likelihood that their natural supports may also be adversely impacted by the same poor health indicators. Figure 3.4 summarizes where Kentucky ranks nationally on key health indicators.

[51] Kaiser Family Foundation. Distribution of the Total Population by Federal Poverty Level. 2016. Available at: https://www.kff.org/other/state-indicator/population-up-to-200-fpl/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

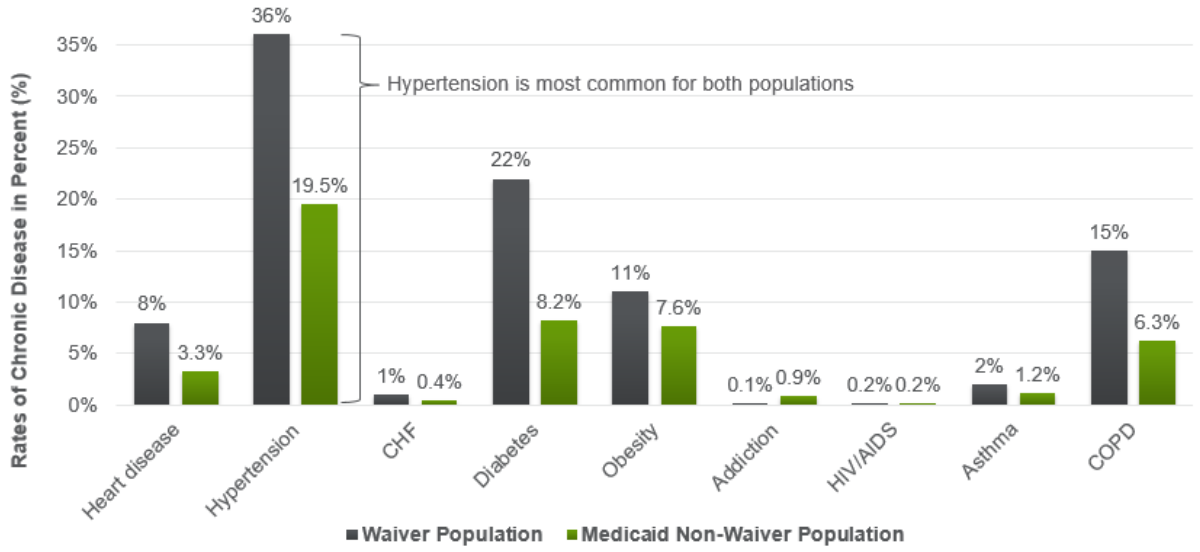
Figure 3.4 Kentucky Health Status Compared to Other States, 2016[52]

Health Indicator	Kentucky	State Rank
Adult Overweight/Obesity Rate	69.1%	5th
Poor Mental Health Among Adults	35.3%	23rd
Adults Reporting Fair or Poor Health Status	22.5%	6th
Percent of Adults Who Have Ever Been Told by a Doctor that They Have Diabetes	13.1%	6th
Opioid Overdose Death Rate (per 100,000 people)	23.6	10th
All Drug Overdose Death Rate (per 100,000 people)	33.5	6th

Among Kentucky's Medicaid recipients, including waiver participants, incidence of chronic diseases is high. For example, eight percent of 1915(c) waiver participants have heart disease compared to just three percent of non-waiver participants. Hypertension remains the most prevalent chronic condition among 1915(c) waiver participants, with 36 percent reporting they are hypertensive versus approximately 20 percent of non-waiver participants. Figure 3.5 highlights the rates of chronic diseases in the 1915(c) waiver population compared to the Medicaid non-waiver population, with the 1915(c) waiver population often reporting higher disease rates for common chronic diseases.[53]

[52] Kaiser Family Foundation. Medicaid State Fact Sheets. June 16, 2017. Available at: https://www.kff.org/interactive/medicaid-state-fact-sheets/
[53] Statistics provided by the Cabinet for Health and Family Services in January 2018.

Figure 3.5. Chronic Disease Rates in 1915(c) Waiver and Medicaid Non-Waiver Populations in Kentucky[54]



3.2 Profile of Kentucky's Medicaid Program

As of March 2018, Kentucky Medicaid and the Children's Health Insurance Program (CHIP) cover 22 percent of the Commonwealth's total population, approximately 1.2 million individuals. Medicaid and CHIP provide services to low-income children, pregnant women, adults, seniors, and individuals with disabilities. Figure 3.6 shows the distribution of health insurance coverage across the Commonwealth's population.

Figure 3.6 Overview of Health Coverage in Kentucky, 2015[55]

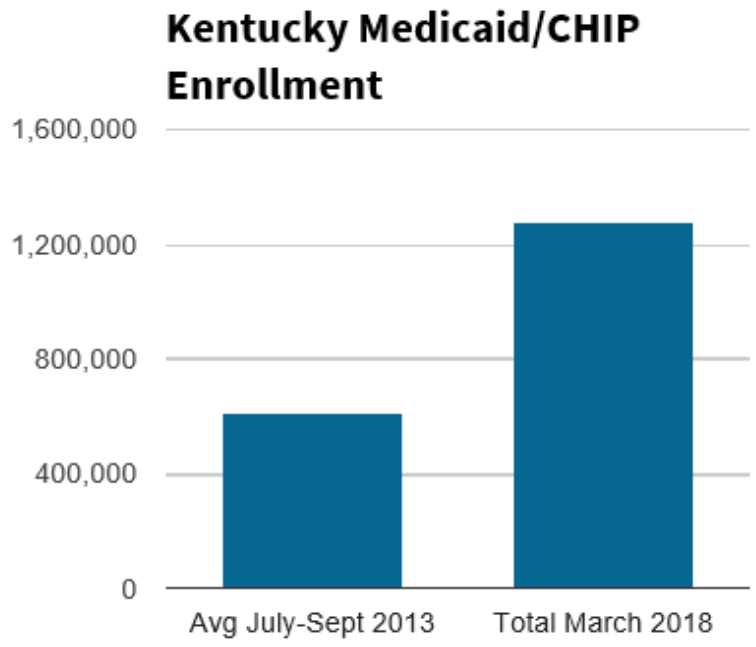
Health Coverage	Percentage*
Employer	45%
Medicaid / CHIP	22%
Medicare	16%
Non-Group	9%
Uninsured	6%

**Note: Percentages do not sum to 100 percent due to rounding.*

[54] Statistics provided by the Cabinet for Health and Family Services in January 2018.
[55] Kaiser Family Foundation. Medicaid in Kentucky. June 2017. Available at: http://files.kff.org/attachment/fact-sheet-medicaid-state-KY

Since the implementation of the ACA in 2013, Medicaid and CHIP enrollment increased in Kentucky from 600,000 in 2013 to over 1.2 million in March 2018, as shown in Figure 3.7. In addition to increasing Medicaid enrollment, the ACA had a significant impact on decreasing the rates of uninsured individuals. In Kentucky, the uninsured rate decreased from 14 percent to 6 percent from 2013 to 2015.[56]

Figure 3.7 Increase in Kentucky Medicaid/CHIP Enrollment Between 2013 and 2018[57]



Over the past two decades, total Medicaid spending has increased in Kentucky and nationally, with the largest increase compared to the national average from FY 2010-2014, as shown in Figure 3.8. Kentucky Medicaid spending increased nine percent during this period while nationally, Medicaid spending increased just over five percent.

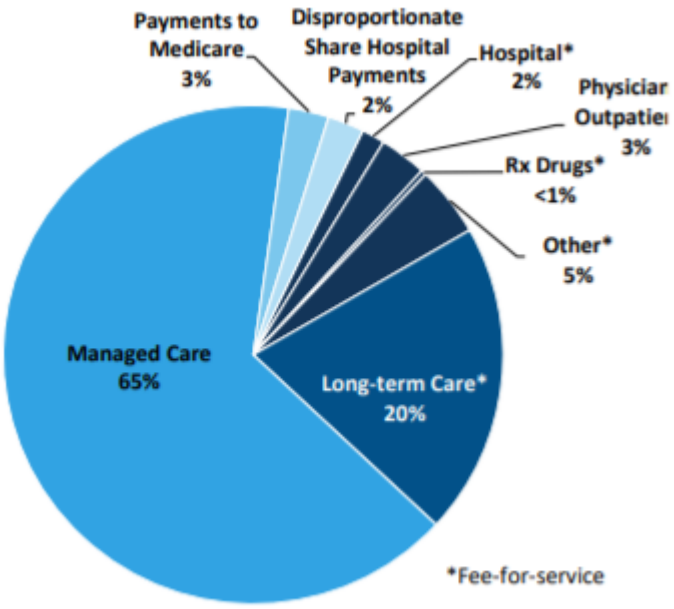
[56] Kaiser Family Foundation. Medicaid in Kentucky. June 2017. Available at: http://files.kff.org/attachment/fact-sheet-medicaid-state-KY
[57] Medicaid.gov. Medicaid & CHIP in Kentucky. June 2018. Available at: https://www.medicaid.gov/state-overviews/stateprofile.html?state=kentucky

Figure 3.8 Average Annual Growth in Medicaid Spending[58]

Location	FY 1990-2001	FY 2001-2004	FY 2004-2007	FY 2007-2010	FY 2010-2014
United States	**10.9%**	**9.4%**	**3.6%**	**6.8%**	**5.2%**
Kentucky	11.6%	8.4%	2.1%	6.9%	9.0%

Total Medicaid spending in Kentucky was $9.7 billion in FY 2016, with approximately 20 percent devoted to LTSS. Additionally, 41 percent of LTSS spending was for home and community-based care.[59] Kentucky has the seventh lowest share of LTSS spending attributed to HCBS, with the national average at 55 percent. [60] This suggests that there may be more room for rebalancing by shifting costs from institutional settings to HCBS settings moving forward.

Figure 3.9 Distribution of Medicaid Spending, FY 2016[61]



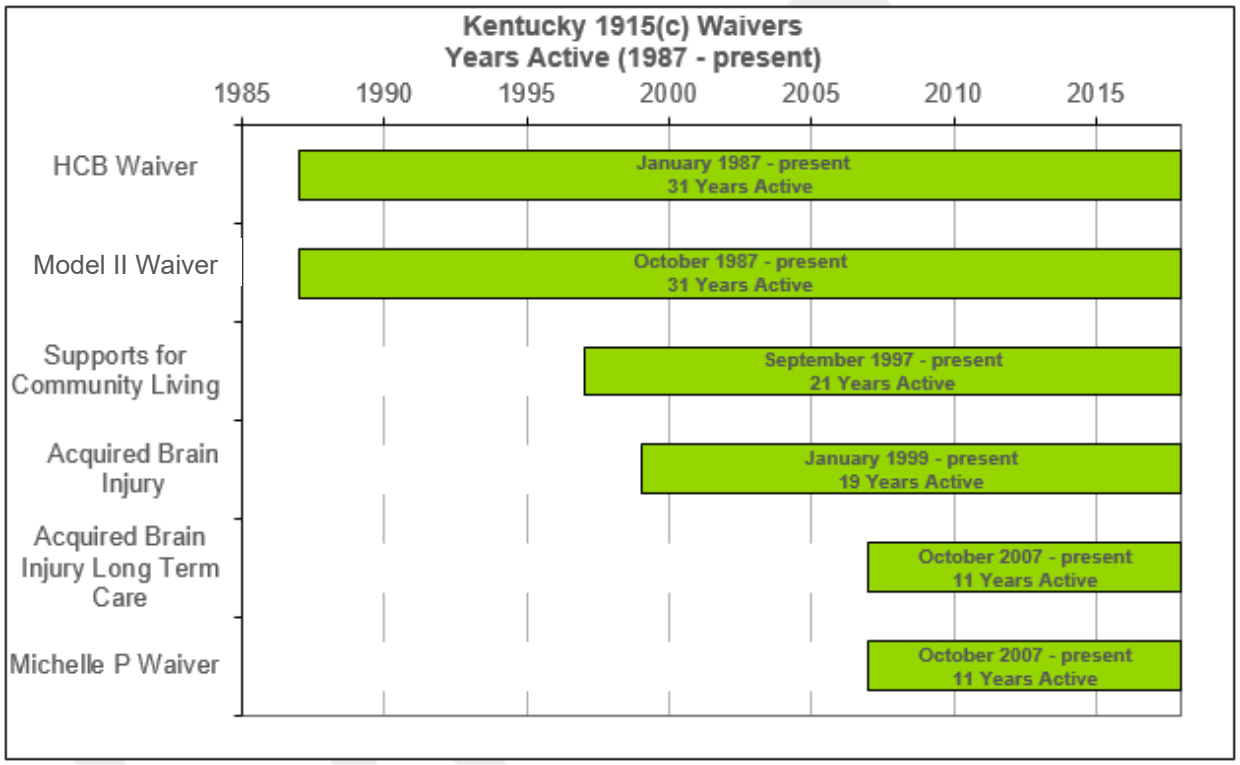
[58] Kaiser Family Foundation. Average Annual Growth in Medicaid Spending. Available at: https://www.kff.org/medicaid/state-indicator/growth-in-medicaid-spending/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[59] Kaiser Family Foundation. Medicaid in Kentucky. June 2017. Available at: http://files.kff.org/attachment/fact-sheet-medicaid-state-KY
[60] Truven Health Analytics. Medicaid Expenditures for Long-Term services and Supports (LTSS in FY 2015. April 2017. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf.
[61] Kaiser Family Foundation. Medicaid in Kentucky. June 2017. Available at: http://files.kff.org/attachment/fact-sheet-medicaid-state-KY

3.3 Profile of Kentucky's 1915(c) Waivers

History of 1915(c) Waivers in Kentucky

Kentucky has operated 1915(c) waivers since 1987, when both the Home and Community Based (HCB) Waiver and the Model II Waiver (MIIW) were first implemented. The Commonwealth currently operates six 1915(c) waivers, shown in Figure 3.10. These waivers include fully approved waivers and waivers that are temporarily extended and are currently under negotiations with CMS.

Figure 3.10 1915(c) Waivers in Kentucky (1987 - present)[62]



Today, all six 1915(c) waivers provide coverage to Medicaid-eligible elderly and disabled Kentuckians who meet eligibility criteria for the individual waivers. Figure 3.11 lists the current waivers in Kentucky and provides a brief description of each.

[62] Medicaid.gov. Kentucky Waiver Factsheet. 2018. https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/Waiver-Descript-Factsheet/KY-Waiver-Factsheet.html#KY0333

Figure 3.11 Kentucky's 1915(c) Waivers, 2018[63]

Waiver Name	Description
Acquired Brain Injury (ABI)	The Acquired Brain Injury waiver program was developed as an alternative to institutional care for Kentucky residents with acquired brain injuries. The ABI waiver focuses on intensive rehabilitation and retraining to assist individuals with acquired brain injury in reentering and functioning independently within a community given the community's existing resources.
Acquired Brain Injury Long Term Care (ABI-LTC)	The Acquired Brain Injury Long Term Care waiver program was developed to serve Kentucky residents as an alternative to institutional care for individuals with acquired brain injuries who have reached a plateau in their rehabilitation level, and require maintenance services to avoid institutionalization and live safely in the community. The ABI-LTC waiver completes the continuum of care by complementing Kentucky's existing ABI waiver, which focuses on intensive rehabilitation for individuals with ABI.
Home and Community Based (HCB)	The HCB waiver program is designed to prevent institutionalization of aged or physically disabled individuals by offering effective, individualized services that ensure the health, safety and welfare of participants so they may remain in their own home and community.
Model II Waiver (MIIW)	The Model II Waiver program provides in-home services for individuals who are dependent on a ventilator for 12 hours or more per day.
Michelle P. (MPW)	The Michelle P. Waiver program offers individualized community-based services to divert individuals who have intellectual or developmental disabilities and otherwise need institutional services from an ICF/IID and to support individuals who transition from ICF/IID institutional services to the community.
Supports for Community Living (SCL)	The Supports for Community Living waiver program offers individualized community-based services to divert individuals who have intellectual disabilities and otherwise need institutional services from an ICF/IID and to support individuals who transition from ICF/IID institutional services to the community.[64]

Collectively, waivers have capacity to provide services to approximately 33,000 Kentuckians, with the two largest waivers being the HCB and Michelle P. waivers (with approximately 17,000 and 10,500 designated slots, respectively, as of March 2018).[65] Figure 3.12 shows the breakout of these figures by each waiver.

[63] Medicaid.gov. State Waiver List. 2018. Available at: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html
[64] Residential services are offered in the SCL waiver.
[65] Statistics provided by the Cabinet for Health and Family Services.

Figure 3.12 Kentucky HCBS Waivers, Target Populations and Slot Counts, March 2018[66]

1915(c) Waiver	Target Population	Slot Count / Waiting list
Home & Community Based	Aged and Physically Disabled	17,050 / 0
Model II Waiver	Technology Dependent	100 / 0
Supports for Community Living	Individuals with Intellectual or Developmental Disabilities (Residential)	4,941 / 2,415
Michelle P. Waiver	Individuals with Intellectual or Developmental Disabilities (Non-Residential)	10,500 / 6,178
Acquired Brain Injury	Adults with Acquired Brain Injury with acute rehabilitative need	383 / 0
Acquired Brain Injury – LTC	Adults with Acquired Brain Injury who require long-term care	320 / 219
Total HCBS Slot Counts / Waiting list		**33,294 / 8,812**

Expenditures by 1915(c) Waiver and Service

In FY 2015, Kentucky's total Medicaid 1915(c) waiver expenditures were $741.5 million, as compared to $957.6 million for nursing facilities and $140.5 million for Intermediate Care Facilities for Individuals with Intellectual Disabilities.[67] Figure 3.13 shows the waiver expenditures for each waiver and average spending per participant based on each waiver's most recent CMS 372 report, between January 2016 and September 2017.

[66] Statistics provided by the Cabinet for Health and Family Services.
[67] Truven Health Analytics. Medicaid Expenditures for Long-Term services and Supports (LTSS0 in FY 2015. April 14, 2017. Available at: https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf.

Figure 3.13 Annual Expenditures by 1915(c) Waiver Between January 2016 and September 2017[68]

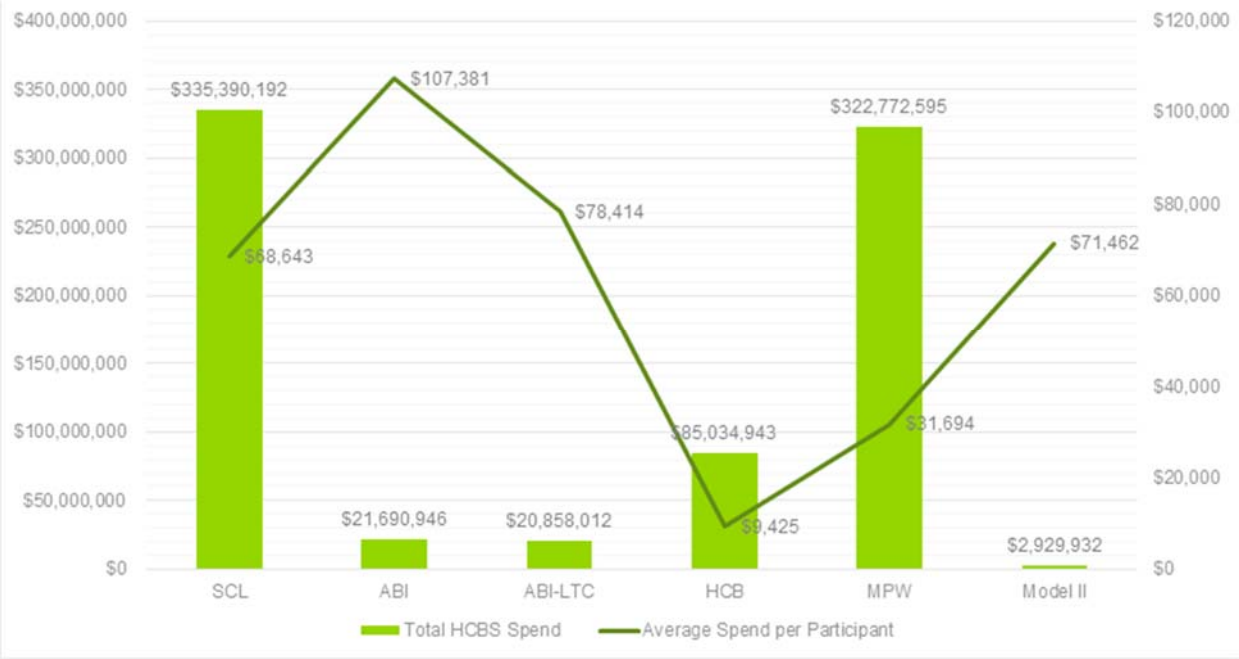


Figure 3.14 depicts the top ten 1915(c) waivers services with the highest expenditures across the Commonwealth's six 1915(c) waivers between January 2016 and September 2017.

Figure 3.14 Kentucky's Top Ten 1915(c) Waiver Services by Total Expenditures Between January 2016 and September 2017[69]

HCBS Service	Total Expenditures	Percentage of Total 1915(c) Waiver Expenditures*	Total Units
Home and Community Supports	$203,812,555	26%	47,073,990
Level 1 Supervised Residential Care	$163,477,662	21%	944,713
Level 2 Supervised Residential Care	$69,397,048	9%	494,419
Day Training	$52,982,654	7%	23,115,378

[68] Based on data from CMS 372 reports between January 2016 and September 2017. Applicable dates varied by waiver within this timeframe.
[69] Based on data from CMS 372 reports between January 2016 and September 2017. Applicable dates varied by waiver within this timeframe.

HCBS Service	Total Expenditures	Percentage of Total 1915(c) Waiver Expenditures*	Total Units
Behavioral Services	$43,287,627	5%	1,303,214
Home and Community Supports (PDS)	$32,096,900	4%	10,596,186
Adult Day Health Care	$30,922,657	4%	11,031,816
Personal Assistance	$28,262,445	4%	5,330,754
Case Management	$23,312,901	3%	156,076
Support Broker (CDO)	$23,182,538	3%	91,084

**Note: Percentages will not sum to 100 percent, as this table represents only the top ten 1915(c) waiver services by expenditures.*

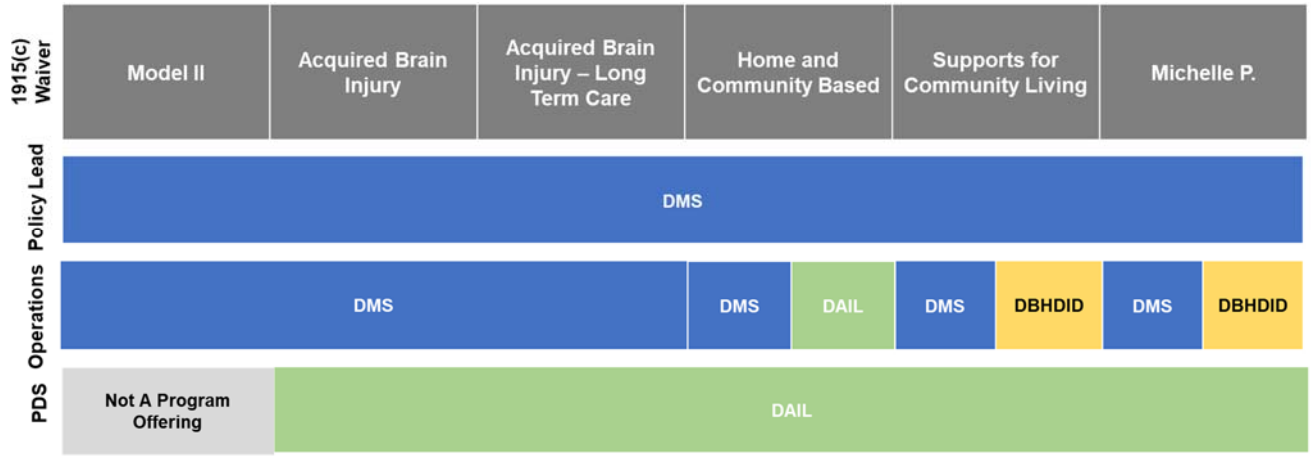
3.4 Cabinet Organizational Structure for Administration and Oversight of 1915(c) Waiver Programs

DMS is one of seven departments in the Cabinet for Health and Family Services (CHFS) and is the Single State Medicaid Agency. See Appendix D for a DMS organizational chart. Two sister agencies, the Department for Aging and Independent Living (DAIL) and the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID), play a key role in operating Kentucky's HCBS waivers along with DMS.

Role of DMS, DAIL and DBHDID in Operating Kentucky's HCBS Waivers

As illustrated in Figure 3.15, DMS has oversight of all six 1915(c) waivers and operates the two Acquired Brain Injury waiver programs and the Model II waiver program. DMS also has oversight of the PDS program. The Department for Aging and Independent Living (DAIL) shares operating functions with DMS for the Home and Community-Based waiver and supports operation of PDS for all waivers that allow PDS. The Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) shares operating functions with DMS for the SCL and Michelle P. waivers.

Figure 3.15 Department Responsibility, by 1915(c) Waiver



Role and Structure of DMS's Division of Community Alternatives

The Division of Community Alternatives (DCA) is the division within DMS that is responsible for HCBS waiver administration and oversight. DCA is divided into branches, organized by waivers the branch oversees. Waivers are assigned accordingly:

Acquired Brain Injury Branch

- Acquired Brain Injury Waiver
- Acquired Brain Injury Long-Term Waiver

Home and Community-Based Services Branch

- Home and Community Based Waiver
- Model II Waiver

Mental Health, Intellectual and Developmental Disabilities (MH/IDD) Community Services Branch

- Michelle P. Waiver
- Supports for Community Living Waiver

Each branch has a manager who oversees the functions and staff of the branch. Individual branches have differing sets of responsibilities for end-to-end program oversight, as the sister agencies have varying levels of delegated responsibilities for the applicable 1915(c) waivers. For example, the Acquired Brain Injury waivers are administered entirely within DCA by the Acquired Brain Injury Branch, while the other two branches partner with an operating agency to share oversight and administration responsibilities. All branches are overseen by a division Assistant Director and Director. At the time of the report release, DCA does not have an acting Director.

In addition to the branch managers, DCA has a manager who oversees the assigned responsibilities and staff for the team from the University of Kentucky's Institute for Pharmaceutical Outcomes and Policy (UK). UK contracted staff oversee and support several waiver-related initiatives including the Kentucky Transitions program, Independent Assessment team for the HCB waiver, and the Commonwealth's transition plan execution to comply with CMS' HCBS Settings Rule of 2014. DMS has assigned oversight of UK contract staff to a Senior Clinical Program Manager who reports directly to the DMS Commissioner.

Chapter 4: Summary of High-Impact Policies and Considerations for HCBS Programs

This chapter offers a summary of policies and/or regulations that directly impact HCBS programs nationally, along with the impacts specifically for Kentucky's HCBS waivers.

4.1 The Olmstead Ruling of 1999

The Olmstead decision, issued in 1999, is a hallmark judiciary ruling that has played a significant role in advancing HCBS delivery and emphasis on rebalancing Medicaid-funded LTSS. The Supreme Court decision declared "unjustified institutionalization of people with disabilities" as unlawful, ruling that care must be delivered in the "most integrated setting appropriate."[70] Although the decision is nearly 20 years old, numerous cases in lower courts have applied Olmstead act principles to cases that have resulted in adverse findings for many states and in some cases, required states to enter settlement agreements with the Federal Department of Justice (DOJ). Attention to Olmstead is critical to establish a sound Medicaid-funded LTSS delivery system, acknowledging that Medicaid is the primary funder of publicly funded LTSS.

Rebalancing in Kentucky

Kentucky lags compared to other states in its progress toward shifting the majority of Medicaid spend from institutional LTSS models to HCBS service delivery. The Commonwealth ranks in the bottom quintile of states based on CMS reporting issued in 2017, ranking 43rd in comparative spend between institutional vs HCBS. Rebalancing progress differs significantly by disability population. Kentucky ranked 25th in the nation for rebalancing specific to individuals with development or intellectual disabilities, spending roughly 81 percent of LTSS spend for HCBS in FY 2015. The Commonwealth is the lowest ranked state in the nation for rebalancing specific to older and physically disabled individuals, spending only 12.5 percent of LTSS spend on HCBS, with the rest devoted to institutional care. It is noted that this low percentage has negatively trended in recent years, when 2014 reporting showed that roughly 15 percent was spent on HCBS for this population.

[70] Kaiser Family Foundation. Olmstead's Role in Community Integration for People with Disabilities Under Medicaid: 15 Years After the Supreme Court's Olmstead Decision. Available at: http://kff.org/medicaid/issue-brief/olmsteads-role-in-community-integration-for-people-with-disabilities-under-medicaid-15-years-after-the-supreme-courts-olmstead-decision/

Figure 4.1 HCBS and LTSS Spending Breakdown: Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY2012 Through 2015[71]

Percentages	FY 12	FY 13	FY 14	FY 15
LTSS as a % of Total Medicaid Spend	29.8%	29.1%	23.9%	20.6 %
% of LTSS spend that is HCBS vs. institutional	37.3%	38.2%	40.9%	41.3%
% of total HCBS spent for individuals who are aging and/or have physical disabilities	14.8%	12.9%	12.7%	12.5%
% of total HCBS spent for individuals who are Developmentally/Intellectually Disabled	71.6%	72.4%	79.7%	81.1%

One initiative that Kentucky has leveraged to promote rebalancing, is the Money Follows the Person (MFP) program. The Deficit Reduction Act (2005) authorized the MFP program to encourage states to facilitate the transition of individuals who choose to move from Medicaid funded long-term care settings (nursing facilities, intermediate care facilities, etc.) into the community. Kentucky was awarded MFP funds beginning in 2007. MFP goals included:

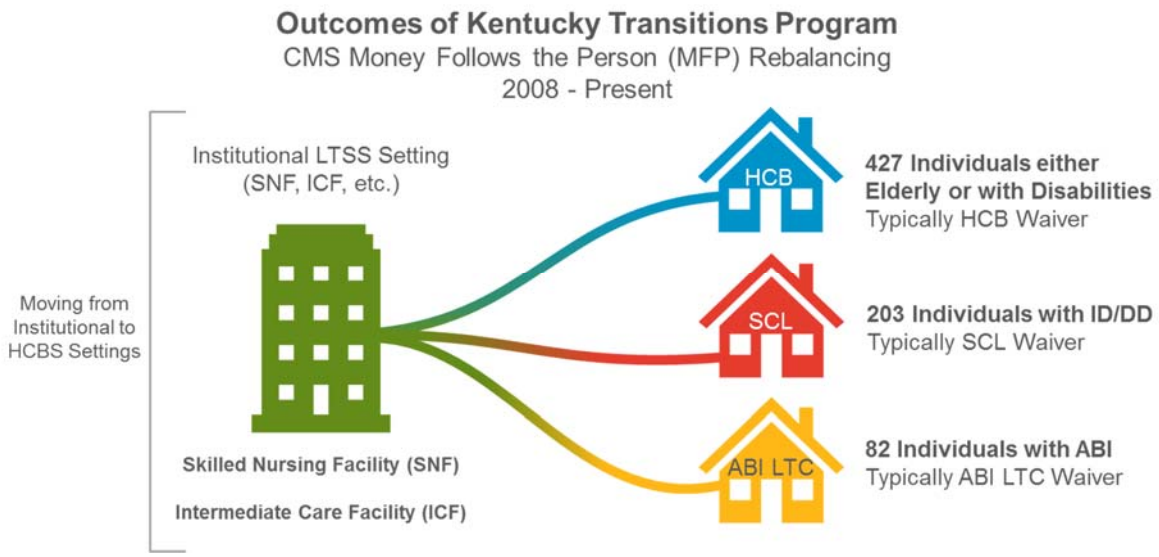
- Increase the use of home and community-based services (HCBS) and reduce the use of institutionally-based services
- Eliminate barriers in state law, state Medicaid plans, and state budgets that restrict the use of Medicaid funds to let people get long-term care in the settings of their choice
- Strengthen the ability of Medicaid programs to provide HCBS to people who choose to transition out of institutions
- Implement procedures to provide quality assurance and improvement of HCBS

Forty-four (44) states and the District of Columbia participated in the MFP initiative, resulting in a nationwide total of 63,337 individuals being transitioned to the community through 2015.[72] Kentucky has shown positive outcomes in its MFP efforts, transitioning 712 individuals from institutional settings into the community, as shown in Figure 4.2.

[71] Truven Health Analytics. Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015. April 14, 2017. Available at: https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf

[72] Hargan, Eric D., Acting Secretary of the Department of Health and Human Services. Report to the President and Congress The Money Follows the Person (MFP) Rebalancing Demonstration. June 2017. Available at: https://www.medicaid.gov/medicaid/ltss/downloads/money-follows-the-person/mfp-rtc.pdf

Figure 4.2 Overview of MFP Transitions – Number of Participants Transitioned to HCBS from Institutional Setting



4.2 HCBS Settings Rule of 2014

CMS issued their final rule (CMS 2249F) in January 2014 that affects HCBS provided through Medicaid waivers. The regulations:

1. Provided a new definition of a home and community-based setting
2. Defined person-centered planning requirements and conflict of interest standards for case management
3. Required states to develop transition plans for bringing all HCBS settings into compliance

The HCBS Settings Rule has resulted in widespread scrutiny of HCBS settings across the states, including debate and need for clarity regarding residential and congregate day settings like adult day health or vocational training sites, to ensure that HCBS services are truly community-based. Settings must support participant access to and inclusion in community and avoid institutional-like qualities. CMS has advocated that the nature of the rule promotes improved community participation and quality of life for individuals who require HCBS and retains their right to full participation in community including access to family and social networks, employment and participation in community like all non-disabled citizens.

CMS required all states to assess congregate and residential provider types, along with their state policies, procedures and other program documentation to ensure that programs are fully aligned with the rule. States were responsible to submit their draft plan to CMS for approval following this assessment, sharing concrete actions and plans for existing providers to transition and update their physical location, layout, and operational practices to fully comply with standards outlined in the rule. The settings rule has significantly impacted how service

packages are composed in 1915(c) waivers. The rule has also overhauled how service planning, coordination and case management services are delivered across HCBS programs in all 50 states. All states must be fully compliant with the rule by March 2022, following a recent 3-year extension issued by CMS in 2017, in response to concerns that provider access could be negatively impacted due to the struggle states have experienced meeting the standards by the original deadline of 2019.[73]

HCBS Settings Requirement

The HCBS Settings Rule outlined numerous settings requirements intended to ensure that service delivery locations and environmental conditions were free of institutional characteristics, to meet the core objectives of community-based service delivery. The rule included several restrictions for where a residential or congregate site can be located and considers the following sites to lack community-based quality:

- Locations in a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, or an institution for mental disease
- Locations in/on the grounds of/adjacent to a public institution
- Locations that have the effect of isolating individuals from the broader community, such as:
    - Farmsteads in rural areas
    - Gated communities for people with disabilities
    - Residential schools

The rule also established specific parameters required for HCBS residential services, to ensure that individuals serviced using in a residential site or model, have similar autonomies and freedoms compared to those who reside in a private residence. New requirements included:

- Participant freedom to control their own schedules
- Access to privacy in their living unit
- Freedom to furnish or decorate their unit as they wish
- Choice of roommate
- Access to food at any time
- Ability to have visitors at any time

Each state must conduct a scan of provider policies and practices and conduct on-site visits to assess risk of non-compliance. Those providers who ran a higher risk of being unable to meet these standards could be placed by the state on “heightened scrutiny” – expanded monitoring

[73] CMCS Information Bulletin, “Extension of Transition Period for Compliance with Home and Community-Based Settings Criteria.” May 9, 2017. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib050917.pdf

and enforcement and assist providers with resolving barriers to compliance within the deadline for full transition.

Person-Centered Planning Requirements

In addition to physical settings requirements, the HCBS Settings Rule includes requirements to improve case management, service planning and coordination activities, by making them more "person-centered" in order to align with a community-based social model of care. Historically, case management practices had operated in a medical model-like fashion, in which an assessment was performed, a participant's needs were identified by his or her case manager, and services were offered based on professional determination of which services were most appropriate to meet the individual's needs, leaving participants with the right to accept or deny services but otherwise giving limited input or empowerment to drive their service plan.

The HCBS Settings Rule includes standards for person-centered service delivery, broadening these principles beyond the person-centered movement, which had been building years prior to the 2014 rule. All 1915(c) waiver programs must now incorporate person-centered planning into the service planning, coordination and monitoring practice, including:

- Allowing the individual participant and/or designated representative to lead the person-centered planning process
- Including family members, friends, and others selected by the individual in the planning process
- Providing individuals with necessary information to make informed decisions about their choice of available services and providers
- Reflecting the individual's strengths, preferences, goals and desired outcomes in the plan development and execution

These standards have had broad impacts to service coordination and case management activities, leading to adjustments in assessment tools, service planning templates, participant educational materials and professional practices, to reinforce a system that allows the participant to self-select the services and supports best aligned with their personal goals and desires for community participation.

Kentucky's Implementation of the Settings Rule

In March 2016, Kentucky submitted its draft Statewide Transition Plan (STP) in response to the HCBS Settings Rule. Following the first round of feedback from CMS, the State requested several technical corrections to receive initial approval. Kentucky resubmitted an updated version on May 17, 2016. CMS subsequently granted initial approval of Kentucky's STP on June 2, 2016.

Kentucky developed its Statewide Transition Plan (STP) over several months and following multiple rounds of feedback from CMS, received initial approval from CMS for two key reasons:[74]

- Kentucky completed its systemic assessment, included the outcomes of this assessment in the STP, and clearly outlined remediation strategies to rectify issues that the systemic assessment uncovered, such as legislative changes and changes to contracts. Kentucky is actively working on those remediation strategies.
- Kentucky submitted the March 2016 draft of the STP for a 30-day public comment period, made sure information regarding the public comment period was widely disseminated, and responded to and summarized the comments in the STP submitted to CMS.

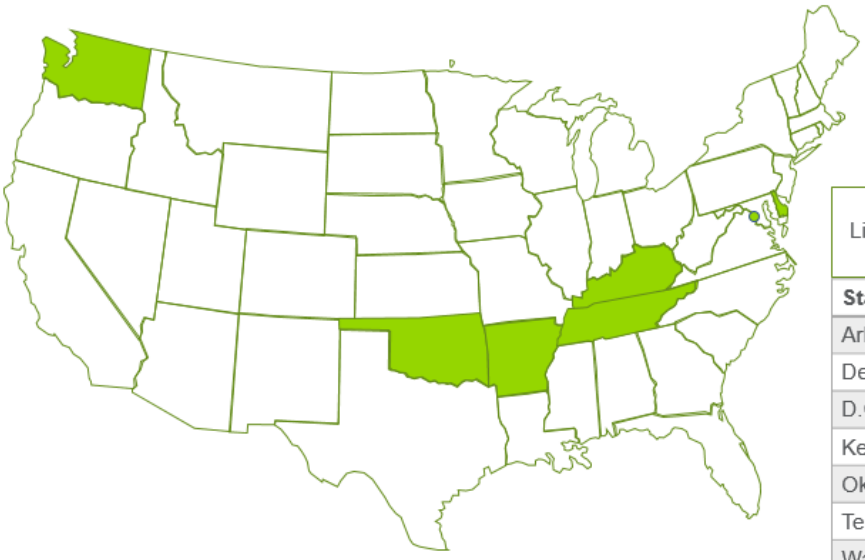
Importantly, Kentucky's transition plan included detailed processes to evaluate and revise the Kentucky HCBS waiver programs, which were broken into four sections, including:

1. Policy and monitoring assessment
2. Provider assessment (residential and non-residential settings)
3. Remedial strategy (focused on state and provider remedial actions)
4. Process for public comment

Final approval was granted by CMS to Kentucky on June 13, 2017, roughly one year following the initial approval of the STP. Kentucky was one of the first states to receive this status and is still only one of seven states (including District of Columbia) granted final approval. Figure 4.3 lists all states granted final approval by CMS to date.

[74] Kentucky Initial Approval of its Statewide Transition Plan (STP). June 2, 2016. Available at: https://www.medicaid.gov/medicaid/hcbs/downloads/ky/ky-intl-appvl.pdf

Figure 4.3 States Granted Final Approval of STP from CMS, as of June 2018[75]



Key:
Lime green states have been granted Final Approval of STP

State	Final Approval Date
Arkansas	June 2, 2017
Delaware	October 13, 2017
D.C.	October 6, 2017
Kentucky	June 13, 2017
Oklahoma	August 10, 2017
Tennessee	April 13, 2016
Washington	October 24, 2017

Progress in Kentucky 2014 to Today

Progress related to the STP is actively occurring and will continue through March 2019. The STP is being implemented in two rounds. Transition plan activities and progress to date falls into four main categories, including:

1. Transition plan
2. Provider compliance
3. Heightened scrutiny
4. Regulations and waiver amendments

Figure 4.4 shows some examples of activities completed to date. Note this figure is not an exhaustive list of STP activities.

[75] Medicaid.gov. Statewide Transition Plans. Available at: https://www.medicaid.gov/medicaid/hcbs/transition-plan/index.html

Figure 4.4 Kentucky Example STP Implementation Activities, by Timeframe and Category[76]

Year(s)	Transition Plan	Provider Compliance	Heightened Scrutiny	Regulations and Waiver Amendments
First Round Changes				
2014-2015	Submit transition plan to CMS	Develop HCBS evaluation tool (monitoring tool for determining compliance)	N/A	Determine regulation language with workgroup for first round of changes
2016	Ongoing	Ongoing	Organize documentation from compliance plan templates, mapping, on-site visits, and review by stakeholders for each setting who will need heightened scrutiny	Revised HCBS regulations become effective
2017 (1)	Ongoing	Submit updated transition plan to CMS	Submit first heightened scrutiny submission to CMS	Ongoing
Second Round Changes				
2017 (2)	Ongoing	Host public forums for providers and participants (families, advocates, etc.) related to the implementation of the second round of changes	Ongoing	Determine regulation language with workgroup for second round of changes

[76] Kentucky Approved Statewide Transition Plan (STP). Available at: https://www.medicaid.gov/medicaid/hcbs/downloads/ky/ky-approved-plan.pdf

Year(s)	Transition Plan	Provider Compliance	Heightened Scrutiny	Regulations and Waiver Amendments
2018-2019	Ongoing	Incorporate second round HCBS final rules in all ongoing reviews	Incorporate second round HCBS final rules in all ongoing reviews	File revised regulations

Future steps and overarching actions that Kentucky must take to comply with CMS are to critically incorporate results and feedback from the current assessment activities outlined in the timeline of activities to maintain good standing with CMS guidance.

4.3 Expansion of the Participant-directed Service Model

Participant-directed services (PDS) has increased in recent years and presented an entirely new model of participant self-managed care, including the ability to opt for expanded employer and budget authorities to maintain more autonomy over care and services. This model represents a stark departure from the traditional service model, where participants were given authority to select their services, and providers, and then relied on providers to supply the individuals responsible to provide in-person, hands-on care. This traditional model, while necessary for those who are not willing and able to self-direct, has been beset by complaints that participants lack autonomy and run a higher risk of dissatisfaction with the individuals who provide their care. The model also represented a departure from traditional model delivery of goods and services, allowing participants greater control and flexibility over how they would use their allocated “budget” to purchase the goods and services needed to maximize community independence and participation.

History of Participant Direction

PDS started as a demonstration program sponsored by the Robert Wood Johnson Foundation (RWJF) and the U.S. Department of Health and Human Services (HHS), titled the “Cash and Counseling” pilot. The pilot was conducted in three state Medicaid programs, to test the ability of HCBS programs to advance “self-determination” principles in the service planning and delivery process. PDS programs have grown and evolved significantly over the last thirty years due to several key federal policy changes as shown in Figure 4.5.

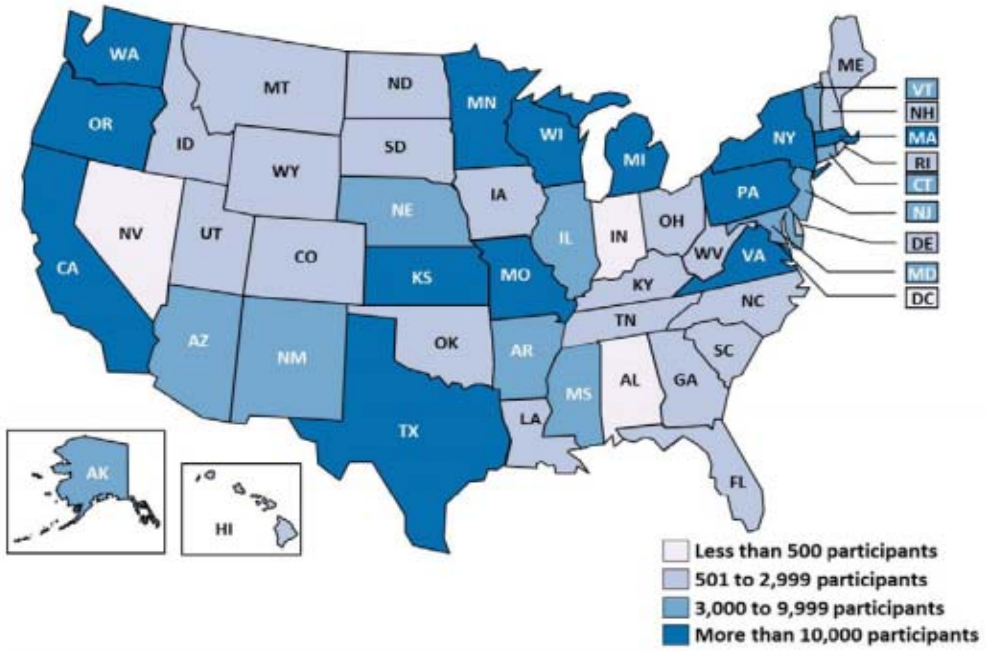
Figure 4.5 Key Federal Policy Changes Regarding PDS[77]

Year	Federal Policy Change
1993	• Congress added personal care to the list of optional services that states could cover under their Medicaid state plan • Congress granted states the explicit authority to provide personal care services in the participant's home • Congress removed regulations requiring personal care service be supervised by a nurse
1999	• The State Medicaid Manual expanded the definition of personal care services to include assistance in performing essential activities of daily living (ADLs) and assistance performing instrumental activities of daily living (IADLs) such as housekeeping, laundry and meal preparation • CMS, then the Health Care Financing Administration, permitted relatives to provide personal care services • CMS guidance acknowledged that services can be directed by the participant
2001	• The New Freedom Initiative created Independence Plus, which mainstreamed participant direction for the first time under 1915(c) waivers

As of 2016, All fifty states and the District of Columbia operate PDS Medicaid programs serving over one million participants[78]; with most states enrolling between 1,000 and 5,000 participants in PDS programs as shown in Figure 4.6. These programs promote independence by transferring employee and budget authority to participants, in contrast to the traditional service delivery model where Medicaid providers or contracted entities manage decision-making authority.

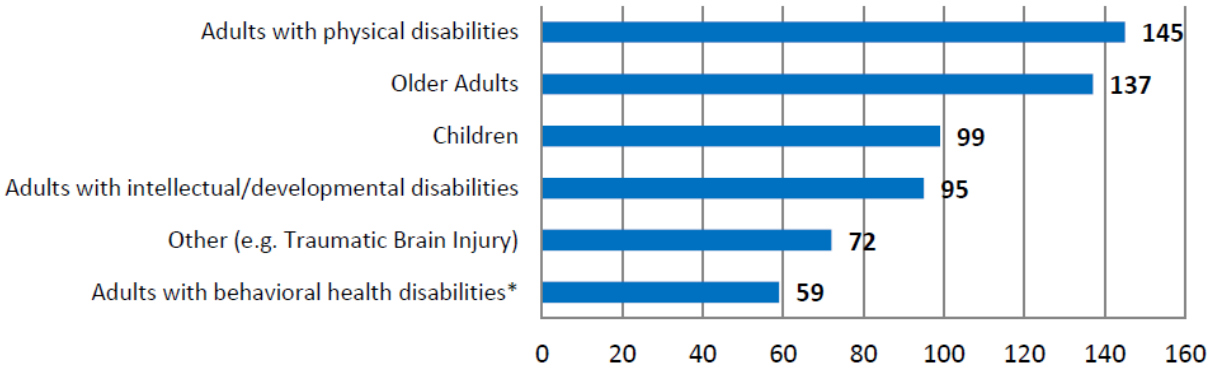
[77] National Council on Disability. The Care for Medicaid Self-Direction: A White Paper on Research, Practice, and Policy Opportunities, May 2013. Available at: https://ncd.gov/rawmedia_repository/23720a02_e755_42f4_b366_dff166ba0c96.pdf
[78] Integrated Care Resource Center. Frequently Asked Questions about self-Direction in Managed Care, April 2017. Available at: http://www.integratedcareresourcecenter.com/PDFs/Self-Direction%20FAQs%2004-27-17.pdf

Figure 4.6 Participant Direction Enrollment by State[79]



There are a variety of disability populations who have benefited from PDS expansion, as detailed in Figure 4.7.

Figure 4.7 Distribution of PDS programs by Population[80]



**Of the 59 programs, 43 are Veterans Directed Home and Community-Based Services (VD-HCBS) programs; while, only 3 of the 59 programs are exclusively designed for adults with behavioral health disabilities.*

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[79] Integrated Care Resource Center. Frequently Asked Questions about self-Direction in Managed Care, April 2017. Available at: http://www.integratedcareresourcecenter.com/PDFs/Self-Direction%20FAQs%2004-27-17.pdf

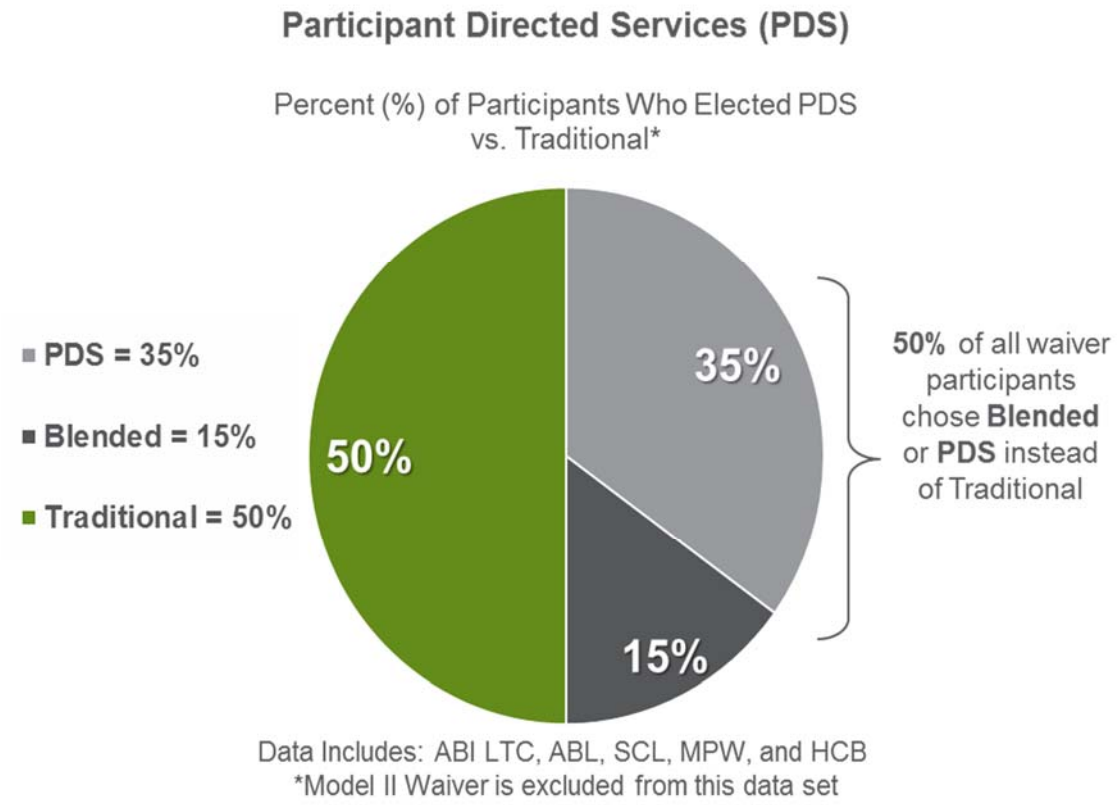
[80] National Resource Center for Participant-Directed Services. Facts and Figures: 2013 National Inventory Survey on Participant Direction. September 2014. Available at: http://www.appliedselfdirection.com/sites/default/files/NRCPDS%20Facts%20Figures%202013.pdf

PDS in Kentucky

In Kentucky, participants can self-direct their services, referred to as Participant-directed Services (PDS). In some waivers, this option has also been historically referred to as the Consumer Directed Option (CDO). Kentucky's PDS model allows people eligible for Medicaid waiver services to choose their own providers for nonmedical waiver services. Provider choice gives participants greater flexibility in the delivery of services received.[81]

As shown in Figure 4.8, PDS is widely used across the waiver programs with 50 percent of all waiver participants choosing either PDS or blended services rather than traditional services. [82]

Figure 4.8 Prevalence of Participant-directed Services across the HCBS Waiver Programs, CY 2013-CY 2017[83]



[81] Kentucky Cabinet for Health and Family Services. Participant-directed Services. Available at: https://chfs.ky.gov/agencies/dail/Pages/pds.aspx
[82] Blended services refer to a combination of different traditional and participant-directed services. For example, a person may choose to receive case management and physical therapy under traditional and choose to receive respite and personal care assistance under participant-directed services.
[83] Data provided by CHFS.

Figure 4.9 Participants Electing to Receive PDS, Blended and Traditional Services by Waiver as of January 2018[84]

Model	ABI-Acute	ABI-LTC	HCB	MPW	SCL
PDS	24	42	2,287	4,967	0
Blended	12	20	267	2,445	345
Traditional	151	173	4,300	2,104	3,717

Financial Management Agencies

As PDS models have expanded, so has the role of *fiscal intermediaries*, third party providers who support PDS models by managing administrative and employer functions required to pay PDS workers and support administrative elements like taxation, background checks and employee screening, payroll management etc. Per Navigant's assessment, Kentucky has 28 fiscal management agencies (FMA) across the Commonwealth, consisting of a mix of Area Development Districts and Community Mental Health Centers who provide this function for different waiver populations.

4.4 Conflict Free Case Management (CFCM) Regulations

In March 2014, the Centers for Medicare and Medicaid Services (CMS) implemented *42 CFR 431.301* requiring states to separate case management from service delivery functions, where possible, to eliminate conflict of interest for services provided under HCBS waivers. This rule addresses conflicts of interest that may arise when one entity is responsible for both case management functions and direct services. CMS provided examples of potential conflicts resulting from such arrangements, including:[85]

- Incentives for over- and under-utilization of services
- Possible pressure to steer individuals to their own service organization, rather than promoting freedom of choice
- Interest in retaining individuals as clients rather than promoting independence and honoring requested or needed service changes
- Difficulty in self-policing the performance of service providers within the same agency

States were required to come into compliance with this regulation to continue receiving federal match for case management services.

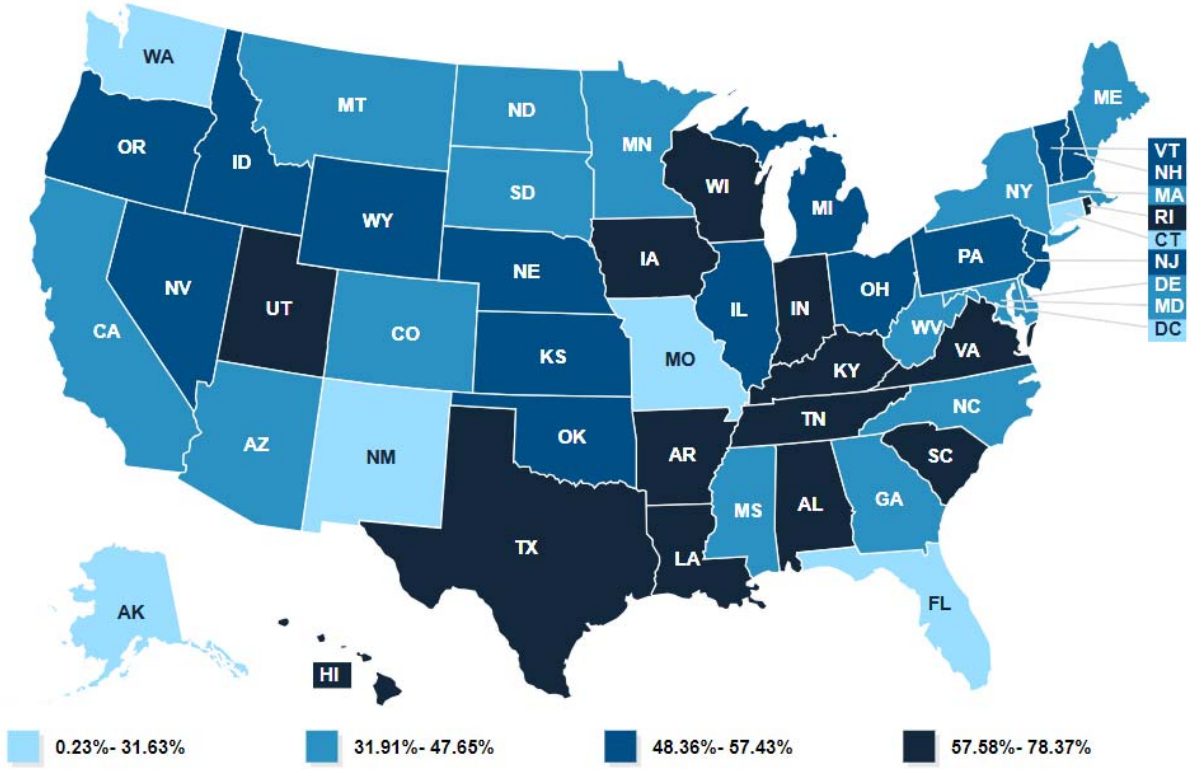
[84] Data provided by CHFS.
[85] Centers for Medicare and Medicaid Services. Conflict of Interest in Medicaid Authorities. January 2016. Available at: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/conflict-of-interest-in-medicaid-authorities-january-2016.pdf

4.5 Provider and Direct Service Provider Shortages

Health Professional Shortage Areas (HPSA)

HPSA designations are used to identify areas and population groups within the United States that are experiencing a shortage of health professionals. Kentucky ranks 13th across the nation in "percentage of need met" (61 percent). Percent of Need Met is computed by dividing the number of physicians available to serve the population of the area, group, or facility by the number of physicians that would be necessary to eliminate the primary care HPSA. Figure 4.10 summarizes the Percentage of Need Met for *Primary Care*, which does not include/exclude physician extenders.

Figure 4.10 Percentage of Need Met - Primary Care HPSA by State, 2017[86]



Location	Percent of Need Met
United States [1]	**48.66%**
Kentucky	61.01%

In addition to clinical healthcare providers, the HCBS segment continues to struggle with recruitment and retention of the necessary quantity of qualified direct care staff. HCBS providers across the country are faced with both significant opportunities and challenges related to staffing. With the increased focus on reducing in institutionalization amongst the aging and disabled populations, there is an increased demand for their services. With the increase in demand for their services, agencies need additional direct care workers who provide necessary

[86] Kaiser Family Foundation. Primary Care Health Professional Shortage. December 31, 2017. Available at: https://www.kff.org/other/state-indicator/primary-care-health-professional-shortage-areas-hpsas/?activeTab=map&currentTimeframe=0&selectedDistributions=total-primary-care-hpsa-designations&selectedRows=%7B%22wrapups%22:%7B%22united-states%22:%7B%7D%7D,%22states%22:%7B%22all%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

care and support individuals who wish to remain in the home. Although there is increased demand for these direct care workers, the supply in many markets is simply not sufficient to allow agencies to deliver services to all those individuals who are requesting it. The following lists several reasons for the lack of available DSPs in the current environment[87]:

- *Lagging wages*
- *Limited to no employee benefits*
- *Physically demanding work with risk for personal injury*
- *High levels of accountability for and oversight of work activities*
- *Isolation from other workers and supervisors while conducting in-home services*
- *Lack of career ladder for advancement*
- *Limited training and professional development*

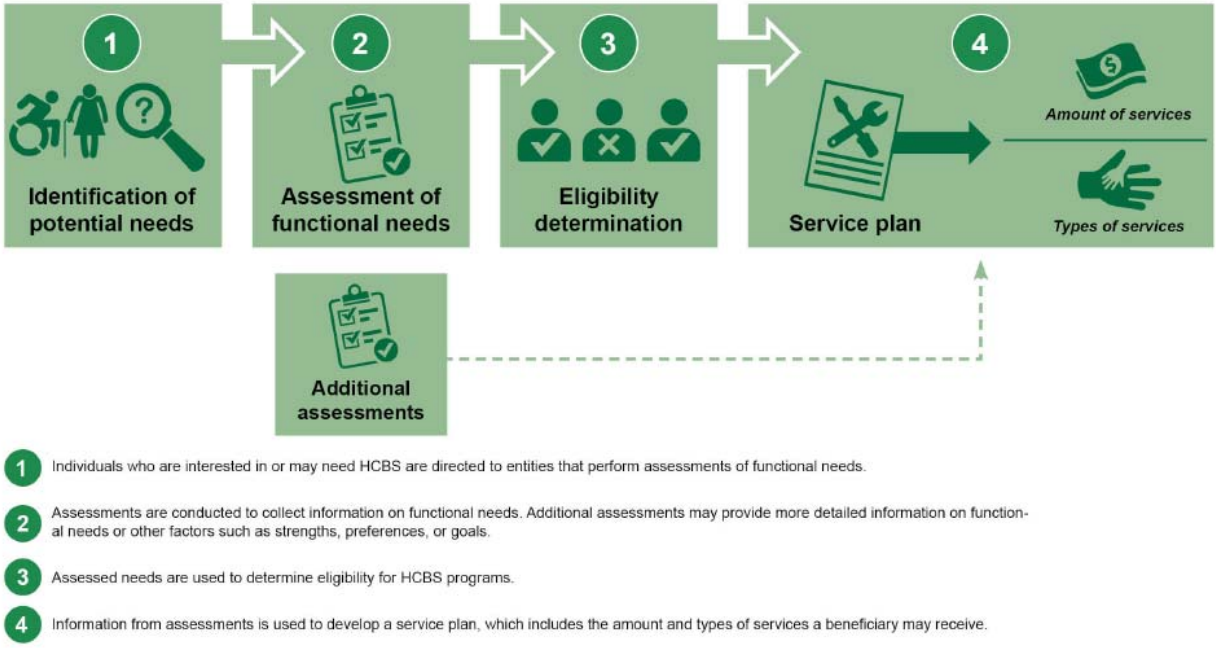
As the overall population ages, there will continue to be an increased demand for these caregivers; however, the 2017 median pay for Home Health Aides and Personal Care Aides was only $11.12 per hour or $23,210 annually according to the U.S. Bureau of Labor Statistics[88]. These low wages are like many other jobs where there is less difficult work and fewer challenges to overcome to gain employment. These challenges, and the existence of other similar paying opportunities, create high turnover and increase training costs because new employees constantly need to be trained.

4.6 Increased Focus on HCBS Assessment Tools and Practices

States use a variety of approaches when developing tools to determine eligibility for LTSS. Functional assessment tools collect information on participants' health status and needs to determine their functional eligibility for Medicaid-covered LTSS. Functional assessment tools differ from general screening tools, such as the Preadmission Screening and Resident Review (PASRR). PASRR evaluates Medicaid recipients to determine the correct care setting. Specifically, PASRR ensures that individuals are not inappropriately placed in nursing homes and identifies if community placement better suits the individual.[89] In contrast, functional screening tools drive the development of service plans to ensure services are designed to meet each individual's needs. Figure 4.11 illustrates how functional assessments determine functional eligibility and aid in the development of service plans.

[87] Institute on Community Integration. The Direct Support Workforce: A crisis or serious systems flaw. May 25, 2018. Available at: http://nisonger.osu.edu/wp-content/uploads/2018/05/Hewitt-Nisonger-5.24.18-handout-version.pdf
[88] Bureau of Labor Statistics. Home Health Aides and Personal Care Aides. Available at: https://www.bls.gov/ooh/healthcare/home-health-aides-and-personal-care-aides.htm
[89] PASRR Technical Assistance Center. 2017 PASRR National Report. Available at: https://www.medicaid.gov/medicaid/ltss/downloads/institutional/2017-pasrr-national-report.pdf

Figure 4.11 Assessments of Individuals' Needs for Medicaid Home and Community-Based Services to Determine Functional Eligibility and Develop Service Plans[90]



Whereas Medicaid-funded institutional LTSS models increasingly include federally prescribed assessment tools like the PASSR and Minimum Data Set (MDS), states are given autonomy to develop and implement their own state-specific approach to functional assessment for HCBS. This has resulted in a vast array of state-to-state tools and approaches. The Medicaid and CHIP Payment Access Commission (MACPAC), conducted a scan of state HCBS assessment tools and practices in 2016, identifying well over 100 tools across all states, with an average of 3 tools in place per state to measure the varied needs across disability populations. This disparity creates challenges to analyze data across nationwide 1915(c) programs to gauge program effectiveness and understand trends in participant need and resulting service utilization. Many states use state-specific tools within their programs, the MACPAC study identified that 49 of 51 states and territories scanned have at least one homegrown tool. Many of these tools lack correspondent infrastructure to easily store and aggregate data. The scan found that 42 states used paper-based models for a total of 74 tools. [91]

Several states have moved toward implementation of a "universal" approach to HCBS assessment, implementing a single tool used across multiple populations to assess need and obtain assessment data. One state that has moved in this direction is California, which has one

[90] United States Government Accountability Office. CMS Should Take Additional Steps to Improve Assessments of Individuals' Needs for Home- and Community-Based Services. December 2017. Available at: https://www.gao.gov/assets/690/689053.pdf

[91] Medicaid and Chip Access Commission. 2016 Report to Congress on Medicaid and CHIP. Available at: https://www.macpac.gov/wp-content/uploads/2016/06/Functional-Assessments-for-Long-Term-Services-and-Supports.pdf

of the largest Medicaid programs in the nation, ranked second in the nation for total spend on LTSS in 2016.[92] The state's legislative analyst's office (LAO), released a report on universal assessment tool implementation after legislative mandates issued to pilot a universal tool in 2 to 4 California counties, recommending statewide expansion of universal assessment approaches.

In the report, the LAO recommended expansion of universal practices statewide to reduce administrative burden, eliminate duplicate care records to improve care coordination, and standardize data. The report noted that of two pilots studied, one in California and one in Washington – there were pros and cons between developing a standardized state-specific tool vs. adopting an existing tool (in the California example, the interRAI tool was adopted with limited modifications), including differing efforts on tool design, systems development and operationalization.[93]

4.7 Increased Focus on HCBS Quality

While quality measurement and clinical performance improvement have evolved in many healthcare segments, quality measurement in HCBS has essentially lagged. Most quality measurement innovation for HCBS has taken place in recent years and represents a growing interest for Federal and state governments, as the demand for HCBS and total spend increase. 1915(c) waiver applications have long required states to indicate a series of "assurances" – performance standards that the SSMA and CMS use to monitor waiver programs. States have the purview to develop their own assurances, based on a series of domains prescribed by CMS.

In 2014, following collaboration with policy makers and leaders in the HCBS field, CMS issued updates requirements for 1915(c) waiver assurances. Whereas many of the prior assurances pertained to administrative oversight, eligibility, financial oversight and other compliance-oriented focus areas, newly established assurances were far more participant driven and focused on health, safety and welfare.[94] This increased focus on participant outcomes has forced states to re-focus on improving several participant protections, including critical incident review and response and grievance and appeal systems.

Another driver of improved quality relates to more clinically innovative initiatives, including the release of National Core Indicator (NCI) tools, which offer targeted quality indicators in unique survey tools that target specialized disability populations. Many states have implemented these participant-facing information collection methods, providing a layer of participant satisfaction measurement into state monitoring and quality oversight. Additionally, quality measures and initiatives have emerged as MLTSS programs have grown nationwide. States are responsible to

[92] Kaiser Family Foundation. Distribution of Medicaid Spending by Service. Available at: https://www.kff.org/medicaid/state-indicator/distribution-of-medicaid-spending-by-service/?currentTimeframe=0&selectedDistributions=fee-for-service-long-term-care&sortModel=%7B%22colId%22:%22Fee-For-Service%20Long-Term%20Care%22,%22sort%22:%22desc%22%7D

[93] Mac Taylor. The Universal Assessment Tool: Improving Care for Recipients of Home- and Community-Based Services. January 2015. Available at: http://www.lao.ca.gov/reports/2015/hhs/uat/uat-012215.pdf

[94] United States Center for Medicaid and CHIP Services. Modifications to Quality Measures and Reporting in §1915(c) Home and Community-Based Waivers. March 12, 2014. Available at: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/downloads/3-cmcs-quality-memo-narrative.pdf

establish quality performance indicators for MLTSS programs, often driven by optimizing the integration of HCBS into a broader service package that incents rebalancing from institutional LTSS settings to the community.

Chapter 5: Assessment Findings

This Chapter provides Navigant's assessment findings. As described in Chapter 2, the Navigant team conducted multiple assessment activities to better understand the state of Kentucky's 1915(c) waiver design and operations and to develop recommendations to improve program operations and effectiveness. One of the underlying objectives throughout this assessment has been to support the State in developing and exhibiting "best in class" program design and delivery to positively improve the health, quality of life and community-based experiences of waiver participants.

5.1 Listing of Assessment Findings

1915(c) Application and Kentucky Administrative Regulation Related Findings

Finding 1: Kentucky's 1915(c) waiver applications vary in their content – including the level of detail across sections and application of regulatory or handbook references. Additionally, some waiver elements need to be updated to better align Commonwealth practices with updated federal requirements and/or HCBS best practices, or to more clearly state program requirements.

Through the appendix-by-appendix review of Kentucky's 1915(c) waiver applications, Navigant identified multiple areas of consideration to improve the clarity, organization, and content of Kentucky's 1915(c) waiver applications.

Multiple Cabinet of Health and Family Services departments are responsible for waiver program oversight and administration, including DMS, the Department of Aging and Independent Living (DAIL), and the Department of Behavioral Health, Development and Intellectual Disabilities (DBHDID). These three departments also played differing roles in the creation of each waiver program and the drafting of the corresponding HCBS waiver applications, and, as described in Chapter 3, the Cabinet designed and implemented the waiver programs sequentially and sometimes very quickly without a high degree of coordination across departments or among waiver programs. As a result, language is not always consistent or aligned across waivers, and these differences have resulted in confusion among internal and external stakeholders as well as administrative inefficiencies. One of the most significant concerns raised by both internal and external stakeholders regarding inconsistencies across waivers is the disparity of service menus and limits. The scope, duration, and limitations of services differ across waivers, including those for PDS. Stakeholders used terms like "haves or have nots" and referred to certain waivers being a "golden ticket," requesting solutions that introduce equitable approaches to service offerings and waiver design across programs.

Additionally, some waiver requirements are phrased ambiguously. Furthermore, the Cabinet has not always updated the waiver applications to account for new federal requirements and best practices. For example, Navigant identified several changes to federal policy and requirements for 1915(c) waivers that Kentucky can address through waiver amendments or as part of other

changes to streamline waiver terms and definitions. Most notable is the need to include in the waivers content that reflects the HCBS Settings

Rule of 2014 requirements and better address waiver assurance requirements released by CMS in 2014.

Figure 5.1 describes inconsistencies across the waivers and other considerations for updating each waiver appendix.

Figure 5.1 Examples of Inconsistencies Across, and Opportunities for Content Improvement Within, Current 1915(c) Waiver Applications, by Appendix

Appendix	Inconsistencies and Opportunities for Content Improvement
Appendix A: Waiver Administration and Operation	• DMS has delegated administrative responsibilities and oversight to other Cabinet departments and contracted entities inconsistently across waivers to conduct administrative activities including utilization management, participant and provider enrollment and quality improvement.
Appendix B: Participant Access and Eligibility	• The tools used to conduct level of care (LOC) assessments differ across 1915(c) waivers. Depending on the waiver, the MAP-351, Kentucky Home Assessment Tool (K-HAT), Health Risk Screening Tool (HRST), or Supports Intensity Scale (SIS) may be used alone or in combination with another tool to assess a participant's LOC and functional status. • Depending on the waiver, staff within the waiver's operating agency, independently contracted assessors, or case managers conduct the assessment. • The Cabinet does not have a standard approach to reserve waiver slots for participants who are experiencing emergencies or for subpopulations across the current waivers.
Appendix C: Participant Services	• Service definitions, scope, duration and limitations, and qualified providers differ across waivers for services of a similar type. • There appears to be opportunity to reconfigure service definitions, so terminology and definitions are consistent across waivers. This is particularly true of many PDS that naturally overlap such as personal care, homemaking services, and community access. • There is opportunity to standardize eligible provider requirements across waivers to align them with standardized service definitions, to reduce current nuances in provider requirements across waivers. • Restrictions and limits on services are not well-defined, and there is a lack of detail on how restrictions and limits apply when developing a service plan.

Appendix	Inconsistencies and Opportunities for Content Improvement
Appendix D: Participant-Centered Planning and Service Delivery	• The requirements for completing person-centered planning from end to end differ significantly from waiver to waiver, specifically with regard to the level of detail and the procedural requirements. Core person-centered planning processes are not standardized across waivers. • The roles and responsibilities of support brokers for individuals who choose to self-direct their services are unclear in all waivers. • Service monitoring requirements and processes for person-centered plan changes needed outside the annual review cycle are not well defined.
Appendix E: Participant Direction of Services	• Education and participant supports for selection of participant direction are not well defined and do not fully depict details requested in CMS' 1915(c) technical guidance. • The policy for employment of family, legal guardians, and legal representatives is not standardized and lacks clarity. • The methodology for PDS budgets and allotted hours differs among waivers (also associated with opportunities discussed under Appendix C and I). • Financial management agencies are treated and paid differently depending on the waiver. For example, ABI, ABI LTC, and HCB waivers are paid as a waiver service; while MPW and SCL are paid as an administrative service.
Appendix F: Participant Rights	• Descriptions for grievances and appeals do not match the current operational practices used in the Cabinet. • Timeframes and participant requirements for grieving or appealing decisions are not always participant-friendly and were found to be written more from a regulator's perspective. • The current grievance system is administered by multiple departments including DMS, DAIL, DBHDID, the Office of the Ombudsman, and the Office of the Inspector General. Roles and responsibilities across departments are not clearly established in current waiver documents.
Appendix G: Participant Safeguards	• All the Commonwealth's 1915(c) waivers currently permit the use of restrictive interventions, which may impose on the rights of individuals who do not receive residential services and reside in a private dwelling. • Current waiver language indicates that critical incidents are categorized, prioritized, and investigated differently depending on the waiver.

Appendix	Inconsistencies and Opportunities for Content Improvement
	• Investigation and response procedures are vaguely described, do not clearly define responsible parties, and do not align with assessed practices. • Across waivers, there is not a standardized approach to coordination of protective services, remediation of critical incidents, and oversight in instances of suspected abuse, neglect, or exploitation.
Appendix H: Systems Improvement	• DMS currently contracts with a fiscal agent who, in turn, contracts with the current Quality Improvement Organization (QIO) to conduct utilization management activities (i.e., prior authorizations and denial reviews). Waiver applications do not offer substantive details of how the QIO is monitored or how oversight of the fiscal agent and QIO is conducted. • Quality improvement measures and reporting frequencies differ across waivers and do not align with an established Quality Improvement Strategy for 1915(c) waivers. • Existing quality improvement strategies are not in full alignment with updated requirements released by CMS in 2014.
Appendix I: Financial Accountability	• Kentucky's current rate setting methodology relies on historical content and may not be well informed by provider costs. The current methodology has been described by providers and stakeholders as lacking in transparency and clarity.
Appendix J: Cost Neutrality Demonstration	• If any substantive changes are made to a 1915(c) waiver service definition or rate setting methodology, Appendix J should be updated to demonstrate cost neutrality.

Finding 2: Existing waivers designate multiple departments within the Cabinet to administer and operate the waivers. Using multiple departments to operate waivers has led to inconsistency in how waiver requirements are applied and operationalized.

As described in Finding 1, multiple departments are responsible for waiver program oversight and administration, including DMS, DAIL, and DBHDID. Finding 1 describes how inconsistencies in waiver language have posed challenges. Finding 2 relates to cases where waiver language was aligned or consistent between waivers, but where departments interpreted waiver requirements differently.

Cabinet staff conveyed that even in cases where language was aligned between two waivers, staff from different departments found the same term or service to mean different things. Cabinet staff and external stakeholders described that external stakeholders commonly speak with several different Cabinet staff when calling with an inquiry, so may receive differing

guidance depending on who they speak to. Thus, participants and providers are challenged to understand and follow program requirements and processes. Further, external stakeholders described challenges accessing service offerings, with participants often having to navigate the multiple departments that administer the waivers.

Providers frequently reported in focus groups that current waiver language is too subjective – and subsequently they frequently encounter differences in interpretation depending on who they speak to at the Cabinet. Likewise, providers who serve multiple regions report receiving conflicting technical assistance from region to region. During Navigant's assessment, DMS confirmed these inconsistencies, noting the need to correct technical assistance previously provided by other departments. Providers advised that the Cabinet has recouped funds in circumstances where the provider followed one Cabinet staff member's interpretation of a policy, only to be told during monitoring activities that the interpretation they were following was not correct.

Finding 3: The current waiver applications do not consistently reference applicable federal rules or Kentucky Administrative Regulation (KAR), contributing to inconsistency across waivers.

States have the option to reference regulations, standard operating procedures, and handbooks within a 1915(c) waiver application. These documents are then considered incorporated into the waiver *by reference*, making waiver language more concise and simplifying the process for making minor modifications or adjustments. For example, the ABI, ABI-LTC, and Michelle P. waivers reference 907 KAR 1:563 generally within the contents of Appendix F-1, whereas the HCB, Model II, and SCL waivers include the specific regulation language. Additionally, ABI-LTC and Michelle P. waivers define provider qualifications for adult day health centers by referencing 902 KAR 20.066, while the HCB waiver includes the regulation language.

Those waivers that include specific regulatory or statutory language have sometimes fallen out of compliance when the regulatory or statutory requirements, or the related guidance, has changed. Also, because the 1915(c) waiver applications do not consistently incorporate external documents by reference, the waivers are vulnerable to appeals with stakeholders citing the complexity and ambiguity of current waivers.

Finding 4: Much of the description of 1915(c) waiver operations is housed in the KAR, which Cabinet staff and external stakeholders find difficult to use. Additionally, KAR contents include operational protocols that may not merit legislative input.

According to feedback obtained from both Cabinet staff interviews and focus group participants, much of the historic reliance on KAR as a mechanism to define waiver operations is driven by the idea that putting items into regulation would require the Cabinet to hold public comment, thereby making the Cabinet more accountable to stakeholders. Navigant observed that both internal and external stakeholders were far more likely to refer to the KAR as an information source than the 1915(c) waiver applications themselves. This has introduced a dynamic where

state regulation was considered the primary source of guidance, even when that regulation conflicted with agreed upon terms housed in the 1915(c) waiver application, which represents the Commonwealth's agreement with CMS.

The current KAR-dependent method requires an extensive, legally prescribed process for promulgating changes to state regulation. The degree of rigor required to promulgate regulation is not always necessary to make operational changes. The Cabinet's dependence on the KAR has impacted the Cabinet's ability to quickly respond to stakeholder requests. Tasks like changing a form or removing outdated language cannot be executed efficiently due to the requirements to adjust the KAR. When Navigant compared the contents of 1915(c) waiver specific KAR to other states with fee-for-service Medicaid HCBS approaches, Navigant found that the KAR included far greater operational detail than other states.

Given the degree of operational detail embedded within the KAR, the absence of handbooks as a resource is a barrier to addressing inconsistencies in terms and in technical assistance provided.

Finding 5: The 1915(c) waiver application standards and requirements sometimes conflict with the corresponding KAR language for a given waiver, which causes confusion among stakeholders who cannot identify which information source is correct.

At times, content included in the waiver applications directly conflicts with content contained within the KAR. One example of a conflict is that *shared living* is a waiver service included in the Michelle P. waiver; however, this service is not addressed within the KAR or actually delivered within the current program. The same is true for community access, community guide, community transitions services, natural supports training, specialized medical equipment, and transportation services.

Conflicting language creates confusion, making it difficult for stakeholders to understand how programs are designed, what services are available, and what rules and requirements apply within a waiver. Even Cabinet staff find these conflicts confusing, and as a result, are left to make their own interpretations when responding to inquiries from external stakeholders.

Finding 6: The Cabinet does not appear to have handbooks, manuals, or other resources to provide stakeholders with guidance or interpretation of waiver program requirements.

As noted in Finding 5, Navigant learned during the staff interview process and during targeted workflow reviews that Cabinet staff spend a significant amount of time answering questions and responding to concerns related to unclear waiver or KAR content. Often, a single Cabinet staff member responds to questions posed by a single provider or other stakeholder, an approach which is not only time-consuming and inefficient, but which leads to inconsistent responses depending upon the circumstances of the stakeholder and the Cabinet member's interpretations.

When Cabinet staff respond to such inquires, they rely upon the KAR and, to a lesser extent, on the waiver applications. Cabinet staff do not appear to have a manual, handbook, or other readily accessible resource that provides guidance for responding to frequently asked questions. Furthermore, Cabinet staff do not appear to have a uniform and coordinated process for documenting responses they have provided to stakeholders' questions. The lack of such a resource exaggerates time needed to respond to providers individually and perpetuates inconsistent responses.

Navigant observed that, in general, the Cabinet lacks user-friendly resources where internal and external stakeholders can easily access information on waiver policy. For example, few mechanisms allow for detailed language, visual depictions, or operational details beyond what is set forth in KAR or the waiver applications. During focus groups, providers expressed strong support for a handbook or other document that offers Cabinet guidance.

HCBS Assessment Related Findings

Finding 7: The Cabinet uses several assessment tools across waivers, each of which focuses on different types of HCBS information. Additionally, different assessor entities conduct each assessment.

The Cabinet currently uses a variety of assessment tools and assessor types across the six 1915(c) waivers, as illustrated in Figure 5.2:

Figure 5.2 Comparison of Assessment Tools across Kentucky's 1915(c) Waivers[95]

1915(c) Waiver	Assessment Tool	Reassessment Frequency	Assessor Entity
Michelle P. Waiver	MAP-351	12 months	CMHCs
	SIS	12 months	Case Manager
	HRST	12 months	Providers
Supports for Community Living Waiver	SIS	12 months	DBHDID
Home and Community Based Waiver	K-HAT	12 months	DAIL
Acquired Brain Injury Waiver	MAP-351	12 months	Case Manager
Acquired Brain Injury/Long Term Care Waiver	MAP-351	12 months	Case Manager

[95] All information taken from most recently approved 1915(c) Waiver.

1915(c) Waiver	Assessment Tool	Reassessment Frequency	Assessor Entity
Model II Waiver	MAP-351 A	6 months	Provider Agency

Each assessment tool has varied levels of detail and information it focusses on, which leads to differing types and amounts of information being captured for different participants. Stakeholders expressed concerns regarding the variety of tools, the reassessment frequency, and the assessor entity because each of these factors influences person-centered planning and access to services. For example, some external stakeholders voiced concern about inequitable access to services for differing disability groups, pointing to differing assessment approaches as a driver of inequity. During focus groups, stakeholders suggested that the absence of a standardized needs assessment seemed to result in “haves” and “have nots” among waiver populations.

Finding 8: Across the waivers, HCBS assessment outcomes data is stored in varying formats and locations, and the data that is stored is not readily accessible to use for broad program analyses or management.

Today there are limited data storing capabilities to house assessment findings beyond uploading completed assessments to the MWMA for record-keeping purposes. The DBHDID separately houses SIS data from SCL waiver assessments. Navigant did not observe that functional assessment data is used to inform broader program design considerations. Rather, assessments are mostly used to inform service plan development. Uploading hard copies of assessments into the MWMA to store assessment information inhibited the Navigant team from accessing that data for population-level analysis.

Finding 9: Assessment tools and methods currently in place are not designed to assess HCBS-related needs for participants under the age of 18.

Although the Cabinet uses multiple assessment tools across its current HCBS waivers, these assessment tools are not designed or tailored to target the different needs for individuals under the age of 18 relative to adults. The lack of a pediatric-specific tool is a concern among both internal and external stakeholders. Internal stakeholders are concerned that waste, fraud, and abuse occur when age-appropriateness is not considered. For example, assessing a child’s level of functional ability with activities of daily living (ADLs) and intermediate activities of daily living (IADLs) can lead to over-estimation of needs. Conversely, external stakeholders, particularly the parents and caregivers of pediatric participants, expressed concern that the lack of a pediatric-specific tool could reduce the accuracy of needs identification, which may lead to under-estimation of need among the under-18 participant population.

Finding 10: The use of an independent assessor function varies from waiver to waiver, raising questions about the potential for conflicts of interest.

As illustrated by Figure 5.2 above, Kentucky's current approach uses multiple assessor types, including state employees who administer the SIS, independent contractors from the University of Kentucky who administer the K-HAT, and providers who assess participants using the MAP-351. Cabinet staff and leadership indicated concerns during staff interviews that participant needs assessment is conflicted and that documented assessment information does not accurately reflect assessed need and can be manipulated to increase unnecessary levels of service and/or benefit providers financially.

DMS staff reported that case managers have said they "document to their audience," to obtain services for participants. Beyond stakeholder concerns about potential conflicts of interest among assessors, the federal government is increasingly concerned about the potential for manipulation of assessment information leading to increased fraud, waste, and program abuse as reflected in the CMS HCBS Settings Rule of 2014 and related guidance.

Finding 11: The Cabinet's independent assessment process presents operational challenges, particularly related to improving coordination among the independent assessor, the participant, and the participant's case manager.

Although independent assessments offer a way to address potential conflict of interest within the needs assessment process, the Cabinet is experiencing operational challenges within its relatively new independent assessment process. Separating the assessment function from the case management role creates segmentation in how needs are identified and translated into a person-centered plan that supports a participant's needs and goals. Internal and external stakeholders, including staff involved in the independent assessment process, described difficulties coordinating the independent assessment process with overall case management and HCBS delivery.

Likewise, during stakeholder engagement activities, many case managers explained that they do not believe they are adequately included in the independent assessment process. Per the Cabinet, case managers may attend the assessment, but there is no clear structure or method for case managers to share additional information when a participant does not accurately respond to assessment questions. Case managers expressed concern that participants do not always respond accurately during independent assessments because they are fearful of being truthful with an assessor they do not know and/or may have a cognitive or intellectual impairment that impedes their judgment.

Stakeholders reported additional challenges within the current independent assessment process:

- The current method for independent assessment has been plagued by challenges attributed to maintaining up-to-date contact information to reach participants, which is required to complete timely assessments.
- Limited performance standards are in place for contracted entities performing independent assessment, particularly related to the response times for event-based reassessments. Need for event-based reassessments are common among HCBS

populations but are not well-resourced or planned for in Kentucky's current approach.

- The Cabinet does not use or mandate a uniform approach to training independent assessors across waivers and does not have a consistent means to track inter-rater reliability, which is needed to monitor that assessors use a tool and determine assessment findings objectively and consistently.

Finding 12: The Cabinet currently uses a chronological approach to manage the Michelle P. waiver waiting list. The Cabinet does not currently have a method in place to screen waiver applicants for waiver eligibility or risk when they apply to the Michelle P. waiver waiting list. This approach differs from the SCL waiver which relies on a risk-based approach for waiting list management.

Throughout the assessment, the issue of waiting lists, particularly for the SCL and Michelle P. waivers surfaced as a frequent area of concern for both Cabinet leadership and external stakeholders. One of the challenges Navigant observed is the lack of eligibility information available for individuals on the Michelle P. waiver waiting list. While the SCL waiver has prioritization categories for which interested individuals are pre-screened, the Cabinet performs no such pre-screening for individuals who request to be added to the Michelle P. waiver waiting list. This dynamic has posed multiple issues, including:

- Difficulty efficiently identifying individuals most at-risk for institutional placement, or who have urgent needs that could influence prioritization of access to services
- Frustration among participants on the waiting list and their families, who may wait multiple years anticipating a Michelle P. waiver slot, only to learn that the wait listed individual was never eligible and should have been identifying alternative resources.
- Administrative burden and inefficiencies encountered when the Cabinet does attempt to pull individuals from the waiting list and initiate services
- Ongoing Cabinet challenges with accurately estimating unmet need to identify necessary budget allocations for additional slots

Service Allocation Related Findings

Finding 13: The Cabinet uses a series of caps and limits that vary by waiver and individual service to manage utilization and to allocate HCBS to participants. The caps and limits are applied broadly, so targeting services to participants based on level of intensity or acuity can be difficult.

Navigant found during its assessment that the Cabinet struggles to allocate resources to participants in a manner that reflects each participant's unique needs, because current waiver requirements set forth a series of service caps and limits. These service caps and limits apply to all participants of a given waiver and so may pose a barrier to developing person-centered plans with sufficient resources to advance participants' needs and goals. Internal and external

stakeholders expressed concern that such universal application of caps and limits to manage utilization inhibits targeting of resources to respond to an individual's community-based needs to offer a meaningful alternative to institutional LTSS. Specific feedback included:

- Some external stakeholders suggested they are allocated more services than necessary, while others stated they do not receive enough services to meet their community-based needs.
- Stakeholders expressed concerns that standards differ from waiver to waiver, leading to "haves" and "have nots" across waiver populations as described in Finding 1.
- Internal and external stakeholders pointed out that universal standards, like the 40-hour a week service standard used on the Michelle P. waiver, offer a "one size fits all" approach that should be updated to complement individualized service planning.

Also important to note, Kentucky was one of six states scanned by the federal Government Accountability Office (GAO) during evaluation of HCBS assessment practices and, of those six states, was the only state where GAO did not identify a formula or methodology that translated assessment findings into eligibility determination or informed service level or allocation.

Appendix E outlines the current 1915(c) waiver service limits and caps by waiver.

Finding 14: The Cabinet uses a medical-model approach for HCBS authorization, which presents undue administrative burden for Cabinet staff and case managers.

Interviews with Cabinet staff members and review of documentation revealed that DMS uses a medical-model approach for service plan authorization using Carewise, a subcontracted vendor who conducts a review of HCBS person-centered plans, and then issues a prior authorization (PA). Each PA is must then be sent to a waiver participant's case manager via MWMA before services can be initiated. Stakeholders expressed, and Navigant observed, multiple concerns with the current PA process and its effectiveness in supporting the HCBS delivery system.

Internal stakeholders cited concerns during staff interviews that Carewise staff conducting reviews are not adequately trained on person-centered planning principles and focus primarily on clinical criteria to authorize HCBS service plans. Cabinet staff explained that HCBS considerations include social-model elements like housing status and environmental conditions, access to unpaid care, and other non-medical factors, and they do not feel Carewise staff adequately consider these elements in the existing service authorization approach.

During focus groups, case managers and service providers frequently complained about the amount of time often required to develop a service plan, submit the service plan, and obtain a prior authorization to initiate services. Many providers suggested the process is often lengthy, leading to gaps where a PA is not in place during annual recertification

In turn, participants experience some days where they receive services that are not yet approved for Medicaid reimbursement. Cabinet staff report that based upon operational reports

pulled in July 2018, less than one percent of HCBS requests are denied by Carewise, which may indicate that the level of administrative complexity and length of time required is not merited.

Another service authorization process discussed during the assessment is the exceptional supports approval process, administered to approve additional services and supports to SCL waiver participants who require levels of service that exceed that covered by the residential per diem rate. To request exceptional supports, a provider must assemble an evidentiary packet and submit it to the DBHDID for review and approval. The evidentiary packet must contain a series of required elements and additional justifying documentation, which stakeholders identified as burdensome. Additional findings related to exceptional supports included:

- Stakeholders expressed concerns about the subjectivity of approval due to the lack of a clear framework to justify what circumstances merit exceptional support. Some stakeholders raised questions about whether residential providers should qualify for exceptional supports allowances to cover staff costs when residents elect not to go to their scheduled adult day training.
- The contents of evidentiary packets vary, leading to stakeholder concerns about subjectivity within the approval process.
- The Cabinet conducts limited follow-up to monitor whether approved exceptional supports are rendered as indicated in a provider's initial request and to monitor how those supports enhance participant care outcomes.

Finding 15: Participants and their caregivers seek more flexibility in how they use their budget, to allow for individualized service planning tailored to meet their needs.

Stakeholders of all kinds identified a need for flexible approaches to better allocate services and individualize service plans as opposed to use of "one size fits all" standards. Some stakeholders explained that the current rules, service limits, and their impact on care planning can inhibit participant ability to accommodate changes when participants' circumstances or informal caregiver structures change. Focus group attendees described perceptions that participants must "use or lose" services they may not always need. Also, as described in Finding 13, services do not always appear to be allocated in a manner that reflects participant need. One individual who publicly testified during town halls indicated that of her two sons allocated 40-hours a week via the Michelle P. waiver, one son needed more services than were available, while the other required less.

Participants, their caregivers, and case managers also expressed concern about the inability to shift services or "bank" hours based on changes in circumstance or care needs. They expressed a need for more flexibility in using their HCBS services to adjust for life events and described that the process for modifying the service plan was too burdensome. The Michelle P. waiver is a good illustration. A participant is currently unable to shift hours within Michelle P.'s 40-hour a week standard to accommodate increased care needs one week and reduced needs

in the following week (e.g., using 60 hours of care one week and then using 20 hours the following week). Participants requested more flexibility in how they use their monthly hours to accommodate common changes in participant circumstance, like the availability of unpaid caregivers, increased need for assistance to attend appointments or community outings, and school vacations for school-age participants.

Other rules seem to impose restrictions that inhibit access to needed services. One example is the current restriction for waiver transportation when an individual in the participant's household owns a car. Focus group participants advised that this standard does not consider that the owner of a vehicle may not be willing or available to offer the waiver participant transportation to support the participant's community-based needs.

Payment Rate Related Findings

Finding 16: The Cabinet lacks a transparent rate-setting methodology across waiver programs that reflects HCBS service delivery requirements and differences in acuity across waiver participants.

Historically, DMS has not conducted rate studies for the six HCBS waivers. Navigant reviewed stakeholder input from participants, providers, and other external stakeholders, many of whom requested the Commonwealth to review the existing rates and methodology to assess if rates are consistent across services and waiver programs. In addition, stakeholders requested a review to determine sufficiency to cover administrative costs, and ways to incent provider participation and support quality of care. Stakeholders have also identified a need for the Commonwealth to consider acuity-based payments to accommodate appropriate reimbursement for higher demand and more complex-care cases.

> *Per Section 1902(a)(30)(A) of the Social Security Act, a State Plan for Medical Assistance must "…assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."*

DMS reports that existing rates have been developed separately for each waiver over time, and the Cabinet has not conducted a thorough review of the rate methodology for HCBS waiver services. Providers have indicated frustration with lagging rates, a disparity in rates for similar services across waivers, and a lack of clarity regarding the basis for rates.

Finding 17: Providers expressed strong interest in understanding the historical basis for current rates. Many providers expressed concern that rates are not sufficient to cover incurred costs to deliver services or make improvements.

Providers expressed a lack of confidence in the existing methodology for HCBS reimbursement. HCBS providers representing a range of services asserted that they are not reimbursed

sufficiently, do not believe the current rates allow them to pay and retain qualified direct care staff, and do not believe that quality will improve until the Commonwealth implements a new, improved methodology that is transparent. External stakeholders frequently cited the reduction in the HCB waiver personal care rate to $11.52 per hour, indicating that the new rate is inadequate and detrimental to participant access to services.

Finding 18: Payment rates vary across waiver programs for services that are similar in nature, which may negatively impact provider network development for waivers offering lower payment rates.

Today payment rates vary from waiver to waiver for common services (i.e., respite, personal care, case management and other HCBS types). This variation stems from the Cabinet's development of waiver programs at different times and for different populations. This variance, along with differing historical rate increases and decreases, has the potential to create inconsistent provider participation across waiver programs. Stakeholders have provided feedback that current rate levels contribute to the Commonwealth's difficulty in recruiting providers and provider shortages for multiple waiver service types, and potentially delays in service delivery and a lack of incentives for high quality care.

Finding 19: A cost survey of providers is needed to help inform an updated HCBS payment rate methodology that considers the factors that drive provider costs.

Many providers and other external stakeholders expressed low confidence that the Cabinet's current methodology reflects important factors that drive their costs. Providers frequently mentioned two factors that have contributed to increasing costs to deliver services:

- *Increasing volume of administrative and documentation requirements*: Many HCBS providers throughout the Commonwealth expressed concerns about increasing volumes of administrative and documentation requirements that they consider burdensome, duplicative, non-billable, and unreimbursed (e.g., hours spent on the phone to navigate MWMA or Carewise PA troubleshooting). Providers reported that the time required for these administrative tasks reduces their availability for value-add and outcome-driven activities to improve care for HCBS waiver participants.
- *Challenges in competing with other industries for direct care staff*: Provider leaders advised that staff often leave for other competitively paying jobs in the fast food and retail industries. These service industries typically offer viable alternatives for employment that require less skill and training for higher wages. Many providers bear the cost of frequent turnover and under-staffing, which negatively impacts service delivery.

Operations Related Findings

Finding 20: DMS, DAIL and DBHDID developed HCBS waiver administrative and operational approaches in siloes. Thus, the same task or workflow is approached

differently from waiver to waiver, depending on the department executing it. The three departments have only coordinated to standardize operating procedures across departments in a limited manner.

As described under Finding 1, DMS, DAIL, and DBHDID each contribute to administering and operating HCBS waiver programs and have done so for multiple years. Over time, each department has established its own unique approach to the same administrative and oversight functions. Navigant learned through stakeholder engagement that having unique approaches leads to ongoing confusion, particularly for providers who render services under multiple waivers and must navigate each department's separate approach for the same work.

During Navigant's operational review, Navigant observed duplication of tasks and inefficiencies when a single end-to-end workstream involved more than one department. One such example of inefficiency is the Cabinet's approach to handling participant grievances. Each department maintains its own system for tracking incoming grievances and its own procedures and responsible parties for responding to and resolving those grievances. Often, a single grievance will be submitted to multiple departments, each of which responds. Furthermore, the department staff members do not always document their responses so that others know what actions have been taken and their result. During staff interviews, Navigant repeatedly heard anecdotes wherein staff in each department had spent several hours working to resolve an issue, only to find out later that the issue had already been resolved by someone in another department.

Finding 21: DMS, DAIL, and DBHDID each have different approaches to developing and maintaining standard operating procedures (SOP) to govern task execution and guide staff on expected work approach.

Navigant's review of SOPs revealed that each of the three HCBS operating agencies has its own approach to SOP development and maintenance. For example, Navigant found that:

- DMS and DAIL have few SOPs in place, and their staff typically maintain their own desk references and are responsible to compile them independently. Operating approaches can differ across divisional branches, with many staff indicating a lack of clear understanding of what colleagues in other branches do.
- DMS is responsible for certain procedures which are exclusive to its role as the SSMA and thus these procedures are not duplicated in the other two departments. These procedures are not well documented.
- Meanwhile, DBHDID has a robust set of SOPs in place, especially for SCL waiver operations. There are designated staff who oversee the SOPs, but at times staff struggle to maintain and update SOPs in a timely fashion. DBHDID has developed several tools and procedures that are specific to SCL and do not align with processes or approaches found in other waivers.
- While DAIL has some SOPs in place, these SOPs do not seem to encompass all the department's 1915(c) related work. The DAIL team is small and seems to rely on

individuals to own a task area and work it independently. DAIL monitors participant-directed services across all waivers. In this capacity, DAIL maintains distinct oversight procedures and tends to approach these procedures separate from the traditional model HCB waiver operations DAIL executes.

These differences in approach to SOP development are reflected in the Cabinet's approach to important operational workflows, including:

- Onboarding new staff and familiarizing them with assigned responsibilities and work approach
- Cross-training staff when a procedure needs to be temporarily or permanently reassigned
- Communicating expectations to staff and objectively measuring their performance on assigned responsibilities
- Identifying places where adjustments are needed to a prescribed work approach to improve efficiency or effectiveness
- Communicating internally among departments to know who is responsible and when to advance a procedural sequence
- Communicating with stakeholders regarding what next steps they should anticipate when they are participating in or awaiting the outcomes of a Cabinet process

The siloed assignment of 1915(c) waiver oversight and administration contributes to the lack of standardization in how departments conduct waiver-related procedures and perpetuates differing approaches across waivers. Navigant observed that Cabinet staff members expend substantial time and effort to compensate for this lack of standardization and to navigate the inter-departmental differences in work approaches that exist today.

Finding 22: DMS is not always well positioned as the single state Medicaid agency for HCBS waiver oversight and lacks clear accountabilities when leveraging sister agencies as a waiver-designated operating agency. DMS has not always had final decision-making authority when departments did not agree on policies or program design.

DMS is the SSMA and, as such, has foremost responsibility for oversight and federal compliance for all of Kentucky's 1915(c) waivers. As is the case in many states, DMS has designated sister agencies as the Commonwealth's waiver operating agency to oversee and/or conduct specific operating functions for several waivers. As described in Chapter 3, DBHDID is the designated operating agency for the Michelle P. and SCL waivers, and DAIL is the designated operating agency for the HCB waiver. According to Navigant's assessment, inter-departmental collaboration between DMS and the designated sister agencies has not been sufficient to clarify roles, responsibilities, and accountabilities within each waiver. Using interdepartmental memoranda of understanding (MOU), DMS establishes interdepartmental agreements with the sister agencies. These MOUs stipulate the responsibilities of each waiver-

designated operating agency. Navigant learned through staff interviews that the terms of that MOU are not always clear to staff and staff in sister agencies reported the MOU terms are often subject to change or are not provided via finalized documents until several months into the MOU term.

DMS staff indicated ongoing challenges with timely access to the information and data needed to report back to CMS. Multiple departments house data for key administrative areas such as critical incidents and quality assurance measures, which makes it difficult for DMS to efficiently report on 1915(c) waiver program performance. There also appears to be a historic lack of clarity over how decision-making authority flows between Cabinet departments, leading to the development and release of waiver policy that DMS did not agree with. This dynamic has contributed to differences among the waiver applications and has impeded DMS' ability to act as the single-state Medicaid authority. External stakeholders also did not always recognize that DMS has final decision-making authority on 1915(c)-related decisions as the single state Medicaid agency.

Finding 23: The current HCBS system lacks a centralized point of entry where external stakeholders can bring questions and concerns.

As described in Findings 1 and 2 and other findings, stakeholders raised a variety of concerns about the decentralized and often uncoordinated approach that DMS, DAIL, and DBHDID take to waiver design and administration. One manifestation of this decentralization is that each department or waiver operating unit, and often multiple people within a single operating unit, respond to calls from external stakeholders. In other words, the Cabinet does not operate a single, centralized point of entry where external stakeholders can bring questions and concerns.

Stakeholders consistently raised concerns regarding poor customer service, particularly to participants. The lack of a centralized point of contact, creates a burden for external stakeholders, including participants and providers, who must "call around" to multiple Cabinet staff for issue resolution. Obtaining answers to questions sometimes requires external stakeholders to call multiple departments. Some stakeholders know to contact the Cabinet Office of the Ombudsman, but others indicated that they wanted to share their concerns with staff who are more intimately familiar with 1915(c) waiver programs and did not know where to turn when they had an issue that did not qualify as a grievance.

Concerns about the quality of Cabinet customer service arose frequently during focus groups. Internal and external stakeholders relayed that the following scenarios are common:

- A caller is transferred multiple times, to multiple Cabinet staff, before the caller finds a Cabinet staff member who has the answer
- A caller is told they will be called back with a response, but never receives follow-up
- A caller speaks with multiple Cabinet staff members who relay differing or conflicting answers to their questions
- The Cabinet staff answering the phone do not convey empathy, fail to acknowledge the

concerns of the caller, and/or lack customer service etiquette

- The person assigned to answer the phone may not be trained in customer service or have strong telephonic communication skills
- The caller is ultimately informed they will have to speak to another agency or department outside of Medicaid to get the help they need, often the Department for Community Based Services (DCBS)

Finding 24: Among DMS, DHBDID, and DAIL, monitoring and annual recertification approaches differ significantly, can be duplicative, and do not always reflect best practices in HCBS oversight.

Departments conduct on-site and desk review monitoring and oversight activities in siloes, leading to duplication in work and inefficient approaches that tax the resources of both the Cabinet and providers. For example, the Cabinet currently completes multiple site visits in a single year for a single provider when that provider serves multiple waivers. A separate site visit is conducted by each department, depending upon the waivers the provider serves. Navigant did not find any evidence during the assessment to indicate that Cabinet departments attempt to coordinate these visits to reduce administrative time or burden for providers, who currently must accommodate multiple reviews of a similar nature from different state representatives.

Depending on the waiver and Cabinet department conducting the review, providers can expect a different monitoring emphasis and degree of rigor. Stakeholders described in focus groups the variability of approaches ranging from a punitive approach to “cite light and go heavy on technical assistance.” Such differences in strategy lead to confusion and introduce administrative burden for providers serving multiple waivers to comply with program regulations. The Cabinet is further exposed in cases where a savvy provider take advantage of differing departmental approaches, noting one department’s approval and another department’s denial for similar waiver requirements. Cabinet staff also expressed frustration with the differing approaches. For example, some staff indicated that they felt their authority as a regulator was undercut, and they and had little confidence that adverse findings would be addressed and enforced.

According to Navigant’s assessment, there are instances where 100 percent of audits are subject to “second-line review” leading to duplicate reviews. While limited quality control reviews are a monitoring best practice, conducting a duplicate review for the entire portfolio being monitored represents an inefficient use of limited Cabinet resources.

In contrast, the Cabinet has, in some cases, restricted its oversight activities in ways that may not reflect best practices. For example, when conducing provider site visits, the Cabinet typically visits one site or a limited number of sites for each provider. While this approach may offer some efficiencies, it may not reflect CMS expectations for depth of monitoring and introduces risks to waiver participants in those sites not visited which in turn, poses risks to the Cabinet.

Finding 25: The level of provider support from the Cabinet varies by waiver. Thus, some providers receive far more technical assistance and training than others.

Cabinet staff and external stakeholders described that the Cabinet uses varied approaches to providing technical assistance and training from waiver to waiver. Navigant observed disparity in the level of technical assistance and guidance that Cabinet departments offered to providers. Whereas SCL and ABI providers have access to on-site technical assistance, HCB waiver providers have limited access to this type of support. Training also varied from provider to provider, as did the degree of support the Cabinet deployed to assist new providers with obtaining their certification and onboarding to the waiver.

Cabinet leadership highlighted concerns with the current disparity in provider support due to two dynamics:

- Certain provider groups are under-trained and lack access to the level of training and technical assistance needed to comply with requirements and enhance services to participants.
- Other provider groups may have become overly dependent on technical assistance and overly defer decision-making to Cabinet staff instead of exercising their own judgment. This becomes problematic when providers blame the Cabinet for influencing their own regulatory non-compliance.

There are also no clear or documented limits for when sufficient levels of technical assistance have provided, beyond which point a formal corrective action process is initiated to address chronic non-compliance.

During focus groups, providers indicated that they are open to equitable, supportive strategies that reflect a collaborative approaching to monitoring and oversight. The Cabinet's current approach to technical assistance relies heavily upon one-on-one interactions and does not frequently use provider bulletins, newsletters, or technical assistance calls to share monitoring trends or relay best practices on a broader scale. Both internal and external stakeholders considered such methods of broad scale communication as promising practices.

Case Management and Person-Centered Planning Related Findings

Finding 26: The Cabinet's transitions in case management to comply with conflict-free case management (CFCM) regulations are not complete, and the Cabinet may have additional opportunities to strengthen case management and CFCM delivery.

Kentucky operationalized CFCM policies several years ago; however, internal and external stakeholders suggested that the rollout of the CFCM policies was disruptive to case management systems and may not have included the necessary levels of training and support

for case managers. Additionally, a variety of stakeholders relayed that case management concerns linger, stemming from response to CFCM regulation.

Per DMS, when CFCM regulations were implemented, providers who offered case management and direct services were offered a choice of which services they would provide to an individual participant and were instructed they could not provide both case management and direct services to a single participant (unless the participant qualified for a geographic exception). Many providers elected to deliver direct services and discontinued case management services. Some providers explained that their decisions were based on the financial considerations, due in part to the favorability of direct service rates.

According to focus group feedback, the shift in case management providers significantly impacted the nature and volume of CM work for providers who retained case management and/or formed new case management provider organizations. Participants whose previous provider discontinued case management services were given a choice among other local CM providers, leading to a redistribution of cases and to expanded caseloads for case managers, some of who were new to the case management field or unfamiliar with new waiver populations they had not previously served.

One waiver that seemed particularly impacted by CFCM implementation was the HCB waiver. Historically, services on the HCB waiver were driven largely through adult day health providers, who provided a “one-stop shop” encompassing several HCBS, including case management. Many adult day health providers chose to focus on delivery of direct services rather than CM, resulting in significant shifts in case management providers for HCB waiver participants. Per case manager feedback provided during focus groups, case management providers who accepted HCB waiver cases were sometimes not familiar with the complex needs of the HCB waiver’s target population of individuals who are aging and/or physically disabled. Several HCB case managers complained in focus groups of a lack of training and support to assist them in meeting these new demands.

Additionally, Cabinet leadership and internal stakeholders expressed concerns that, although CFCM has been implemented in regulation, there may still be conflict of interest in day-to day-practice. Many internal stakeholders and some external stakeholders identified that providers can still influence service plans, especially in areas where provider choice is limited. Although the Cabinet has included conflict of interest as a topic in case manager training, additional training, support, and case-by-case Cabinet remediation when case managers report being unduly influenced by a provider during the person-centered planning process would further strengthen case management delivery.

Finding 27: A method or standard to deter excessive caseloads is not in place.

One of Navigant’s assessment findings, which was heavily reinforced during stakeholder engagement activities, is wide variability in caseload sizes. Many stakeholders commented that case managers need a reasonably sized caseload to perform their responsibilities effectively. The current landscape of caseload sizes across the Commonwealth is depicted in Figure 5.3

Figure 5.3 Kentucky 1915(c) Case Manager Caseload Sizes

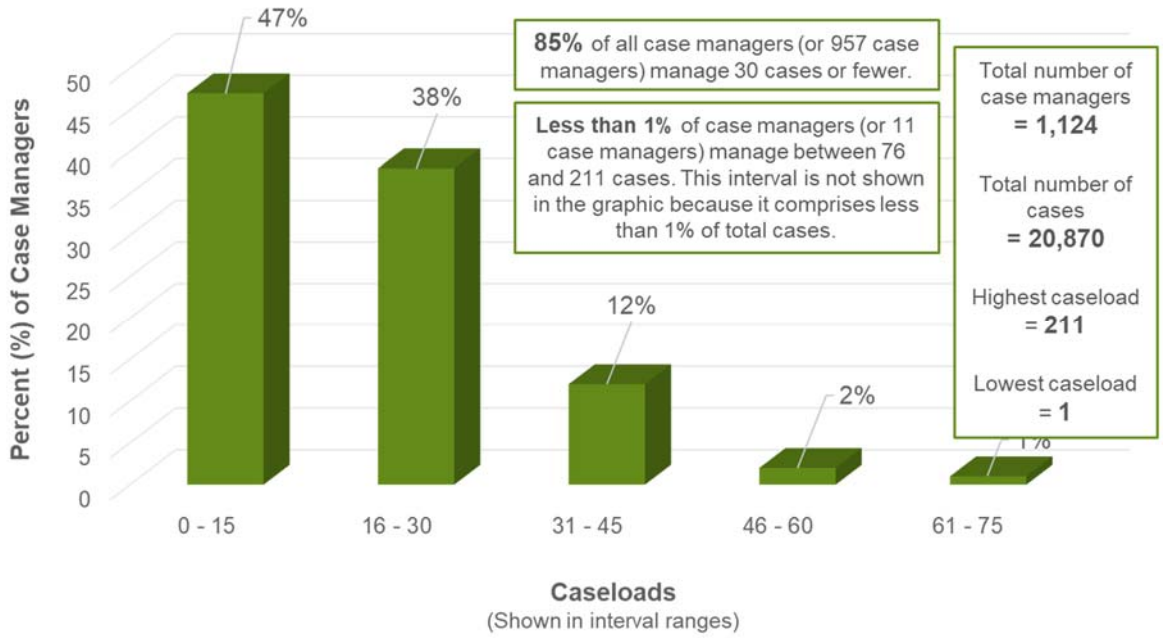


Figure 5.3 shows two noteworthy patterns:

- A substantial number Kentucky's HCBS CM caseloads fall in the 0-15 range. This may point to many cases where a participant has high acuity or demand, reflecting an appropriate distribution of cases. Conversely, this graph may indicate that some case managers have caseloads that are too "light," and this pattern may point to opportunity to better distribute caseloads, as in many regions case management resources are limited.
- Roughly 15 percent of Kentucky's HCBS CM caseloads exceed 30 individuals. Caseloads of this size begin to raise questions regarding the ability to sufficiently handle monthly monitoring requirements and other assigned case management responsibilities.

During town hall testimony, attendees made several requests for the Cabinet to address case management challenges including excessive caseload size. Case management providers also described challenges in retaining case managers and the resulting impacts of case manager turnover. For example, case management providers described circumstances where they temporarily transferred caseloads from a departing case manager to another "acting" case manager, resulting in a high caseload for the "acting" case manager until a new, permanent case manager was hired. They further described that transitions of participants among case managers led to increased administrative costs, and aggravated case manager turnover and workload concerns.

Finding 28: Person-centered service planning (PCSP) approaches and tools vary across waivers and across case management providers.

As noted in Finding 1, Navigant found that prescribed processes and requirements for PCSP differ across waiver applications. Furthermore, the Cabinet has limited requirements for PCSP forms or templates beyond what is housed within the MWMA system, the system in which case managers input person-centered service plans. During the assessment, Navigant staff encountered a variety of questions, interpretations, and perspectives related to PCSP areas. Common questions included:

- What comprises an appropriate person-centered goal?
- What is the role of the case manager in monitoring a goal, and what are the expected practices for engaging participants in the monitoring and outcome assessment process?
- How should participants' personal preferences, strengths, and goals be assessed and documented?
- What strategy should case managers use to address dignity of risk, and how should the participant's autonomy to take on risk and consequence be considered during person-centered planning?
- What health, safety, and welfare concerns are considered high-risk and automatically merit intervention or referral?
- What expected role does a case manager play in linking participants to health care services, and providing support beyond coordination of 1915(c)-specific services?

Some Cabinet staff members raised concerns about the lack of clarity and specificity regarding PCSP requirements. They explained that this lack of clarity and specificity can inhibit the ability of the Cabinet to influence the approach external stakeholders take to instituting PCSP and increases the likelihood that case management approaches will vary significantly among providers. Staff indicated that providers appear to lack clarity in what is expected of them and what constitutes best practice for HCBS case management. Navigant also determined this to be a risk when reviewing the contents of the 1915(c) application Appendix D across waivers, as the contents varied in substance and clarity as discussed in Finding 1. While the Cabinet offers some training and technical assistance, Navigant did not observe evidence of strong to support case managers when they encounter complex cases.

Additionally, the Cabinet is challenged to efficiently monitor PCSP delivery, due to gaps in formal guidance that require Cabinet staff to individually interpret expectations when working with providers and navigate a vast array of provider-specific tools and templates while conducting desk reviews and on-site monitoring.

It should be noted that the case management community continues to debate the Cabinet's role in providing additional guidance on how to conduct PCSP. While some case management providers encouraged the Cabinet to offer more training, technical assistance, and standardized templates to support their compliance, other providers advised they wanted to retain their current level of autonomy to develop and implement their own best practices.

Finding 29: More coordination is needed between case management providers, DMS, and DCBS child and adult protective services units to address suspected abuse, neglect, and exploitation (A/N/E) of waiver participants.

There appears to be an insufficient level of coordination, joint investigation, and information sharing among the necessary entities involved in investigating, responding to, and preventing future A/N/E for waiver participants. Navigant observed minimal linkages between 1915(c) waiver operations and service delivery and DCBS child and adult protective services. Linkage of these programs is critical to uphold 1915(c) waiver assurances addressing incidents of A/N/E. DMS is required as the single-state Medicaid agency to have strategies in place to respond to suspected A/N/E and treat these episodes as critical incidents.

Finding 30: Case management providers indicated they struggle with declining payment rates while assuming expanded responsibilities, which in some cases may be excessive.

As described in Finding 18, the Cabinet reimburses case management providers at different rates across waivers; these providers also have varying responsibilities from waiver to waiver based on how the waiver is designed, making it difficult for the same provider to provide case management for multiple waivers. Case managers and case management provider administrators expressed concerns with what they consider excessive standards, such as the requirement that HCB waiver case managers be on-call 24/7, as stipulated in KAR.

Finding 31: Participants and their caregivers reported that support brokers providing case management service to participants who use PDS lack training and understanding of the roles and responsibilities of a support broker.

Many focus group attendees and Cabinet staff alike expressed concern that support broker services do not offer supports beyond review of time sheets and minimum service monitoring activities. Conversely, support broker providers believe there is limited support from the Cabinet in training or technical assistance to address standards for monitoring PDS. Support brokers described minimal support and even threats to their own personal safety as a result of reporting suspected waste and abuse.

HCBS Related and Non-HCBS Service Related Concerns

Finding 32: Participants struggle to identify available primary care and specialty providers throughout the Commonwealth, and providers struggle to recruit and retain direct care staff.

Limited access to services and limited provider choice were recurring themes in stakeholder feedback. Participants described their struggles to access physician services and various types of specialty care, including but not limited to PDS workers, home delivered meals, general and specialized therapies, and community supports. Many participants and caregivers described having to travel long distances to Lexington, Louisville, and neighboring states to obtain needed

care. Additionally, external stakeholders described widespread challenges finding HCBS providers who can accept new clients. Some focus group participants relayed that provider shortages extend beyond rural areas of the state into parts of the Louisville, Lexington, and Cincinnati metropolitan areas. For example, families of pediatric waiver participants described difficulty finding case managers, therapists, general and specialty physicians, and other providers who were willing to serve pediatric patients or who had pediatric expertise. Some focus group participants also described having outdated or inaccurate information about participating providers.

A lack of available workforce also impacts Kentucky's provider network. Many provider administrators who attended focus groups reported ongoing struggles to recruit, train, and retain a qualified workforce to deliver direct care. Providers advised that they compete with employers that require less skills and higher wages in industries like fast food, retail, and other unskilled job types. They further explained that the churn of employees who leave due to the pressure and demands of a direct care role, coupled with its historically low pay, creates recurring costs and administrative burdens for providers. Small providers expressed that staff turnover is particularly challenging due to their limited resources and ability to absorb excessive overhead costs.

Finding 33: Some service provider requirements appear to pose obstacles to building a sufficient network of HCBS providers.

As noted in the prior finding, some participants and their caregivers described challenges in finding qualified and available HCBS providers. Based on a review of the Commonwealth's provider requirements, Navigant identified some waiver program provider participation requirements that appear to be more rigorous than necessary. For example, the Commonwealth requires homemakers to meet standards for home health providers, and requires that meal delivery providers deliver meals hot, thereby excluding providers of frozen meals and providers whose distance and equipment limit their ability to assure meals are hot upon delivery. Similarly, Michelle P. waiver community access providers, who render a service intended to help participants build and retain social connections in the community, must have a bachelor's degree and one year in the field of intellectual or developmental disabilities. Although this is a service that should be delivered by individuals who have sufficient training or experience working with individuals who have intellectual or developmental disabilities, Navigant suggests that a college education may not be necessary to effectively deliver this type of support. The requirements could limit the pool of qualified providers. Additionally, participants noted that they have encountered providers that were hesitant or unwilling to offer certain services due to the associated monitoring risks and frequent recoupments associated with delivery of a service.

Finding 34: Participant-directed services are frequently used in the Commonwealth, in part because of a lack of traditional providers, and also to offer participants more control and autonomy over their HCBS delivery.

As depicted in Chapter 4, a substantial number of the Commonwealth's waiver participants use Participant-directed Services (PDS). Through stakeholder engagement, Navigant identified several dynamics that lead individuals to select PDS in Kentucky:

- The desire for greater control and autonomy in employee selection
- The ability to pay a different rate to attract a specialized or uniquely qualified employee
- The ability to schedule services outside of usual business hours and to have increased scheduling flexibility
- The shortage of traditional providers (described in Findings 32 and 33) in many geographic regions
- The ability to compensate family members and other natural supports to provide long-term services and supports

Some stakeholders described that they experienced high no-show or turnover rates using traditional providers and that PDS offered flexibilities enabling participants to more effectively recruit and retain employees and achieve lower no-show rates. Likewise, some participants described that one benefit of having caregivers who were personally connected to the participant led to reduced no-show rates. Participants and their natural supports also described the cascading and potentially long-term impacts of provider no shows. For example, if a participant's formal caregiver does not show up for work one morning, that participant may be unable to attend his or her scheduled therapy appointment and then be unable to provide 24-hour notice to the therapy provider. Participants explained that therapy providers often cap the number of patient no-shows they permit before terminating a patient. So, a participant whose formal caregiver is unreliable may, in turn, cause the participant to lose access to therapy services, which could result in a decline in the participant's quality of life and independence.

PDS allows participants some flexibility in what hourly rates are paid and the time of day when services are provided. Some participants and their natural supports also described that PDS offers them a greater sense of employee accountability and connection than they have with traditional providers, since the PDS worker is employed by the participant directly.

Some participants described positive experiences hiring natural supports to, for example, provide community access services. A participant's natural supports may be more familiar with and integrated into the participant's community and with ways to support the participant's unique needs and goals and, thus, better positioned than a traditional provider to successfully provide community support services. One example of this was the employment of a young adult participant's friend to facilitate community access, which allowed the participant to receive needed supports while integrating the participant into activities with his peers.

Finding 35: Participants are often under-educated about the requirements of the PDS model. The current approach lacks strategies and supports to assist participants to self-manage employer authorities. The current approach does not clearly establish criteria to qualify a participant as "appropriate" to self-direct their care.

Navigant learned through policy, operational, and stakeholder engagement assessment activities that, although PDS offers many benefits, it also introduces significant task

requirements and administrative responsibilities for participants, some of which are challenging for individuals who may have impairments or lack literacy skills needed to manage their PDS responsibilities.

Navigant did not identify a consistent or well-documented approach to informing participants of PDS requirements or to otherwise helping participants understand the options to support them with fulfilling PDS requirements. Tools and resources are not in place that explain the specific employer and budget authorities or to support participants to self-assess and identify their willingness to observe PDS responsibilities. Internal and external stakeholders did not seem to understand that the process of executing employer and budget authorities can be individualized to support participants based on their specific needs, and that minimum supports from financial management entities are federally required.

Finally, internal and external stakeholders were unable to articulate a consistent and clear understanding of what qualifies or disqualifies an individual from self-directing their care. The Cabinet needs to develop clearer policy to support case managers, support brokers, Cabinet staff, and other stakeholders to determine when a participant may not have the executive ability or willing and able representatives needed to self-direct. Cabinet staff, case managers, support brokers, and other stakeholders explained that they sometimes experience difficulties communicating with participants when PDS may not be in the participant's best interest, denying access to PDS when it is inappropriate for an individual, and/or upholding a denial when it is appealed.

Finding 36: A substantial number of parents and guardians serve as PDS employees for a waiver participant. The Cabinet has concerns about abuse of PDS and stakeholders strongly expressed widespread concerns over whether parents and guardians should be disallowed as PDS employees.* It is important that the Cabinet clarify its *policy stance on this issue.

Many parents, legal guardians, and legal representatives of adult participants currently act as PDS employees, as indicated in Figure 5.4. This data is not directly tracked; thus, the figures below were developed as an estimate, using compared addresses between a participant and the participant's PDS employee to attempt to estimate how many parents and guardians currently provider care. These figures may include individuals who are PDS workers, are not a parent or guardian, but co-reside with the participant.

Figure 5.4 PDS Employees Listed as Parent/Guardian by Waiver as of January 2018[96]

ABI-Acute	ABI-LTC	HCB	MPW	SCL	Total
6	17	453	2,601	43	3,120

During Navigant's assessment, the Cabinet expressed a desire to understand the impact of PDS, citing instances where community members had inquired "how to be paid to provide care to their child" and did not understand that additional responsibilities and documentation would be required. Cabinet staff and stakeholders throughout the Commonwealth have expressed concerns that while some families have leveraged PDS as an opportunity to improve their support systems and the care provided to the waiver participant, others may receive PDS funds without advancing a participant's person-centered goals.

During focus groups and town hall testimony, many parents and other family members of participants expressed their fears of losing the ability to act as PDS employees, and highlighted reasons why they depended on PDS to secure their child's or other family member's care. Some parents and siblings advised they had given up paid employment to meet the needs of their children and would have to place their child in an institution or face extreme financial hardship without PDS employment. This concern was echoed by parents with both children under 18 years old and those with adult children. Many parents who spoke about the potential disallowing of parents as providers also suggested that family members provide better care to the participant because of their personal connection. Participants and natural supports in rural areas with a shortage of direct care labor were particularly concerned with finding a replacement worker if parents could no longer act as PDS employees.

Navigant researched state approaches to allow parents, spouses, legal guardians,[97] and legal representatives.[98] Navigant found that:

- Some states disallow some or all of these groups from acting as a paid PDS employee, while other states allow them.
- Navigant was unable to identify a state that once allowed these groups to act as a PDS employee and later restricted the option; thus, Navigant was not able to identify strategies states used to mitigate consequences of such a policy change.
- States that allow members of these groups to act as a paid PDS employee can impose requirements stipulating circumstances under which the state will *allow* use of this

[96] There is no specific data field that exists to identify a PDS worker as a parent or guardian of the participant. The figures depicted in Figure 5.4 were pulled as an estimate, using matching addresses between a participant and the participant's PDS employee as a way to attempt to estimate how many parents and guardians currently provider care. Counts may include individuals who are PDS workers, are not a parent or guardian, but co-reside with the participant. Data was collected by DMS.
[97] The 1915(c) waiver technical guidance tends to refer to guardians within the context of individuals under age 18.
[98] Guardians and other designees of individuals aged 18 and older

option, including the following circumstances:

- If the parent, spouse, legal guardian, or legal representative has had to reduce their paid employment to provide needed care
- If all available options have been exhausted prior to employing the parent, spouse, legal guardian, or legal representative
- If a participant lives in a remote or rural area where they cannot secure another provider
- If the participant has behavioral risks that cannot be managed effectively by another provider

The Cabinet needs to clarify policy on whether parents, legal guardians, or legal representatives are allowable PDS workers, and need to provide educational tools and monitoring templates to support public understanding of the policy. The Cabinet also needs a framework to accurately approve or deny these requests. Currently, the Cabinet spends a significant amount of time and staff resource attending appeals hearings on this issue.

Finding 37: Health- and first aid-related screening requirements for PDS workers are a barrier for participants to recruit employees of their choosing.

External stakeholders described that the health and first aid-related screening requirements presented an obstacle to hiring PDS employees. Each PDS employee is required to demonstrate compliance with these health- and first aid-related screening requirements for each participant they serve. PDS employees are generally expected to bear the costs associated with compliance, such as the cost of obtaining a tuberculosis test; however, during focus groups and other stakeholder engagement activities, participants and their natural supports explained that participants often reimburse PDS employees for these costs. PDS employees find the cost of complying with these screening requirements prohibitive and are often inclined to instead pursue jobs (such as jobs in fast food restaurants) that do not require them to bear these upfront costs.

Navigant also observed that the Commonwealth does not operate a statewide registry for PDS providers to record their evidence of compliance with health- and first aid-related screening requirements. Thus, each PDS provider must produce this information for each of the PDS participants he or she serves, leading to administrative burden for both PDS providers and employers.

Finding 38: Criminal background check requirements for PDS workers are not clear and are a barrier for participants to recruit employees of their choosing.

During operational reviews conducted with Cabinet staff, staff familiar with the PDS employee approval process indicated that criminal background restrictions needed to be better clarified and communicated to participants. Conversely, participants have expressed that while the PDS model allows them flexibility in hiring, there are many restrictions that inhibit their ability to recruit individuals they deem strong candidates.

During focus groups, direct care workers reported needing several background checks within a year to serve multiple participants. Each background check takes time and costs money for PDS participants and/or their potential employees. During focus groups, many waiver participants indicated they struggle to manage the costs of recruiting staff and obtaining required background checks. Stakeholders also reported inefficiencies, such as requiring the same PDS employee to obtain the same background check for each participant they serve within a year. Some external stakeholders also believe that some criminal background issues should be eligible to be waived to employ a person with non-violent criminal background findings, if the individual is a family member or co-resides with the participant, and the participant or his/her legal representative consents to waive the standard.

As is the case with health- and first aid-related screening requirements, Navigant observed that the Commonwealth does not operate a statewide registry for PDS providers to record their evidence of compliance with criminal background check requirements. Thus, each PDS provider must produce this information for each of the PDS participants he or she serves, leading to administrative burden not only for PDS providers and employers, but also for the judicial system.

Finding 39: Financial Management Agencies (FMA) vary in their capabilities and performance, and the Cabinet has established few formal standards to govern their performance.

FMAs in the Commonwealth operate with varying levels of technological and administrative infrastructure to process documents and perform administrative responsibilities. These differences lead to differing levels of FMA support across the Commonwealth, resulting in inequitable services and supports to PDS participants. Participants in Kentucky's PDS program are currently common law employers of PDS employees. Participants report not having a clear understanding of their responsibilities as common law employers or of the documentation required to participate in PDS without FMA and case manager support. Participants reported varying degrees of support provided by FMAs and case managers regarding PDS employment.

According to Navigant's assessment, Kentucky has 28 FMAs, comprising a mix of Area Development Districts and Community Mental Health Centers, each of which provide this function for different waiver populations. External stakeholders and Cabinet staff have expressed widespread concerns with the variability in performance across FMAs. While some agencies operate using efficient, technology-based solutions, others have practices that place undue burden on participants. Feedback from stakeholders included scenarios where:

- Participants or their PDS workers are required to drive long distances to submit required documents in person due to lack of a technological interface to submit timesheets
- Some FMAs use practices that delay the timeframes for PDS employee approval, such as batch submission of background checks, which results in participants waiting extended periods to have receive approval while the FMA holds documentation for submission

- Varied levels of support and advisory assistance from FMAs with taxation and payroll questions that could be complex for participants or their natural supports to research and understand on their own

During the assessment, Navigant did not identify clear, defined performance standards for FMAs that promote participant friendly, efficient approaches to service.

Stakeholder Engagement Related Findings

Finding 40: The Cabinet does not appear to have a communication strategy or plan in place, nor does it appear to have a rigorous process for vetting written correspondence.

Stakeholder engagement can take many forms and serve many purposes. One important function of stakeholder engagement is informing external stakeholders and the Legislature about anticipated changes in waiver program policy and operations. Such communications are typically one-directional, conveying a message from the Cabinet to external stakeholders.

Navigant observed deficiencies with the Cabinet's approach to written correspondence. Navigant learned in focus groups that participants often find DMS letters confusing and that their case manager is not always aware that the Cabinet has issued certain correspondence. Lack of clarity in letters and other formal communications is of concern when considering CMS guidance related to Medicaid-issued communications. Providers likewise noted that correspondence from the Cabinet is often confusing. Navigant's review of operational procedures and interviews with Cabinet staff did not reveal that the Cabinet has a stakeholder communication strategy or plan, nor did Navigant identify a rigorous, standardized process for vetting written correspondence before it is released.

Finding 41: Historically, the Cabinet has underutilized stakeholder engagement as a tool to inform policy development. Past engagement methods are largely passive in nature and limit the ability of stakeholders to provide meaningful input. This finding also applies to the Cabinet's engagement of formal advisory bodies and state committees, which can add value when developing and operating 1915(c) waiver programs.

Navigant found that the Cabinet underuses stakeholder engagement to inform policy decisions, program design, and waiver operations. While stakeholder engagement has occurred in the past, Navigant learned that the interactive sharing of ideas and concerns and collaborative development of solutions has historically occurred with only a select group of stakeholders connected to Cabinet leaders or influential in the HCBS community. The frequency, methods, and content of stakeholder communications vary across the waivers, reflecting the differing approaches employed by each of the operating agencies.

Much of the Cabinet's past methods for broad stakeholder engagement were passive (e.g., public comment, question and answer). These methods can be valuable but using them as the

sole engagement method limits the Cabinet's opportunity to provide additional education, answer questions, and/or engage with stakeholders to convey stakeholders input is understood and used when developing policy.

One stakeholder engagement opportunity Navigant identified is maximizing how the Cabinet engages formal bodies and committees in 1915(c) waiver-related policy development and program design, including:

- The Kentucky Council for Medical Assistance (MAC), and its technical assistance committees (TACs)
- Governor or Legislative appointed committees – such as the H.B. 144 Commission, or the Kentucky Council for Autism Spectrum Disorders
- Committees and panels from other state entities, such as the Protection and Advocacy for Persons with Developmental Disabilities (PADD) board, or the Commonwealth Council for Developmental Disabilities (CCDD)

The Cabinet sends DMS designees to present departmental updates to many of these bodies but often does not have the opportunity to seek targeted input or present proposed concepts for consideration. A review of recent TAC transcripts showed the current pattern consists of committee members voicing concerns to the Cabinet, followed by Cabinet response to clarify their position, with little further engagement.

Finding 42: Historically, the Cabinet's approach to HCBS stakeholder engagement has largely relied upon ad hoc interactions with stakeholders. To the extent the Cabinet has used more structured approaches to stakeholder engagement, those have typically been focused on provider stakeholders.

Limited formal stakeholder engagement has, in some cases, meant that legislators and Cabinet staff members and leaders have relied upon informal or ad hoc communications from stakeholders. Thus, personal anecdotes and the perspectives of a small number of highly active stakeholders may have presented limited experiences, while other stakeholders were not heard. As a result, the Cabinet and the Legislature have sometimes made program and operational decisions without fully understanding the impact of those decisions on stakeholders, especially participants.

The Cabinet does not have in place a documented communications strategy and workplan for HCBS-related programs, nor, it appears, for the Medicaid program overall. Further aggravating stakeholder engagement, the updates to the Cabinet website in Spring 2018 caused historical web addresses and links to become invalid and navigating the new Cabinet website became challenging since internal links were disrupted during the go-live for the new website.

Finding 43: Stakeholders lack education about the federal requirements and other rationale that govern Cabinet decision-making.

Throughout stakeholder engagement activities, stakeholders raised concerns that the Cabinet often issues decisions without explaining their underlying rationale. Cabinet staff explained, and Navigant observed that stakeholders are not always fully informed about federal requirements that may restrict the Cabinet from making the changes they suggest. One example that emerged related to conflict-free case management rules. While many participants and caregivers suggested that they were not happy to change case management providers, they did not always appear to understand that this change was federally mandated, and that the Commonwealth could not override this federal policy.

Finding 44: Stakeholders have responded positively to the level of engagement and methods used during 1915(c) waiver assessment, but lack confidence that the Cabinet will continue to be transparent and inclusive in the future.

One notable observation during assessment activities was that external stakeholders were often complimentary and appreciative of interactive engagement methods, including the focus group format and the opportunity to testify at town halls. Stakeholders have commented favorably on the recent increased level of communication with the Cabinet, and have offered constructive feedback about what they would like to see moving forward, including:

- Increased transparency and timely updates about future design of waivers
- Moving beyond the term “stakeholder” being synonymous with “provider” and offering more outreach and timely notification to participants and their caregivers, including individuals on waiver waiting lists
- Equal opportunity to participate in engagement methods, so that all types of stakeholders are equally able to provide their input
- Increased use of information sharing reporting after engagement to confirm that Cabinet representatives accurately interpreted the stakeholder input provided
- More intentional outreach and effort to engage individuals in far eastern and western Kentucky, and targeted inclusion of stakeholder types who may be less represented in the current approach

Quality Related Findings

Finding 45: Quality and service outcomes are under-emphasized in the Cabinet’s current HCBS program management and oversight approach, and the Cabinet’s data and analytic infrastructure is insufficient to support rigorous continuous quality improvement processes.

Stakeholders internal and external to the Cabinet reported that the Cabinet is focused heavily on compliance, particularly compliance with documentation and administrative requirements. Many stakeholders expressed interest in moving forward with an increased focus on quality,

suggesting that the focus needs to be on best-in-class delivery of HCBS services and participant outcomes.

Multiple provider representatives asked that the Cabinet do more to recognize and share best practices and take a more holistic approach to monitoring. This approach should balance the importance of regulatory compliance with an expanded focus on improving quality and participant outcomes within the waiver services provided. Stakeholders recognized that there is opportunity to improve quality in HCBS across the Commonwealth but often struggled to identify measures and targets the Cabinet should consider. This difficulty in conceptualizing a quality framework suggests to Navigant that the Cabinet will need to drive quality improvement and lead the way as a purchaser.

Navigant's interviews with Cabinet staff members and the review of available reports and data substantiated the stakeholders' comments, and Navigant observed that the Cabinet does not have the infrastructure or resources that are essential to successfully implement continuous quality improvement processes. Critical to continuous quality improvement is access to complete and accurate data, as well as the ability to analyze that data and generate timely reports. The Cabinet has had limited capability to evaluate the status quo, identify gaps in care, develop performance targets to be achieved via closing some of those gaps, implement interventions to close those gaps, and re-measure those performance areas.

Generally, limited program-wide performance data are available and, when such data are reported, they are often reported using raw numbers rather than relative figures (such as a utilization rate). Also, data are often reported as a point-in-time figure rather than being trended over time. Thus, available data do not enable effective use of quality improvement cycles. Not surprisingly, the Cabinet's current approach to waiver management, including quality management, reflects its longstanding approach to separately managing and operating the waivers. Thus, approaches to quality management are not always aligned across waivers, and the Cabinet has wide ranging quality goals across its six HCBS waivers.

Cabinet HCBS staff members spend much of their time addressing individual inquiries from participants and their natural supports, as well as from providers. Thus, the focus is on resolving the inquiries (which require attention in the near-term) rather than on establishing long-term goals to achieve program performance. Like many states, Kentucky currently focuses its HCBS quality management resources on compliance and procedural matters and does not embrace its CMS-approved comprehensive quality improvement strategy or another continuous quality improvement strategy as much as it could. In effect, long-term planning and the quality improvement cycle have taken a back seat to compliance management.

Finding 46: The Cabinet has does not appear to be fully prepared to respond to CMS modifications to waiver assurance requirements issued in 2014.

The Cabinet modified its waiver applications to reflect new waiver assurance requirements CMS issued in 2014; however, Navigant observed limited evidence of the Cabinet's operational readiness to fully meet these requirements. For example, the Cabinet's information systems and

operational workflows do not appear to be aligned to successfully achieve performance targets set forth in the waiver assurances. Navigant identified the following key areas that require adjustment to address these performance targets: critical incident management; coordinated response to abuse, neglect and exploitation; and participant protections.

Finding 47: While the Cabinet does measure program performance in some areas, the measurement and reporting activities are not part of a disciplined continuous quality improvement cycle, and transparency is limited.

The Cabinet has different quality assurances among its six HCBS waivers and has not established a continuous quality improvement cycle that allows for interdepartmental review of data-informed trends and program findings, to then develop and implement quality improvement strategies. As noted in Finding 46, the Cabinet does not appear to be prepared to meet CMS's quality assurance requirements. Best practices indicate that continuous quality improvement requires infrastructure and processes that extend beyond those required by CMS's quality assurance framework, so it is not surprising that Navigant also observed the Cabinet lacks a continuous quality improvement process and associated culture.

Navigant observed, and Cabinet staff confirmed during interviews, that the staff do not generally have readily available information about program performance, population service use, or gaps in care. Likewise, apart from compliance matters being "worked" by Cabinet staff, Cabinet staff are not generally tasked to achieve program-wide performance targets related to quality of care. The only identified integration of any nationally developed framework is DBHDID's use of the National Core Indicators (NCI) tool for individuals living with developmental and intellectual disabilities and participating in Michelle P. and SCL waivers. However, Navigant did not identify that the Cabinet incorporated NCI survey findings in a meaningfully way to improve those waiver programs. Some program performance information is shared with MAC, but that data is generally presented using raw numbers rather than relative measures, limiting its value in quality management. Public reporting about program quality has otherwise been minimal.

Likewise, HCBS waiver quality management is not aligned with the quality strategy in place for Kentucky Health Partnership, the Commonwealth's Medicaid managed care program. HCBS waiver-oriented quality activities focus primarily on HCBS services and do not consider the participants using a holistic perspective that addresses other health services that may impact overall participant health and wellness. Some opportunities may exist to align quality management by, for example, developing a set of core measures that is common across all HCBS waivers and, potentially, across the entire Kentucky Medicaid program.

Waiver Configuration

Finding 48: Despite the wide range of participant needs served through the Commonwealth's HCBS waivers, stakeholders expressed a need for waivers designed to serve additional subgroups and cover different services.

The Commonwealth's waivers serve a wide range of participant needs, yet some stakeholders indicated a need for waivers to serve additional subgroups and cover different services. For example, during the Fall 2017 focus groups and the Spring 2018 public comment period, external stakeholders voiced frustration with waiver waiting lists, expressed concern that some of the waiver participants' needs were not well addressed by the menu of services in their existing waivers, and expressed need for an Autism-specific 1915(c) waiver. Stakeholders also expressed interest in a waiver targeting people who have Serious Mental Illness (SMI).

Finding 49: Although there is Cabinet and stakeholder interest in reconfiguring the 1915(c) waivers, the current state of operations and information availability poses obstacles to identifying the most appropriate configuration of waivers for the Commonwealth.

As described in Finding 1 and other findings, the Commonwealth's six HCBS waivers were developed separately over time to address the needs of particular groups of participants. Thus, these waivers were not part of a holistic strategy to design an HCBS program that would best meet the needs of Kentuckians who live with disabilities. Furthermore, based on interviews with Cabinet staff members and review of readily available data, Navigant's understands that Kentucky has never conducted a comprehensive assessment of its existing HCBS waiver configuration.

Navigant has also observed that Kentucky's readily accessible and available HCBS waiver program data are limited. For example, much of the data that would be necessary to evaluate the current waiver program configuration (e.g., assessment data, Medicare claims data for waiver participants who are dually eligible for Medicare and Medicaid) are not readily available today. Additionally, changes are needed to improve the management and operation of the waivers as they are configured today. Any available data reflects performance of HCBS waiver programs that are not operating as efficiently and effectively as possible. As a result, the Cabinet is challenged to determine whether the current configuration needs to change to improve HCBS delivery or if the current configuration would meet needs if it was improved.

Lastly, implementing too much change at once could pose substantial risks to the program, its participants, and other stakeholders. Internal and external stakeholders have conveyed throughout the assessment that they are wary of changes, due to challenges with prior roll-outs including major changes to the SCL and HCB waivers, as well as the initiation of the Michelle P. waiver.

5.2 Assessment Limitations

Navigant has worked collaboratively with the Cabinet to conduct a thorough assessment of Kentucky's 1915(c) waivers. This assessment has several notable limitations, outlined below.

- **Stakeholder engagement.** As described in earlier chapters, stakeholder engagement was one of several key sources of information for development of assessment findings. Several factors should be considered when interpreting and generalizing the input from

external stakeholders:

- **Stakeholder outreach.** Due to the novelty of the stakeholder engagement methods employed for this assessment, the Cabinet did not have in place a stakeholder contact list, nor did it have relationships established with partner organizations (such as provider associations, advocacy groups and the like) that could support the Cabinet in notifying stakeholders about stakeholder engagement activities. The Cabinet worked to build that list during Navigant's assessment and continues to do so for future engagement. However, it appears that notice of the stakeholder engagement opportunities (as well as supports, like transportation reimbursement, available to waiver participants) may not have effectively reached or captured the attention of the stakeholder community.
- **Sample sizes.** As noted in Chapter 2, attendance at stakeholder engagement meetings (i.e., town halls and focus groups) was high, relative to prior stakeholder engagements conducted by the Cabinet. In-person stakeholder meetings typically engage a small sample of all stakeholders relative to surveys and some other stakeholder engagement methods, but still prove an effective means of communication and dialogue with stakeholders.
- **Sampling bias.** As described in earlier chapters, the Cabinet does not have a history of conducting broad-based, interactive stakeholder engagement activities. With meetings held in 10 locations around the Commonwealth and an email inbox, the stakeholder engagement activities were designed to be accessible to various waiver subpopulations and other stakeholders. Nonetheless, some subpopulations may have been relatively underrepresented, such as but not limited to elderly waiver participants and their natural supports and some historically heavily involved HCBS advocates, as well as individuals on HCBS waiver waiting lists. Thus, Navigant's findings may or may not reflect the needs of *all* waiver participants and may not be widely generalizable to all waiver subpopulations.

- **Cabinet leadership and staff changes.** Navigant did not have access to the historic leaders of the 1915(c) waiver programs. When DMS initiated Navigant's assessment, much of inter-departmental leadership was relatively new to either their Cabinet post or to 1915(c) waiver oversight, which impeded Navigant's ability to obtain historical perspective on past policy decisions and waiver approaches, such as rate setting methodologies. Thus, at times Navigant was unable to gather information and gain insights about the rationale for designing the various waiver program features.
- **Cabinet website updates.** In the Spring of 2018, the Commonwealth reconfigured its website. The update rendered many of the online resource documents (e.g., historical MAC meeting agendas, transcripts and other meeting materials) inaccessible as Navigant prepared this report. As a result, in some limited cases, the findings may not be reflective of review of all program policies, operational protocols and related online

documentation now available.

- **Timing.** The Cabinet engaged Navigant in Spring 2017 with the intent that Navigant conduct a 90-day assessment of the Commonwealth's HCBS waiver programs. The Cabinet then extended the timeframes for the conduct of this assessment and delivery of this findings report, and, as a result, the assessment timeframe expanded to approximately 14 months. This extended timeframe allowed the Cabinet time to address other (non-HCBS-related) priorities and offered the opportunity for Navigant to conduct a more thorough and extensive assessment. However, the extension of the study timeframes did introduce challenges in keeping external stakeholders engaged through lengthy periods of "down time" between stakeholder engagement events. Also, Navigant's experience in working with other states gleaned that stakeholders can become saturated if presented with too much information within a short period of time. During the assessment, the Commonwealth was planning and preparing intensively for implementation of Kentucky HEALTH. These planning and preparation activities engendered a high degree of stakeholder interest and stakeholder engagement in formal and informal interactions. As a result, HCBS-related stakeholder engagement may have been deflated, and some external stakeholders may have been confused about the implications of various initiatives.
- **Data Limitations.** As noted throughout the findings, data limitations constrained Navigant's ability to conduct broad-scale quantitative evaluation. There is a lack of readily accessible data on 1915(c) participants stored in a way to allow for independent data analysis, sufficient for the Navigant team to draw decisive conclusions about the status of waivers, their utilization patterns, and other administrative information. Thus, assessment timing and budget resources prevented Navigant from conducting data analysis to profile the waiver programs and the people they serve, to test or validate both internal and external stakeholder concerns, to identify gaps in care, or to measure participant experience. Navigant's profile of the Commonwealth's HCBS programs relied instead upon figures and statistics that *were* readily available to the Cabinet and presents data aggregated by the Cabinet at Navigant's request or already in the Cabinet's possession. As noted in Chapter 6, data that are available today (and any data that are not readily available but relate to the current and recent fiscal years) reflect the experience of HCBS waiver programs that may not be operating as efficiently and effectively as possible. The most critical time to rely upon program data will be in the upcoming years, to evaluate the impact of any changes implemented as a result of this assessment and to inform future assessments. Future studies (including the proposed Phase II HCBS program assessment recommended in Chapter 6) should more thoroughly examine waiver program enrollment, waitlist, assessment, utilization and expenditure data, as well as any available survey and participant experience data. Future studies should use historical data to establish baseline measures that can be compared to near real time program performance measurement. Some specific examples of data limitations Navigant encountered are noted below.

- **Participant assessment and service plan data.** At the time of Navigant's assessment, participant assessment data was not available in a uniform or automated format, thus could not be linked to participant service use. Thus, Navigant was not able to examine, for example, the degree to which service plans appear to be aligned with assessment findings or the degree to which a participant's actual service use reflects services in their service plan.
- **Timeliness.** As is true for any claims data, claims data is lagged due to claims processing timeframes and the time required to transfer claims data to the data warehouse. Thus, any analysis conducted with the Commonwealth's HCBS claims data will rely upon data that is generally approximately three months old or older. Such claims lag hampers the Commonwealth's ability to rapidly assess the impact of new policies or, for example, the impact of a market event or political event. Timeliness is less of a concern for the assessment of historical utilization and spending patterns than it will be for ongoing, proactive management of the HCBS waivers, when the Cabinet should rely upon claims data to assess the impact of quality improvement and compliance interventions.
- **Dually eligible participants**. The Commonwealth's data for people who are dually eligible for Medicare and Medicaid excludes claims history for services reimbursed by Medicare (such as acute care and prescriptions). Thus, Navigant was unable to thoroughly profile this significant portion of Kentucky's HCBS waiver participants.
- **Waitlisted individuals.** At the time of Navigant's assessment, limited data was available for individuals who are on the waitlist, so Navigant was unable to validate some of the concerns stakeholders raised about the ultimate waiver eligibility of people who are waitlisted.

Chapter 6: Recommendations

This chapter describes Navigant's recommendations based on findings identified during the 1915(c) Home and Community-Based Waiver Redesign Assessment. The recommendations offer methods for the Cabinet to advance its goals as stated in Chapter 1.2: *Assessment Goals* and to address findings in *Chapter 5: Assessment Findings.* In the *Introduction to Recommendations* below, Navigant outlines the structure of the recommendations using a "Home" and Community-Based metaphor illustrating how the recommendations collectively build towards a stronger HCBS delivery system reflective of Kentucky's goals. Refer to Appendix H for a crosswalk of how findings support these recommendations.

6.1 Introduction to Recommendations

When presenting preliminary recommendations during town halls, Navigant used the metaphor of constructing a home, optimizing the Cabinet's processes and waiver design to better serve participants and other stakeholders. Much like the construction phase in home building, the Cabinet must critically evaluate each core component as a building block towards improve waiver administration that meets the growing needs of these programs. Using this metaphor, Navigant has categorized the recommendations as follows:

- ***Foundation:*** Recommendations 1 through 4 represent the home's "foundation" – which are the elements of the program, either policy or decision-making methodology, that form the basis for how the program works. Poorly written procedures and documents and policies and methodologies that are not sound or easily understood can present challenges to the delivery of HCBS services. Navigant's recommendations offer clear improvement strategies for the foundational 1915(c) waiver policies and decision-making methodologies.
- ***Living Space:*** Recommendation 5 impacts the home's "living space" – providing ground-rules to encourage a system where all can function within daily operations. Day-to-day program operations within the Cabinet serves as the "living space" with rules, regulations, and decision-making authority needed to guide staff through their work routines and to assist in service delivery. Standardized procedures for these operations would make for a more productive and "livable" living space.
- ***Walls:*** Recommendations 6 and 7 pertain to the home's "walls" – which wraparound the structure of the home, providing strength and overall stability. The elements that "wraparound" the HCBS program to provide services serve as "the walls" – including the case management system, and a well-designed participant-directed services system for those who choose to self-direct their services.
- ***Roof:*** Recommendation 8 represents the home's "roof" – providing protection from the elements. Oversight and monitoring activities performed by the Cabinet act as "the roof." Waiver participants, providers and the program itself are protected when the Cabinet ensures the system is running according to rules and regulations. And, as houses must

meet zoning requirements and other laws and regulations, the 1915(c) waivers must meet federal, state and local requirements. The Cabinet's monitoring and oversight activities should protect participants from abuse or poor-quality service delivery.

- ***Front Yard:*** Recommendation 9 represents the home's "Front Yard" – the presentation of the home to others. Similarly, stakeholder engagement is the primary method for the Cabinet to present to the public, acknowledging how important it is to work in partnership to have a strong HCBS system. While the stakeholders themselves are foundational to the program, stakeholder *engagement* activities are the primary way that the Cabinet presents to stakeholders and welcomes them into the decision-making process.
- ***Future Plans – Home Maintenance:*** Recommendation 10 represents the home's "Future Plans – Home Maintenance" – which focuses on how one must plan for what will need to be maintained, fixed, or replaced. This is true for managing HCBS programs as well and should be a part of the Commonwealth's plan. Quality improvement strategies are a key driver of program maintenance. Through quality improvement, the Cabinet can start to work with stakeholders to identify broader system improvements to drive improved outcomes and enhance participants' experiences on the HCBS waivers.
- ***Future Plans – Remodel / Addition:*** Recommendation 11 represents the home's "Future Plans – Remodel / Addition" – which focuses on ways the home may need to be remodeled or changed to meet the future needs of its inhabitants. Similarly, the Cabinet must consider how the 1915(c) waiver program needs to consider future remodel or reconfiguration to meet the needs of stakeholders including participants and providers.

Figure 6.1 "Home" and Community-Based House Metaphor

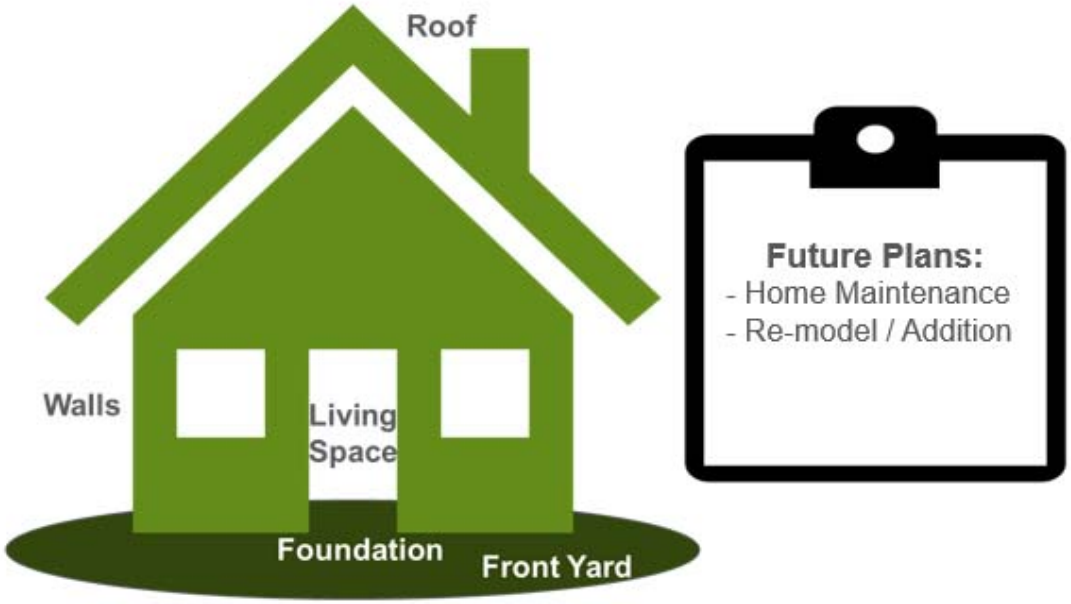


Figure 6.2 lists the 11 recommendations:

Figure 6.2 List of Navigant's Phase I Recommendations

No.	Recommendations	Section of the "Home"
1	Standardize provider qualifications, services definitions and waiver operations across 1915(c) waivers when appropriate, including waiver-specific regulations to be promulgated in KAR	Foundation
2	Move to needs-based care planning with a universal assessment tool, completed by an independent entity	Foundation
3	Implement a prospective, data-driven individual budget process, using an algorithm that quantifies participant's needs based on information obtained through assessment, and translates that quantification into a budget the participant can use on a monthly or annual basis to obtain waiver services	Foundation
4	Develop a sound rate-setting methodology, informed by a study of the reasonable and necessary costs incurred by providers to serve waiver participants	Foundation
5	Develop standard operating procedures using a standardized template across the Cabinet, to include as part of a training program for Cabinet staff responsible for administration and oversight of the 1915(c) waivers.	Living Space
6	Update and enhance the case management approach for HCBS waivers, implementing updated tools, performance standards and training that better reinforces and supports case managers	Walls
7	Streamline PDS delivery by reducing the disparity between fiscal management agency (FMA) operations, and strengthening program policies and procedures	Walls
8	Centralize operations and oversight under one quality management business unit	Roof
9	Implement an ongoing, formal stakeholder engagement process, including TACs & MAC	Front Yard
10	Implement a quality improvement strategy to increase emphasis on improving service outcomes and participant experience	Home Maintenance
11	Conduct a future assessment of the need for waiver reconfiguration, once aforementioned recommendations are implemented and reviewed for effectiveness	Re-model / Addition

6.2 Recommendations

This chapter outlines the detailed recommendations for Phase I. In addition to expounding on what improvements could result from each recommendation, Navigant includes information on how the recommendation is supported by and reflected in national best practices, describe anticipated next steps should the Cabinet elect to proceed with the recommendation, and pose some high-level decision points and considerations the Cabinet will need to address in order to implement a recommendation.

Recommendation 1 – Standardize provider qualifications, service definitions and waiver operations across 1915(c) waivers when appropriate, including waiver-specific regulations to be promulgated in KAR.

Recommendation 1 is part of the *foundation* of the "Home" for Home and Community-Based Services. For Kentucky's 1915(c) waivers to operate consistently and efficiently, Navigant recommends standardizing provider qualifications, service definitions and waiver operations to the greatest extent possible. Navigant also recommends modifying the waiver application contents to better align to standards established in CMS' 1915(c) technical guidebook.

Recommendation: Standardize provider qualifications, service definitions and waiver operations across 1915(c) waivers when appropriate, including waiver-specific regulations to be promulgated in KAR.
Recommendation Description: Navigant recommends revising language contained in the 1915(c) waiver applications to streamline and improve waiver operations. Navigant recommends a coordinated approach between DMS and sister agency teams to develop the content of waiver amendments to maximize consistency in language and content across waivers. This process should incorporate best practice revisions proposed during policy review assessment activities. To the extent the waiver language serves unique disability groups with specialized needs, Navigant recommends retaining and leveraging waiver language tailored to respective populations and services within each waiver. Navigant recommends reviewing the contents of waivers on an annual basis to identify and address any future updates or enhancements needed to waiver applications, including addressing any changes in federal requirements or state program needs. In addition to 1915(c) waiver application changes, Navigant recommends moving the bulk of operational protocols and regulatory interpretations out of KAR and into user-friendly provider manuals and operating procedures, developed and annually reviewed by a single, designated team within the Cabinet. Navigant recommends the waiver regulations to prescribe only core expectations and requirements for waiver programs and HCBS delivery – thus reducing the system's current heavy reliance on agency regulations, which have been described by stakeholders as cumbersome, not user-friendly, and subject to misinterpretation. Operational protocols and manuals would then be referenced in the KAR to allow for streamlined updates. As needed, proposed updates would then undergo review by the technical assistance committees (TACs) and through public review and comment.

Recommendation Rationale: Navigant anticipates that updating the 1915(c) waiver application requirements, aligning them with a less cumbersome series of waiver-related KAR, and then establishing handbooks with additional operational guidance from the Cabinet would help address several challenges, address various assessment findings, and result in efficiencies such as those noted below:

- Incorporating handbooks, manuals, and other documents into the KAR, by reference, would allow for a more nimble and responsive administration process that would be more informative to providers, participants, and stakeholders.
- Adjust language across the waiver applications to incorporate easily understood language offering standardized Cabinet guidance for requirements and best practices that can be applied similarly across all waivers.
- Offer additional formal guidance within handbooks or manuals to support providers in implementing prescribed policies and operational procedures.
- Fully align policies and additional guidance to address current differences in requirements across policy sources to enhance program integrity.

Additionally, adjusting policies to be clearer and streamlined across waivers should decrease the time and resources that providers and the Cabinet currently devote to avoidable provider disputes, complaints, and requests for technical assistance.

The waiver application is comprehensive and detailed; therefore, standardizing the waiver applications where appropriate would offer participants and providers greater transparency, allowing the Cabinet to deliver a more consistent message to stakeholders of the 1915(c) waivers.

Cabinet Goals Advanced by this Recommendation:

- Maximize consistency in definitions and requirements across waivers
- Establish standardized procedures for all waiver management administration activities
- Design services that address participants' community-based needs, including populations who are under-served or not served by today's waivers
- Optimize case management to support person-centered planning and abide by conflict free case management regulation

Expanded Rationale for Recommendation

Navigant is making this recommendation to help the Cabinet address challenges related to today's 1915(c) waivers and related polices. The rationale for this recommendation is described below.

- **Incorporating handbooks, manuals, and other documents into the KAR, by reference, would allow for a more nimble and responsive administration process that would be more informative to providers, participants, and stakeholders.** The current waiver related policies, including 1915(c) waiver applications and waiver-related KAR, require lengthy CMS and/or Kentucky legislature review and approval, which while appropriate for substantive changes, becomes cumbersome and time-consuming when

the Cabinet identifies needed operational and administrative adjustments. Using handbooks and other document types that can be incorporated by reference will ease this process when making non-substantive changes to policy (e.g., changing a form for efficient completion) by avoiding a lengthy and inefficient review process. Navigant recommends aligning waivers to better address policy, while moving operational procedure and other more practical information into other sources, which can be incorporated into KAR by reference.

- **Adjust language across the waiver applications to incorporate easily understood language offering standardized Cabinet guidance for requirements and best practices that can be applied similarly across all waivers.** According to the assessment, Kentucky's waiver programs emerged and evolved at different times and have rarely been considered collectively when developing HCBS policy. Waivers developed earlier in the process have not been updated to account for changing regulations, which has contributed to program variances. Navigant identified opportunities to re-write or expand waiver language to make language easier to understand, while better articulating expected practices in areas that can be approached similarly regardless of participant population, such as:
    - Person-centered planning and service coordination
    - Critical incident management and oversight
    - Participant-directed service design
    - Participant protections, including grievance and appeal systems
    - Participant rights, including the use of restrictions and restraints

  Making these recommended updates to the waivers should advance several Cabinet goals, namely, *maximizing consistency in definitions and requirements across waivers.* Updated waiver language would also help reinforce other Cabinet goals including:
    - Improving case management and person-centered planning
    - Honing service menus
    - Establishing standard administrative and operating procedures
    - Setting the stage for incorporating new decision-making methodologies

  Variation in policy also impacts waiver-related KAR. The level of conflicting nuances between waivers makes it difficult for providers to offer services under multiple waivers; therefore, Navigant recommends streamlining and clarifying waiver contents to address the Cabinet goal of *diversifying and growing the provider network*, by reducing some of the administrative complexities that exist today.

- **Offer additional formal guidance within handbooks or manuals to support providers in implementing prescribed policies and operational procedures.** As noted in Navigant's assessment and reflected in stakeholder feedback, there is no

central source of guidance that provides the Cabinet's interpretation of waiver rules and regulations. Such ambiguity has created challenges for Cabinet staff, providers, and participants as they work through day-to-day questions that require Cabinet direction. Even in states with well-written policies, if such policies are not institutionalized and consistently enforced, there will be internal and external stakeholder concerns. Thus, Navigant recommends development of formal manuals or handbooks, including a process for routine training and enhancement of these tools. Developing a common source of additional guidance or detailed instructions that providers and participants can reference will promote transparency and create efficiency for Cabinet operations.

While the Cabinet presently uses a variety of tools to provide support to providers and stakeholders (e.g., training, technical assistance site visits, and event-based responses), Cabinet staff do not apply these tools consistently, creating stakeholder confusion about HCBS-related policies. Navigant recommends using a more standardized, disciplined approach to information sharing and instruction, such as the development of HCBS handbooks that are easily referenced, offer a single-set of information, and can be reviewed and adjusted to better support stakeholders and Cabinet staff in navigating the complexities of waiver policy and procedure. Navigant anticipates this step would further support the Cabinet goal of *maximizing consistency in definitions and requirements across waivers.*

- **Fully align policies and additional guidance to address current differences in requirements across policy sources to enhance program integrity.** Navigant recommends correcting instances where information housed in the 1915(c) waiver application directly contradicts or poorly aligns with the contents of the KAR. Aligning all policies is a must for a well-designed HCBS system.

Related National Trends and Best Practices

Based on prior experience and research, Navigant identified the following national trends regarding regulation management and waiver consistency:

- **Governments' approach to regulations has evolved into a dynamic regulatory management superseding traditional 'command and control.'**[99] Since the 1970s, the United States Code of Federal Regulations (CFR) has increased by over 100,000 pages of regulations.[100] In addition, KAR volumes have increased from four books in 1975 to 14 books by 2016.[101] Regulations can have a valuable purpose in government and offer guardrails for the services the government offers; however, on the federal and state level, government entities are considering improvements to regulatory design and

[99] Organization for Economic Co-Operation and Development. The Evolution of Regulatory Policy In OECD Countries, Available at: https://www.oecd.org/gov/regulatory-policy/41882845.pdf
[100] Broughel, J. Regulation on the Rise in Kentucky, September 2016. Available at: https://www.mercatus.org/publication/regulation-rise-kentucky
[101] Organization for Economic Co-Operation and Development. The Evolution of Regulatory Policy In OECD Countries, Available at: https://www.oecd.org/gov/regulatory-policy/41882845.pdf

function, including alternatives to regulation such as incentives.[102] In Kentucky, there are more than 4,700 state regulations, and approximately 85 percent of them have never been reviewed for effectiveness or ongoing need.[103]

- **The Centers for Medicare and Medicaid Services (CMS) emphasizes consistent language across 1915(c) waiver applications within a state.** In Navigant's experience, CMS has encouraged states to streamline their waiver operations into consistent, centrally-housed locations when appropriate - decreasing the siloed approach many states, including the Commonwealth, currently use to operate waivers. By standardizing and streamlining 1915(c) waiver processes, states have the ability to shift their focus on managing varying regulatory requirements to developing strategies to provide improved quality and access to care.

Anticipated Actions Related to this Recommendation

Should the Cabinet elect to implement this recommendation, they should draft waiver language based on Navigant's assessment of all six 1915(c) waiver applications. The Cabinet should consider changes across the entire application template, to reflect opportunities where Navigant has suggested standardization and HCBS best practices.

If CMS considers the Cabinet's changes to the waiver language to be "substantive," the Cabinet must comply with the federally mandated public comment period for stakeholders to offer their feedback on 1915(c) waiver policy changes.[104] If changes are not considered to be substantive, the Cabinet may still wish to hold a 30-day public comment period to allow stakeholders opportunity to provide their input and ask questions before drafts are submitted to CMS for approval.

In conjunction with these 1915(c) waiver application updates, Navigant also anticipates the Cabinet would conduct a review of the Commonwealth's 1915(c) waiver regulations contained within the KAR with the intention of reducing the number of regulations and revising regulations to focus on the core components of the programs. Navigant recommends considering the following questions to reduce the "red tape" within waiver-related regulations:

1. Do regulations align with 1915(c) waiver contents?
2. What operational components may not require regulatory definition or need to be vetted through the legislative process?
3. What protections does the regulation offer participants, providers, and the Commonwealth?

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[102] Organization for Economic Co-Operation and Development. The Evolution of Regulatory Policy In OECD Countries, Available at: https://www.oecd.org/gov/regulatory-policy/41882845.pdf
[103] Red Tape Reduction. Available at: http://redtapereduction.com/About.aspx
[104] Government Publishing Office. Electronic Code of Federal Regulations, 42 CFR 441.304. Available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=1b8f235518da223a44f9a006f9e494b8&mc=true&node=se42.4.441_1304&rgn=div8

4. Is the regulation enforceable? If so, how can the Commonwealth monitor and conduct enforcement?
5. What penalties, sanctions, or actions should be allowable if the regulation is violated?
6. Can the KAR be revised to reference other materials (e.g., provider handbooks) as opposed to describing policies and procedures in the regulations? If so, what are the requirements when a referenced document is edited?

Please note that all changes made to the KAR will have to be conducted in accordance with requirements defined by the Kentucky legislature, including required public review periods and committee review.

Highlighted Cabinet Decisions to Proceed with this Recommendation

Should the Cabinet implement this recommendation, the Cabinet would need to address the following strategic or operational considerations:

- Will the Cabinet modify the six existing 1915(c) waivers?
- Which provider qualifications, service definitions, and waiver operations would DMS standardize across 1915(c) waivers?
- Will the Cabinet update the KAR and/or leverage handbooks or manuals?
- What is the implementation timeline?
- When does the Cabinet anticipate submitting revised 1915(c) waivers for public comment?
- When does the Cabinet anticipate releasing revised 1915(c) waiver applications to CMS for review and approval?

Future Stakeholder Input

The 1915(c) waiver amendments process may include stakeholder engagement, including input from both internal and external stakeholders.

Internal to the Cabinet, Navigant recommends the Cabinet identify a core waiver team responsible for most of the review and drafting tasks associated with this recommendation. Upon the core waiver team updating the 1915(c) waivers, the Cabinet should review each appendix in a collaborative group setting and seek sister agency input from DMS, DAIL, and DBHDID.

External to the Cabinet, and consistent with Federal regulation, CMS requires the Commonwealth submit a 1915(c) waiver amendment for any changes made to the waiver applications. Prior to formally submitting the waiver amendment, CMS requires at least 30-days of public comment for “substantive” changes to the waiver application, in accordance with *42 CFR 441.304(f)*. CMS defines substantive changes to include but not be limited to:

- Revisions to services available under the waiver including elimination or reduction of

services or reduction in the scope, amount, and duration of any service

- A change in the qualifications of service providers
- A change in rate methodology
- A constriction of the eligible population
- Consolidating waivers
- Adding services
- Changes in performance measures or the quality system

The Commonwealth's regulation promulgation process also requires a stakeholder engagement process including the opportunity for external stakeholders to submit comments. If KAR is revised to reflect changes made in the 1915(c) waiver application, the Cabinet is required to facilitate a 30-day public comment period and host a public hearing as described in Kentucky Revised Statutes (KRS) Chapter 13A.[105] As part of this stakeholder engagement process, the Cabinet should consider relying on the MAC and TAC and/or convene an advisory panel of external stakeholders as Navigant suggests for other recommendations.

Recommendation 2 – Move to needs-based care planning with a universal assessment tool, completed by an independent entity using a uniform operational approach across waivers, with electronic capture and data management of assessment information.

Recommendation 2 is part of the *foundation* of the "Home" for Home and Community-Based Services. In the current 1915(c) waivers, multiple entities complete the functional assessments, using varying tools and processes that are unique to each waiver. Navigant recommends moving to needs-based care planning, using a universal assessment tool to be completed by an independent assessor source for all six 1915(c) waivers. The functional assessment is a core component of a sound HCBS system, and a well-designed assessment tool is foundational in supporting that participants' needs are identified and adequately addressed in their person-centered service plan. Better assessment tools and systems also improve data collection and analysis capabilities, which are foundational to future design and innovation considerations for waiver programs.

Recommendation: Move to needs-based care planning with a universal assessment tool, completed by an independent entity.

[105] The administrative entity must notify the public of a public hearing no later than five workdays prior to the date of the scheduled public hearing. Written comment period shall begin on the date the administrative regulation is filed and shall run until 11:59 p.m. on the last day of the calendar month in which the administrative regulation was published in the Administrative Register.

Recommendation Description: Navigant recommends the Cabinet implement a validated universal assessment tool that contains sub-sections to assess the unique needs of specific populations with disabilities (e.g., individuals who have ABI, individuals who have ID/DD, individuals under 18, etc.) In addition, the Cabinet should adopt a standard approach to independently assess participants, using conflict-free entities. To support the selection and implementation of a universal assessment tool, Navigant recommends appointing an advisory panel of external stakeholders to recommend which tool may be the best fit for the Commonwealth's needs.

Recommendation Rationale: Navigant recognizes the dynamic needs and circumstances of waiver participants, and further appreciates the Commonwealth's goal to allocate its limited resources according to need and risk for long-term institutionalization. Needs-based care planning would improve transparency among participants, providers, and DMS as resource allocations would be based on a standardized process to appropriately assess need across all 1915(c) waiver populations. Strengthening the waiver assessment process with or without a standardized tool would help assure that the appropriate information is captured to adequately assess functional and community-based needs, to inform service plan development and resource allocation to waiver participants.

This recommendation should help to improve the following elements of HCBS assessment practices:

- A uniform assessment tool would cut back on the differences in existing tools, such as varied timeframes for re-assessment, to standardize focus areas and address concern that having different assessment tools could lead to inequitable approaches used across disability populations. A new tool would also allow the Cabinet to introduce a more targeted tool to assess participants under 18 years old.
- Use of a single assessment entity using a uniform approach to conduct HCBS assessment would address existing disparity in practices between waivers, including how the process flows with person-centered service planning and the annual recertification processes, and address concerns about varying levels of conflict of interest among assessor types.
- Implementing electronic capture and storage assessment data would make this information accessible for population-level analysis, which is needed to inform overall HCBS program design and innovation.
- Introducing a method to "pre-screen" waiver applicants placed on the waiting list would allow the Cabinet to better understand the extent of unmet need across the Commonwealth to inform future waiver budgeting and prioritization of wait listed individuals.

A standardized tool and approach to functional assessment across waivers, coupled with aligned systems to track and store assessment data would support the ability of Kentucky's HCBS programs to identify and meet the needs of waiver participants.

Cabinet Goals Advanced by this Recommendation:

- Enhance quality of care to participants
- Implement a universal participant assessment and individualized budgeting methodology
- Curb preventable increases in total spend for HCBS programs
- Design services that address participants' community-based needs, including populations who are under-served or not served by today's waivers
- Make provider funding consistent with reasonable and necessary program costs

Expanded Rationale for Recommendation

Navigant is making this recommendation to help the Cabinet address challenges related to today's current assessment methodology. The rationale for this recommendation is described below.

- **A uniform assessment tool would address the differences in existing tools, such as varied timeframes for re-assessment, to standardize focus areas, and address concern that having different assessment tools could lead to inequitable approaches used across disability populations. A new tool would also allow the Cabinet to introduce a more targeted tool to assess participants under 18 years old.** The existing differences among current assessment tools and inability of tools to fully assess individuals under 18 years of age creates challenges for the assessment process. While Navigant recommends implementing a standardized tool that can be leveraged across disability populations, a separate tool might be needed for individuals under age 18. Stakeholders have expressed reservations about implementing a universal assessment tool, driven by concerns that differences in needs across disability types may not be addressed with a single tool. However, there are several common areas of HCBS assessment that universally apply across disability populations. Navigant suggests that incorporation of a "skip logic" could be used to customize certain assessment information to specific individuals or populations based on the responses to core assessment elements.

  Federal initiatives related to assessment tool standardization also point to the value of using a uniform assessment tool to consistently evaluate common assessment areas. Federal initiatives that promote adoption of a standardized assessment tool include the Balancing Incentive Program (BIP) and the Functional Assessment Standardized Items (FASI), per CMS' Testing Experience and Functional Assessment Tools (TEFT), as well as research from the Centers for Healthcare Strategies Inc. (CHCS) for the state of California.

Figure 6.3 Prevalent Assessment Tool Domains

Functional Assessment Tool Domains	BIP[106]	FASI[107]	CHCS[108]
Activities of Daily Living	✓	✓	✓
Instrumental Activities of Daily Living	✓	✓	✓
Medical Conditions/ Health status	✓		✓
Cognitive Function and Memory/Learning Difficulties	✓		✓
Behavior Difficulties	✓		✓
Natural (Informal Caregiver) Supports		✓	✓
Assistive Devices		✓	

Navigant anticipates use of a universal tool that assesses domains depicted above in a standardized way, offering sub-sections to assess disability- or need-specific areas would advance the Cabinet goal to *implement a sound method for universal participant assessment and resource allocation via an individualized budget methodology.* A uniform approach would help to address stakeholders' perceptions of inequitable access to services for differing disability groups that stems, in part, from differing assessment approaches and assessment tools.

A single tool would also offer a uniform source of information needed to implement individualized budgeting (should the Cabinet choose to proceed with that approach), as individualized budgeting is most successful when sound assessment information is available. Finally, implementing a universal assessment tool allows the Cabinet and external stakeholders an opportunity to critically consider what areas should be included in an assessment, providing a platform for the Cabinet to obtain population-level information related to areas that may currently be under-focused, such as caregiver stress and risk, vocational support needs, etc.

- **Use of a single assessment entity using a uniform approach to conduct HCBS assessment would address existing disparity in practices between waivers,**

[106] Mission Analytics Group. The Balancing Incentive Program: Implementation Manual. Available at: http://www.balancingincentiveprogram.org/sites/default/files/Balancing_Incentive_Program_Manual_2.0.pdf
[107] Demonstration Grant for Testing Experience and Functional Tools. TEFT FASI Alpha Test Report. January 26, 2017. Available at: https://www.medicaid.gov/medicaid/ltss/downloads/teft-program/fasi-alpha-test.pdf
[108] CHCS interviewed five states: Arizona, Minnesota, Tennessee, Texas, and Wisconsin. More information available at: http://www.cdss.ca.gov/agedblinddisabled/res/CCI/chcs-uniform_assessment_mltss-9-12-13.pdf

including how the process flows with person-centered service planning and the annual recertification processes, and address concerns about varying levels of conflict of interest among assessor types. Beyond stakeholder concerns about potential conflicts of interest among assessors, the Federal government is increasingly concerned about the potential for manipulation of assessment information that may poorly allocate resources. Kentucky has taken steps to mitigate potential conflict of interest by implementing independent case management for the SCL and HCB waivers; however, providers conduct assessments for other waivers. Cabinet leadership reports ongoing concerns that assessment information is misrepresented so that participants unduly access more services, and/or providers derive undue financial benefit.

Navigant identified several opportunities related to the operationalization of independent assessment. Navigant recommends a single entity and standard approach to independent assessment, to complement use of a uniform tool or any set of tools selected. A standardized approach using a centralized source of independent assessment should be staffed by qualified, well-trained, independent assessors. The independent assessment process should address several concerns expressed by stakeholders about how assessments are currently conducted:

- Organizational and tracking systems should be implemented to ensure timely completion of annual assessments. It is difficult to maintain up-to-date contact information to reach participants, which is required to complete timely assessments.
- Case managers seek more inclusion and independent assessors should share adequate levels of information with them. There is also no observed method for case managers to share additional information, to mitigate instances when a participant does not accurately respond to assessment questions.
- There is a need for better defined performance standards for contracted entities performing independent assessments, including required cycle times and response times for event-based re-assessments. Event-based re-assessments are common among HCBS populations but are not well-resourced or managed in the current approach.
- Standardized training approaches are needed, likely on an annual basis, so assessors are well-versed in best practices for HCBS assessment. Additionally, there is a need for criteria across all waivers to promote inter-rater reliability across assessors, to promote equitable and objective approaches to needs assessment.

Accurately and comprehensively assessing the needs of HCBS waiver participants using methods to avoid potential conflict of interest and reflect operational best practices would result in accurate understanding of participant need, leading to more confidence that the level of services and supports allocated to participants is appropriate. Independent assessment, when well executed, can help to minimize the waste and potential fraud that occurs when assessment information is manipulated and can improve the participant experience by introducing an efficient and effective assessment process that

accurately captures participant need. Therefore, Navigant anticipates this recommendation will support the Cabinet goal to *curb preventable increases in total spend for HCBS programs*.

- **Implementing electronic capture and storage assessment data would make this information accessible for population-level analysis, which is needed to inform overall HCBS program design and innovation.** According to Navigant's assessment, one common feature among HCBS assessment practices across waivers is that completed assessment tools are uploaded to MWMA using a scan of the original form. This has limited Navigant's ability to conduct quantitative analysis of participant demographics, functional needs, and other drivers of HCBS utilization. Navigant recommends that the Cabinet identify data solutions that provide efficient, accessible ways to store assessment data that can then be aggregated and analyzed at a population level. While certain information is available via the Medicaid Management Information System (MMIS), existing functional assessment information cannot be efficiently analyzed. The information captured via assessment is critical to understand the broad needs, utilization trends, and needed program modifications that would be considered in Navigant's Phase II of 1915(c) waiver assessment.
- **Introducing a method to "pre-screen" waiver applicants placed on the waiting list would allow the Cabinet to better understand the extent of unmet need across the Commonwealth to inform future waiver budgeting and prioritization of wait listed individuals.** Throughout Navigant's yearlong assessment, Cabinet leadership and stakeholders frequently raised the issue of waiting lists, particularly for the SCL and Michelle P. waivers, as an area of concern. Navigant observed that one of the most significant challenges is the lack of 1915(c) waiver eligibility information available for individuals on the Michelle P. waiver waiting list. While the SCL waiver has prioritization categories for which interested individuals are pre-screened to identify if there are emergency-based needs for waiver entry, there is no pre-screening performed for individuals who request to be added to the Michelle P. waiver waiting list. Implementing a pre-screening method would help to address several issues, including:
    - It is difficult to identify individuals most at-risk for institutional placement, or who have urgent needs that could influence prioritization of access to services.
    - Participants on the waiting list may wait multiple years anticipating a Michelle P. waiver slot, only to learn that the individual was never eligible and should have been identifying alternative resources.
    - There are administrative inefficiencies when the Cabinet attempts to pull individuals from the waiting list and initiate services. The Cabinet estimates that only 1 in 5 participants contacted from the waiting list are ultimately eligible, resulting in a loss of time and resources devoted to making contact and, at times, assessing individuals who are not eligible. This also slows the Cabinet's ability to make timely contact and initiate services for individuals who are eligible, which is especially problematic when attempting to address individuals with urgent or emergent needs.

- The Cabinet currently struggles to fully understand existing unmet need, which could inform targeting of future budget requests for additional slots.

Navigant recommends the Cabinet employ waiting list pre-screening practices to efficiently capture potential waiting list candidates' risk factors for institutionalization, community-based crisis, and other considerations – in other words, managing the waiting list based on identified needs or risk, instead of the current "first come, first served" approach. An approach that screens prospective participants for risk of institutional LTSS and/or community-based risks would help the Cabinet to better triage participants who have urgent needs and provide needed information to better inform future budget allocations and slot counts for 1915(c) waivers. During Navigant's assessment, the Cabinet attempted a project to implement a pre-screening solution for the existing Michelle P. waiver waiting list and was advised that Michelle P.-related KAR do not allow assessment of waiting list candidates. Thus, KAR restrictions would need to be examined and adjusted to allow for updating the Commonwealth's approach to waiting list pre-screening and management for the Michelle P. waiver.

Related National Trends and Best Practices

Implementation of a universal assessment tool promotes consistency in holistically assessing the needs of all individuals served within a program. Recognizing the inefficiency of having multiple assessments (e.g., increased administrative burden, limited ability to make comparisons across waivers, additional training needs, etc.), many states are moving to standardized assessment tools, used across multiple populations and programs.[109] Standardized assessments serve a variety of purposes including:[110]

- Establish individualized, person-centered assessments which help inform care planning.
- Offer information to providers for the delivery of services and supports, allowing them to compare the acuity of the populations they serve and their required supports.
- Provide data for planning and resource allocation at the local and state level.
- Produce reports from the system that can assist state agencies and legislators understand the needs of the populations served and how their needs vary across programs.
- Develop the data and reports that are necessary to comply with federal quality assurance requirements.

CMS has conducted two recent initiatives to explore uniform HCBS tools and practices:

- **Testing Experience and Functional Tools (TEFT) program[111] -** CMS implemented the TEFT to test the effectiveness of specific questions used to conduct needs

[109] CE Reed and Associates. Analysis of State Approaches to Implementing Standardized Assessments. April 2012.
[110] CE Reed and Associates. Analysis of State Approaches to Implementing Standardized Assessments. April 2012.
[111] United States Government Accountability Office. CMS Should Take Additional Steps to Improve Assessments of Individuals' Needs for Home- and Community-Based Services. December 2017. Available at: https://www.gao.gov/assets/690/689053.pdf

assessments. The questions in the TEFT assessment are used across multiple HCBS populations including:

- Advanced age
- Intellectual or developmental disabilities
- Physical disabilities
- Serious mental illnesses
- Traumatic brain injuries

Six states (including Kentucky) received grants to test the assessment questions for validity and reliability. CMS plans to distribute the questions that were proven to be valid and reliable to all states in 2018, demonstrating CMS' commitment to the development of assessment tools that can be used across multiple populations.

- **Balancing Incentive Program (BIP)[112] –** This program required participating states (including Kentucky) to collect information related to participants' needs, but unlike TEFT, allowed states to choose the assessment questions. Kentucky used the BIP as an opportunity to replace a long-standing instrument with the Kentucky Home Assessment Tool (K-HAT).[113] Assessment questions in BIP could differ by population but had to collect information on 26 topics that spanned five broad domains:
  - Activities of Daily Living (ADLs)
  - Instrumental Activities of Daily Living (IADLs)
  - Medicaid conditions/diagnoses
  - Cognitive functioning, memory, and learning
  - Behavior concerns (e.g., injurious, uncooperative, or destructive behavior)

  Twenty states successfully incorporated all 26 topics in their needs assessment. After the BIP initiative ended in 2015, CMS provided information and lessons learned to the public. CMS continues to facilitate state development of tools that effectively assess the needs of those served by 1915(c) waivers.

Anticipated Actions Related to this Recommendation

Should the Cabinet elect to implement this recommendation, they should plan for the following:

- Selection of a universal assessment tool, with specialized sub-sections to address

[112] United States Government Accountability Office. CMS Should Take Additional Steps to Improve Assessments of Individuals' Needs for Home- and Community-Based Services. December 2017. Available at: https://www.gao.gov/assets/690/689053.pdf
[113] Mission Analytics Group. Balancing Incentive Program – State Reflections and Recommendations. February 2016. Available at: http://www.balancingincentiveprogram.org/sites/default/files/BIP_State_Reflections_and_Recommendations_Report_FINAL_508.pdf

population or service specific components, that consistently and adequately collects functional information and supports improved service planning. Tool selection should include input from stakeholder advisory panels.

- Development of business specifications including defined performance standards to guide vendor or home-grown development of an independent assessment tool.
- Development of an implementation plan including user acceptance testing and training for new assessors.
- Development of ongoing monitoring protocols for assessing inter-rater reliability both when first deploying an independent assessment entity and then monitoring the entity for quality improvement purposes.
- Stakeholder training and agreements between the selected independent assessment vendor and case management entities would likely be needed to facilitate timely information sharing with case managers, who need to understand the assessment process and outcomes to support development of the participant's person-centered plan.
- Technology solutions and procedures for assessment data collection, storage, and transmission would be necessary to optimize use of standardized assessment data for broad, population-level waiver analysis and to inform Cabinet program management.

Over time, with sound technology solutions and data management, the Cabinet would compile comprehensive data to better understand participants' functional and health related needs and other information. This data and information could inform future waiver design, performance management, and monitoring. The Cabinet would also be better able to analyze data across multiple waivers, which would improve leadership's ability to understand where leadership should allocate resources and make program adjustments to better serve under-served populations and respond to changes in participant needs.

As part of this process, the Cabinet must also consider:

Assessment Tool Source – When implementing a standardized tool, the Cabinet can decide among several different approaches, including:

- Using a tool developed by another state or by a vendor, *without* modification
- Using a tool developed by another state or by a vendor, *with* modification
- Creating a home-grown, state-developed tool

Each option has advantages and disadvantages. For example, while allowing for more freedom and flexibility in the development, creating a home-grown, state-specific tool requires a longer development and implementation period, more financial and staff resources, and additional barriers for tool validation. Given a lack of staff resources across the Cabinet, this approach could create potential delays during implementation. Modifying or maintaining a tool currently used in another state may shorten the development and implementation time for the Commonwealth and allow the Cabinet to leverage the successes and mitigate implementation

issues more readily. However, using a tool developed by another state or vendor may require significant "new" funding and may require additional changes to account for unique features within the Commonwealth. For each option, the Cabinet would need to carefully weigh implementation costs and time as well as availability of staff resources.

Implementation Time and Costs – The Cabinet would need to determine their overall budget and timeframe for the universal assessment tool implementation. Total cost to design, modify, program, and implement a new universal assessment tool can be resource-demanding and costly. Research has shown that it often takes at least two years for full implementation, which could impede timely access to the type of functional assessment data that is required to properly assess waiver reconfiguration needs and approaches.[114] In addition, acquiring a license for a new assessment tool may have significant costs to the Commonwealth and require a specific platform to run properly.

Staffing for Implementation of an Assessment Tool – Qualified and sufficient assessor staffing is an important factor to consider when implementing HCBS assessment with or without a uniform tool. Regardless of the tool chosen, assessors would need to have the necessary qualifications and standardized training on the new tool to conduct assessments. To ensure assessors are trained properly, the Cabinet would need to develop a standardized approach at the time the Cabinet implements the tool as well as annual training on the tool. Lastly, the Cabinet should focus on developing adequate oversight efforts to monitor assessors and ensure inter-rater reliability among assessors.

Highlighted Cabinet Decisions to Proceed with this Recommendation

Should the Cabinet implement this recommendation, the Cabinet would need to address the following strategic or operational considerations:

- Will the Cabinet elect to use a single uniform assessment tool?
- Will a different tool be needed for participants under the age of 18?
- How would the Cabinet develop the tool (tool developed by another state, with or without modification; home-grown tool; etc.)?
- What would the timeline be for implementation?
- What is the budget for universal assessment tool development and implementation?
- Will the Cabinet opt to implement an independent assessment approach for all waivers?
- How would the Cabinet procure an independent assessment vendor who would be responsible to conduct assessments going forward? Will this vendor be identified via competitive procurement or some other contracting method?
- How would the Cabinet conduct oversight activities for the independent assessment

[114] CE Reed and Associates. *Analysis of State Approaches to Implementing Standardized Assessments.* April 2012.

vendor?

- What qualifications would be required for assessors? Will this vary across waivers?
- Where and how will assessment data be stored? How would it be shared with CMS?

Future Stakeholder Input

Stakeholder engagement is a critical phase of the assessment tool development process. It is important to understand issues that need to be addressed in the new tool. The stakeholder process should be inclusive of the populations, programs, and associated entities that would be impacted by the assessment process. If the Cabinet chooses to implement this recommendation, Navigant recommends the Cabinet consider establishing an advisory panel to advise on the key considerations outlined above, for a set duration of time. The Cabinet should inform this panel on its decisions regarding all of Navigant's recommendations, to allow for stakeholder input and avoid having a siloed approach for individual recommendations. Navigant recommends the panel have a diverse representation of provider and participant stakeholders to fully inform design and implementation. Potential panel representatives could include:

- Representatives with pediatric expertise
- Representatives with aging expertise
- Representatives with ID/DD expertise
- Representatives with ABI expertise
- Representatives with behavioral health/management expertise
- Participants from various waivers
- Case management representatives
- Direct service provider representatives from various 1915(c) waivers

Recommendation 3 – Implement a prospective, data-driven individualized budget process, using an algorithm that quantifies participant needs based on information obtained through assessment, establishing a budget the participant can use on a monthly or annual basis to obtain waiver services.

Navigant recommends implementing an individualized budgeting methodology to objectively allocate waiver resources based on an individual's needs within the cost neutrality limits agreed to by CMS. It is necessary to have a method for determining how assessed needs for participants translate into their approved level of HCBS so that the Cabinet can judiciously allocate resources based on participants' risk of institutional LTSS and their needed level of service and support. An individualized budgeting methodology will provide a deliberate approach for allocating resources to address stakeholder concerns about the current practice for care planning and service caps, especially for individuals with higher acuity.

Recommendation: Implement a data driven individualized budgeting methodology, using an algorithm that quantifies participants needs based on information obtained through assessment, establishing a budget the participant can use (e.g., on a monthly or annual basis) to obtain waiver services.

Recommendation Description: Navigant recommends the Commonwealth's individualized budgeting method be based upon algorithms that produce a budget based upon a set of characteristics known to influence service utilization (e.g., age, medical conditions, ambulatory status, ADL status, cognitive impairment, etc.). The methodology would account for these variables and factor in historical costs. Historical costs alone – while useful for maintaining budget neutrality – may be limited in reflecting current participant needs for a variety of reasons (e.g.., historical changes in policy/rates, new participants).

Rationale: The Cabinet has expressed challenges in allocating resources to participants in an objective, individualized way, and has implemented a series of service caps and limits that stakeholders report can pose a barrier to participants with higher acuity of level of care. Internal and external stakeholders have concerns that existing challenges inhibit the ability of programs to effectively drive resources in a way that truly addresses community-based needs and offers a meaningful alternative to institutional LTSS.

This recommendation should help to improve the following elements of HCBS service allocation practices:

- A standardized methodology will introduce a more objective approach that can be easily understood and more broadly applied across waiver populations, helping to mitigate concerns about "haves" and "have nots" across waiver populations.
- An updated approach with less service-specific caps and limits could allow participants more flexibility in how they use their budget and individualize their service plan.
- Updating the service allocation approach would allow the Cabinet to optimize their method of service plan approval, which currently relies on an external vendor to conduct a utilization review of person-centered service plans based on a medical model approach, to provide prior authorization before services are initiated.
- Use of a data-driven methodology would better align the Commonwealth with CMS guidance that individualized budgets be:
  - Evidence-based: the budget should be influenced by current payment rates and support needs that can be verified via assessment
  - Consistent: determination of support needs and budget is the same or similar for all involved in the process
  - Transparent: the budgeting process and algorithm should be open to public inspection

o Regularly evaluated: using an established method and time frame of evaluation[115]
Cabinet Goals Advanced by this Recommendation: • Enhance quality of care to participants • Curb preventable increases in total spend for HCBS programs • Design services that address participants' community-based needs, including populations who are under-served or not served by today's waivers • Implement a universal participant assessment and individualized budgeting methodology

Expanded Rationale for Recommendation

Navigant is making this recommendation to help the Cabinet address current challenges related to today's methodology for managing utilization and allocating resources to participants. The rationale for this recommendation is described below.

- **A standardized methodology will introduce a more objective approach that can be easily understood and more broadly applied across waiver populations, helping to mitigate concerns about "haves" and "have nots" across waiver populations.** Today, there is a sense among stakeholders that participants on some waivers are "haves" while on other waivers are "have nots" – the belief that regardless of level or intensity of need and risk of institutionalization, a participant on the SCL or ABI/ABI-LTC waivers will more services offered to them than participants on the HCB or MPW waivers. Appendix E depicts a roster with limits and standards for service provision across waivers to demonstrate how approaches differ across waivers. Implementing a standardized approach to how service limits and caps apply across waivers, with or without individualized budgeting, can help to improve transparency among HCBS participants and other stakeholders on what is allowable within each waiver, and what limits exist so individuals understand service offerings and available resources.

  Navigant anticipates that an individualized budgeting method that uses objective data and a consistent formula to approach the varied needs across individual participants would help the Commonwealth address, in part, current challenges that could lead to inequitably serving waiver participants. Additionally, a clearly understood approach to allocating services will support the Cabinet in utilization management, including when the Cabinet must deny a service request that is outside allowable limits. Today, the Cabinet struggles with appeals when they seek to deny a request, in part because there is not a clearly understood standard or logic. Objective, individualized resource allocations would advance the Cabinet's goal to implement a *sound strategy for resource*

[115] The Council on Quality and Leadership. Individual Budgets and Fiscal Intermediaries. Available at: https://c-q-l.org/resource-library/publications/cql-publications-for-free/quality-in-practice-guides/individual-budgets-and-fiscal-intermediaries

allocation via an individualized budget methodology.

- **An updated approach with less service-specific caps and limits could allow participants more flexibility in how they use their budget and individualize their service plan.** Current waiver service definitions are restrictive and present challenges in addressing the needs of individuals who are of higher acuity or have individualized needs or circumstances. Navigant recommend balancing the need to manage utilization with the goal of providing participants the ability to individualize their service plans to accommodate their personal circumstances.

  Navigant suggests that individualized budgeting offers a balance, which would allow participants the flexibly use funds to tailor their plans, avoiding "one size fits all" approaches that may be restrictive. Adjustments as simple as relaxing restrictions that may not be universally appropriate (e.g., denying participants waiver transportation when someone in their household has a vehicle) or considering total utilization over a longer term instead of managing utilization within limited periods (e.g., considering annual utilization instead of monthly utilization), could enhance the ability of participants to individualize their plan to meet their needs. This recommendation has the potential to advance the Cabinet goal of: *Designing HCBS programs that offer a menu of services* (in this case flexibility to tailor existing services) *that address participants' community-based needs, including for populations who are under-served by today's waivers.* The recommendation also advances the Cabinet goal of: *Curb preventable increases in total spend for HCBS programs*.

- **Updating the service allocation approach would allow the Cabinet to optimize their method of service plan approval, which currently relies on an external vendor to conduct a utilization review of person-centered service plans based on a medical model approach, to provide prior authorization before services are initiated.** There are concerns both among Cabinet leadership and internal and external stakeholders that the current service plan approval approach, which relies on a third-party vendor, Carewise, to conduct a medical-model oriented utilization review resulting in issuance of prior authorization, may not be the ideal method for HCBS programming. Navigant recommends considering an approach that better leverages case managers as the source of service approval within the course of developing a person-centered service plan. The Cabinet can then monitor this process to ensure that case managers effectively manage waiver resources within defined limits established by the Cabinet, while screening for any fraud, waste, or abuse concerns. The Cabinet can leverage additional authorization processes for any high-cost goods or services or impose a threshold where a service plan is subject to additional review and approval using a standardized method with objective approval criteria. For instance, a home modification over a certain cost, or significant increase or decrease in personal care hours over a certain percentage might be subject to additional review by the Cabinet.

  This recommended approach is reflective of HCBS best practice and will help address

stakeholder concerns that social determinants and non-medical elements are not considered in the current approach. Additionally, this recommendation will help to reduce the length of time it takes for HCBS to be initiated, which currently relies on the cycle time required to submit a person-centered service plan to Carewise and receive a prior authorization. This helps the Cabinet to advance their goal of *curbing preventable increases in total spend for HCBS programs* while also *enhancing quality of care to participants*.

Related National Trends and Best Practices

Individualized budgeting for HCBS services emerged in part as participant-directed service programs expanded, a trend that has advanced since the 1990s. The purpose of individualized budgeting was to move from a medical model service planning approach to one that offered participants greater autonomy to self-select and manage their service plan, acknowledging that HCBS impact a person's daily living and quality of life. Across states there is significant variability in the populations that use individualized budgets; however, the elderly and disabled are the most prevalent population.

Conceptually, individualized budgets drive an objective, mathematical assignment of "budget" via an algorithm that:

- Factors in "inputs" from a participant's assessment to establish "need."
- Includes factors that adjust for financial realities, including existing HCBS reimbursement rates and waiver budgetary realities.
- Results in a quantified allocation of dollars, distributed to the participant to use as a "budget" to purchase goods and services that support home and community-based needs and goals.

While the individualized budgeting approach has been applied largely to participant-directed services, there is certainly opportunity to consider methods to objectively allocate resources to establish budgets for traditional service delivery. The participant's case manager would work with the participant to select, obtain, and implement their service plan using person-centered methods. Participants with a similar diagnosis or disability type might vary in the acuity of their condition and/or intensity of their needs. Having a clear methodology that effectively drives resources to individuals as objectively as possible offers benefit to participants *and* the state, allowing the state greater flexibility in diverting institutional care.

Boston College's National Resource Center for Participant-directed Services, published a handbook on the development of self-directed programs and policies. In this handbook, they described six *essential elements of individualized budgeting methodology,* including:

1. Accuracy: The methodology should reflect a valid assessment and provide amounts sufficient to meet participants' needs.
2. Consistency: The methodology should be consistently applied across the program, state, and eligible population.

3. Reliability: The methodology should produce consistent results over time with repeated application.
4. Equitability: The process should ensure that participants with the same or similar needs and circumstances receive comparable budgets. Not only should participants who direct their services receive budgets comparable to those in the traditional service system (assuming comparable needs), but a rational and fair relationship between the cost of traditional services and the participant-directed budget should exist.
5. Flexibility: The process should allow changes to the budget to be made easily and in a timely fashion to accommodate changes in participants' circumstances and choices.
6. Transparency: The process should be open to public inspection.[116]

Individualized Budgeting Approaches

There are two primary methodologies for development of individualized budgets:

1. *The prospective* method
2. The *retrospective* method

In the prospective method, the benefit amount is determined prior to conducting person-centered service planning to establish the participant's HCBS service plan. Typically, the state bases a benefit amount upon an objective assessment of the participant's needs using statistical models that identify total dollar amount or the upper limit. The state's determination of the total budget then drives establishment of a service plan containing participant's needed services and supports. The prospective approach allows state agencies to control costs and project expenditures while allowing participants full control of the budgeted amount.

Minnesota is an example of a state that uses a prospective model with an established spending limit to determine individualized budgets for HCBS. The State's methodology for generating individualized budgets considers 28 characteristics/variables that have been demonstrated to most influence or predict costs. Establishing a spending limit is based on the scores for the variables, as well as historical costs. The method assumes that the set dollar amount would cover all of a participant's identified needs, but if it does not, the State conducts a re-assessment to determine changes in medical and functional needs and makes necessary changes.[117]

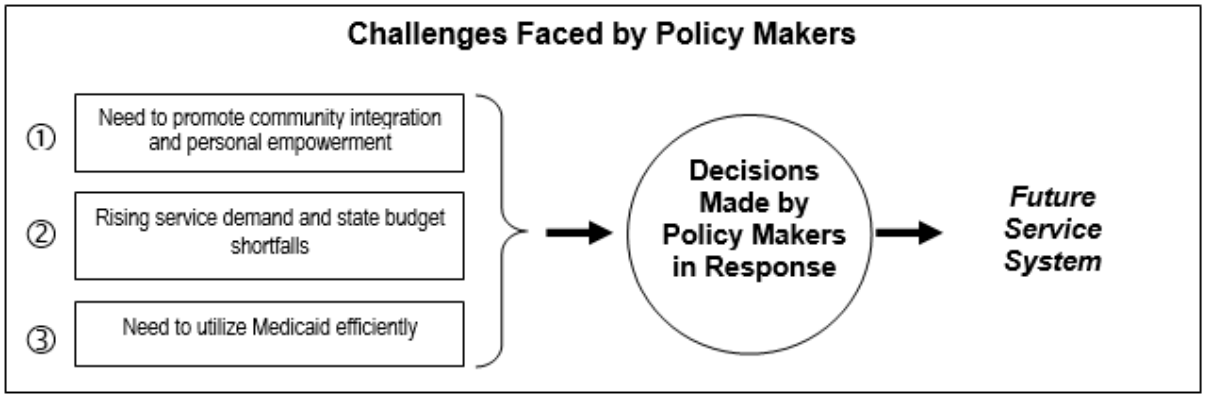
In contrast, the retrospective method is a more open-ended process where the benefit amount is determined *following* the person-centered service plan process, contrasting from the prospective method where the individual's budget is established before person-centered planning is initiated. The retrospective method is prone to subjective decisions based in part on

[116] Boston College National Resource Center for Participant-directed Services. Developing and Implementing Self-Direction Programs and Policies: A Handbook. May 4, 2010. Section 5-1.A. Available at: https://www.bc.edu/content/dam/files/schools/gssw_sites/nrcpds/cc-05.pdf
[117] Rutgers Center for State Health Policy. Participant-Centered Planning and Individual Budgeting. July 2005. Available at: http://www.cshp.rutgers.edu/Downloads/6810.pdf

personal preference and "wants" rather than using empirical data to allocate resources based on "need." In New Hampshire, individuals discuss needs and develop a map of potential services. Individuals discuss cost in relation to the service plan with consultation on creative, resourceful, economic approaches to address needs.[118]

Regardless of the type of budget setting methodology, policymakers continue to seek greater efficiency and equity, while considering what drives individualized levels of need and resulting service costs across individuals and disability populations.[119] In a 2009 report focused on the use of the Support Intensity Scale assessment tool to aid in development of individualized budgets, authors highlighted three ongoing challenges that policymakers face, indicated in Figure 6.4.

Figure 6.4 Challenges Faced by Policy Makers when Developing Individualized Budgeting Methodology



http://www.nasuad.org/hcbs/article/developing-individual-budgets-and-reimbursement-levels-using-supports-intensity-scale

Regardless of the specific nuances states apply to individualized budgets (methodology for budget calculation, population served, geography, assessments, and reviews), objective data-driven approaches to individualized budgets can provide states with an approach to individualized budgeting that is accurate, consistent, reliable, and most importantly, equitable and transparent to participants.[120] Best practice, according to the National Association of States United for Aging and Disabilities (NASUAD), dictates that states must be able to 1) objectively describe their process, 2) ensuring consistency in their methodology that is regularly reviewed and monitored, 3) provide flexibility in how funds are used, and 4) contribute to ongoing analysis

[118] Rutgers Center for State Health Policy. Participant-Centered Planning and Individual Budgeting. July 2005. Available at: http://www.cshp.rutgers.edu/Downloads/6810.pdf
[119] NASUAD. Developing Individual Budgets and Reimbursement Levels Using the Supports Intensity Scale. Available at: http://www.nasuad.org/hcbs/article/developing-individual-budgets-and-reimbursement-levels-using-supports-intensity-scale
[120] Suzanne Crisp. Developing And Implementing Self-Direction Programs And Policies: A Handbook Chapter 5: Individual Budgeting. May 4, 2010. Available at: http://www.bc.edu/content/dam/files/schools/gssw_sites/nrcpds/cc-05.pdf

of expenditures as a method to continuously improve.[121]

It is important to note that implementing an individualized budgeting methodology across all the 1915(c) waivers is very complex. While this approach has been used across populations, including for the aging, physically disabled, and those with intellectual/developmental disabilities, many states have separate methodologies per disability to reflect the differing drivers of need and utilization within distinct waiver populations. A unique methodology for each waiver also allows the state to account for the differing cost neutrality requirements that tie back to different institutional alternatives for which a population would eligible.

Navigant recommends using the following assessment information to drive quantification of need, based on criteria used in other states:

- Activities of Daily Living (ADL) needs (e.g., bathing, dressing, toileting, transferring, etc.)
- Instrumental Activities of Daily Living (IADLS) needs (e.g., house cleaning, meal preparation, shopping, medication management, etc.)
- Medical conditions or presence of skilled nursing needs
- Memory or cognitive impairments
- Behavioral challenges
- Sensory impairments

There is significant variability in how states choose to implement and manage individualized budgets. Regardless of that variability, Navigant recommends that the Cabinet incorporate the following best practices into the Commonwealth's individualized budget design:

1. ***Use of a formal and consistent assessment tool***, as indicated earlier, to implement an objective and empirically driven approach to budget setting. This element is important to encourage positive stakeholder perception of equity and confidence in the process and resulting budget.[7] In a survey conducted by the National Association of State Directors of Developmental Disabilities Services (NASDDDS), 66 percent of respondents indicated that they did not consider their approach to individualized budget setting to be based upon empirical data.[122]

    a. Use of a formal assessment tool in combination with the individualized budget improves data integrity and the ability to make sound decisions based upon variables that have strong correlation to financial impacts. This approach creates data sets that tell an informed story, which can lead to greater improvements in quality and efficiency. It is highly recommended that the Commonwealth consider

National Association of State Directors of Developmental Disabilities Services. Having It Your Way: Understanding State Individual Budgeting Strategies. Available at: http://www.nasuad.org/sites/nasuad/files/hcbs/files/41/2043/IBExecutiveSummary.pdf

[122] National Association of State Directors of Developmental Disabilities Services. Having It Your Way: Understanding State Individual Budgeting Strategies. Available at: http://www.nasuad.org/sites/nasuad/files/hcbs/files/41/2043/IBExecutiveSummary.pdf

empirical data and standardized needs-based assessments in their approach to individualized budgets.

2. Recommendations from the NASDDDS survey also promote ***development of efficient processes to authorize and monitor needs***. One example they cited was for the state to allow certain assessment and resulting budget revisions by phone, and to define general categories of covered services and supports. It is difficult to predict all nuances associated with specific service aspects. For this reason, services should be grouped into like categories to promote flexibility and efficiency in processing.

    a. Additionally, approvals that require numerous steps and reliance upon a removed, central authority can create unnecessary "red tape" that slows participant's access to needed services.

3. ***Development of software to monitor and manage individualized budgets.*** Some states have used off the shelf products while others with greater data mining capabilities have built sophisticated approaches that include web-based tracking.

In Kentucky, the development of an individualized budget methodology is also dependent on the development of a sound rate methodology, as described in Recommendation 4.

Anticipated Actions Related to this Recommendation

Should the Cabinet elect to implement this recommendation, the Cabinet must conduct the following high-level steps:

- The Cabinet would need to conduct data analysis to understand the drivers of utilization, how those drivers can be quantified based on assessment information, and then develop an algorithm that adequately quantifies a participant's "budget" based on assessed needs and estimated costs to meet those needs.
- The Cabinet would need to conduct a significant amount of modeling to analyze programmatic costs and adjust the algorithm to assure that an individualized budgeting approach allowed the Cabinet to meet cost neutrality requirements of the 1915(c) waivers.
- The Cabinet would need to design and implement systems to automate assessment information input and budget development.
- The Cabinet would need to conduct extensive stakeholder education, including to participants, their caregivers and other supports, providers, case managers, Cabinet staff, and other Cabinet departments such as the Ombudsman and Office of Administrative Hearings. This is necessary so that all parties understand individualized budgeting principles, the methodology, and how this shift fundamentally changes how service plans are developed and utilization is managed.
- The Cabinet would need to develop effective communication strategies to help external stakeholders understand changes in service caps and restrictions and educate stakeholders on what goods and services are allowable, at what level, and what

happens when a participant exhausts his or her budget prematurely.

Highlighted Cabinet Decisions to Proceed with this Recommendation

Should the Cabinet implement this recommendation, the Cabinet would need to address the following strategic or operational considerations:

- Will the Cabinet elect to implement an individualized budgeting approach?
- If so, would the Cabinet target one or multiple disability populations for initial roll-out?
- Will the Cabinet implement a standardized, universal assessment tool, which is needed to support this recommendation?
- Will the Cabinet elect to undergo a rate methodology study, which is needed to support this recommendation?
- What data tools and resources are available to develop the needed infrastructure to collect and use data to develop individualized budgets?
- Will the approach be applicable to both traditional and participant-directed service budgeting? Or would individualized budgeting be used only for developing participant-directed service budgets?
- Will an individualized budget be limited from month to month, or monitored over an annual term?
- How would service limits and funding caps be set for goods and services, including those goods and services that would be excluded for purchase using the budget?

Future Stakeholder Input

As further described in Recommendation 9, Navigant recommends that the Cabinet consider establishing an advisory panel to receive input from a diverse group of external stakeholders for a set duration of time for the individualized budgeting methodology development process. This advisory panel would not solely focus on this recommendation but would consider implementation of other recommendations. Use of an advisory panel(s) aligns with Navigant's recommended approach for most recommendations that would directly impact participants and their service planning process. Proceeding with this recommendation would require significant updates to waiver language, thus would likely require a 30-day public comment period, and corresponding updates to state regulation, which entails a further public comment and legislative process. There also may be opportunities for the Cabinet to facilitate educational sessions on individualized budgeting and the impacts it would have on various stakeholders.

Additionally, proceeding with this recommendation will require significant levels of education with both internal and external stakeholders. Making changes to standards and limits across HCBS will require training and education of Cabinet staff involved in monitoring, case managers, HCBS providers, and waiver participants and their representatives. Navigant advises that a blend of educational formats and "leave behind" materials that participants can use as a

reference will help to maximize positive impact while changing the existing HCBS allocation approach.

Recommendation 4 – Develop a sound rate-setting methodology, informed by a study of the reasonable and necessary costs incurred by providers to serve waiver participants.

Recommendation 4 allows the Commonwealth to develop what Navigant considers to be part of the *foundation* of the "Home" for Home and Community-Based Services – a sound payment and rate-setting methodology for how providers are reimbursed for the services they deliver. Navigant recommends that the Commonwealth conduct a comprehensive rate study, encompassing a provider cost and wage study, provider engagement, data analysis, and financial modeling to establish a payment methodology for CMS review. Such a study would allow the Commonwealth to lay the necessary groundwork for making future rate adjustments as needed. The study would also allow the Commonwealth the opportunity to review rates across all HCBS waivers, rather than solely examining and/or modifying rates for one HCBS waiver without understanding systemwide needs and impacts when adjusting rates.

Recommendation: Develop a sound rate-setting methodology, informed by a study of the reasonable and necessary costs incurred by providers to serve waiver participants.
Recommendation Description: Navigant recommends the Cabinet conduct a comprehensive rate study for all HCBS waiver services. The study would focus on developing rates that are consistent with the efficiency, accessibility, and quality of care standards federally required by U.S.C. Section 1396a (a)(30)(A) and updating payment practices to align with the reasonable and necessary costs to provide HCBS services. The study should include a provider cost and wage survey, opportunities for further provider engagement, provider and program data analysis, and financial modeling to establish a rate-setting methodology for CMS review. This study would need to consider the funding of any newly developed rates, including state budget constraints.
Recommendation Rationale: As detailed in Chapter 6: *Assessment Findings*, DMS reports that existing rates have been developed separately for each waiver over time and the Cabinet has not conducted a thorough review of the rate methodology for HCBS waiver services. Providers have indicated frustration with lagging rates, a disparity in rates for similar services across waivers, and a lack of clarity regarding the basis for rates. Rates that are more consistent between waiver services and programs may encourage providers to participate in more waiver programs than they do today. The Cabinet would incorporate the rate methodology into state regulation to ensure that the agreed upon method is documented transparently and adhered to in future rate adjustments. This recommendation reflects the need for the following, consistent with Navigant's formal assessment of the HCBS system: • Develop a rate-setting methodology across waiver programs to reflect HCBS service delivery requirements and differences in acuity across waiver participants to offer more targeted reimbursement, where appropriate

- Develop a transparent payment and rate-setting methodology that is easily communicated and understood by CMS, the Cabinet, providers, and other stakeholders to meet federal requirements
- Consider how consistency in payments can be achieved across services and waiver programs, which will support provider network development efforts and encourage providers to serve more waivers
- Assess how rates reflect the resources required by providers to meet the existing volume of administrative and documentation requirements and to more appropriately consider these costs when building the agreed upon rate structure
- Better understand provider challenges in competing for direct care staff in other industries to allow the Cabinet to promote continuity of care and enhanced quality of care

Cabinet Goals Advanced by this Recommendation:

- Enhance quality of care to participants
- Diversify and grow the provider network
- Make provider funding consistent with reasonable and necessary HCBS program costs

Expanded Rationale for Recommendation

Navigant is making this recommendation to help the Cabinet address challenges related to today's current rate methodology. The rationale for this recommendation is described below.

- **Develop a rate-setting methodology across waiver programs that reflects HCBS service delivery requirements and differences in acuity across waiver participants to offer more targeted reimbursement, where appropriate.** DMS has historically not conducted rate studies for the six HCBS waivers. Navigant reviewed stakeholder input from participants, natural supports, caregivers, case managers, advocacy organizations, and providers, many of which requested the Commonwealth to review the existing rates and methodology to assess if rates are consistent across services and waiver programs and appropriately account for acuity differences. In addition, stakeholders requested a review to determine sufficiency to cover administrative costs, and ways to incent provider participation and support quality of care. Stakeholders have also identified a need for the Commonwealth to consider acuity-based payments to accommodate appropriate reimbursement for higher demand and more complex-care

> *Per Section 1902(a)(30)(A) of the Social Security Act, a State Plan for Medical Assistance must "…assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."*

cases. Establishing a sound rate-setting methodology across waiver programs would advance the Cabinet's goal to *make provider funding consistent with reasonable and necessary HCBS program costs.*

- **Develop a transparent payment and rate-setting methodology that is easily communicated and understood by CMS, the Cabinet, providers, and other stakeholders to meet federal requirements.** Providers have reported difficulty and frustration in understanding the historical basis for current rates. Additionally, CMS requires that states adequately and transparently communicate their rate setting methodology as part of their 1915(c) waiver application or renewal. A rate study would allow the Commonwealth to *clearly document and explain the payment and rate-setting methodology for HCBS services to providers and other stakeholders and meet federal requirements.*
- **Consider how the Cabinet can achieve consistency in payments across services and waiver programs, which will support provider network development efforts and encourage providers to serve more waivers.** Today, there is variance in payment rates from waiver to waiver for common services (i.e., respite, personal care, case management and other HCBS types) that stems from the development of waiver programs at different times and for different populations. This variance, along with uneven historical rate increases and decreases has the potential to create inconsistent provider participation in waiver programs. Stakeholders have provided feedback that current rate levels contribute to the Commonwealth's difficulty in recruiting providers and provider shortages for multiple HCBS, and potentially delays in service delivery and a lack of incentives for high quality care. A payment and rate-setting methodology that can help address these provider supply issues would help to advance the Cabinet's goal to *diversify and grow the provider network.*
- **Examine how rates reflect the resources required by providers to meet the existing volume of administrative and documentation requirements and to more appropriately consider these costs when building the agreed upon rate structure.** Many HCBS providers throughout the Commonwealth expressed concerns about increasing volumes of administrative and documentation requirements that are burdensome, duplicative, non-billable, and unreimbursed (e.g., hours spent on the phone to navigate MWMA or Carewise prior authorization troubleshooting). Providers reported that the time required for these administrative tasks reduces their availability to spend on value-add and outcome-driven activities to improve care for HCBS waiver participants. Navigant recommends that the rate study include consideration of the costs of these required administrative activities. This outcome would also advance Cabinet's goal to *make provider funding consistent with reasonable and necessary HCBS program costs.*
- **Better understand provider challenges in competing for direct care staff in other industries to allow the Cabinet to promote continuity of care and enhanced quality**

of care. HCBS providers often seek cost-effective methods to recruit and retain workers; however, these providers are uniquely challenged in that they compete for labor with other industries that employ high volumes of unskilled labor. Stakeholders provided feedback that staff often leave for other competitively paying jobs in the fast food and retail industries. These service industries typically offer viable alternatives for employment that require less skill and training for higher wages. Many providers bear the cost of frequent turnover and under-staffing, which negatively impacts service delivery. Addressing staff payment concerns is critical to advance the Cabinet's goal of *enhancing quality of care to participants.*

Related National Trends and Best Practices

Reimbursement for delivering HCBS occurs through either managed care or fee-for-service (FFS) payment arrangements. Managed care arrangements include a fixed amount of money per-member, per-month (PMPM) paid to a care provider for covered services, whereas FFS payment arrangements reimburse providers for each separate service they provide. Provider reimbursement for the 1915(c) waivers in Kentucky uses the FFS arrangement.

States have two primary methodologies to consider for rate-setting:

- **Prospective Rate Methodology:** Method of reimbursement in which payment is based on a predetermined, fixed amount; or
- **Retrospective Rate Methodology:** Method of reimbursement in which payment is based on interim rates, then reconciled later to reimburse providers based on actual costs.

CMS outlines common prospective and retrospective HCBS rate setting methodologies in a FFS payment system, summarized in Figure 6.5.

Figure 6.5 Common FFS HCBS Rate-Setting Methodologies [123,124]

FFS Payment Methodologies	Description	Rate-Setting Example
Fee Schedule (Prospective)	Provider receives a fixed, pre-determined rate for a single service for a designated unit of time.	Personal care services offered in certain adult waivers may have a FFS rate of $3.47 per 15- minute increments. For four hours of personal care service provided per day, the provider would bill 16 units at a rate of $3.47 and receive a total of $55.52.

[123] Note: In addition to the prospective and retrospective rate methodologies listed in Figure 6.7, CMS may approve other methods including milestone-based payments and outcome-based payments.
[124] Centers for Medicare and Medicaid Services. Rate Methodology in a FFS HCBS Structure. February 2016. Available at: https://www.medicaid.gov/medicaid/hcbs/downloads/rate-setting-methodology.pdf

FFS Payment Methodologies	Description	Rate-Setting Example
Negotiated Market Price (Prospective)	Provider receives the market price of the service, with an expectation that some negotiation would take place to reach an agreed upon market price.	If an individual required a bathroom modification, the provider would bill 1 unit for the modification at the negotiated market price.
Tiered Rates (Prospective)	Provider receives payment for *one* service in which the rate varies by an identified characteristic of the individual, the provider, or some combination of both.	Daily rates for services provided at residential care facilities range between five service levels (e.g., $50 day for service level 1 through $200 per day for service level 5).
Bundled Rates (Prospective)	Provider receives a fixed, pre-determined rate for a pre-determined amount of time that includes the delivery of *multiple* services.	Reimbursement for a Supported Living Program offered in an HCBS waiver uses a bundled rate for Independent Living Skills Training (ILST), Personal Care, Homemaker, and other services.
Cost Reconciliation (Retrospective)	Provider receives payment after filling cost reports or cost surveys created by the state. Involves interim rates set by the state using the claims history information.	The state compares costs incurred by the provider per cost report and reconciles against the interim rate. (e.g., a provider is reimbursed using an interim rate of $200, but incurs $250 of cost; therefore, is reconciled to $250 at the end of the pay period).

States maintain the flexibility to determine which FFS payment methodology (or methodologies) to employ, and CMS encourages states to think broadly about the provision of HCBS and their role in broader payment reform initiatives to determine if rates are sufficient. In terms of choosing between the various rate methodologies – fee schedule, tiered, bundled, negotiated rates – Navigant recommends looking carefully at the goals of the state, participant needs, and the state's HCBS service delivery system to determine the best approach. In Navigant's experience, for example, states often look to tiered rates for residential care and adult day based on acuity to better reflect and support variances in participant needs.

Regardless of the payment and rate methodology Kentucky chooses, to arrive at sound rates that meet all federal requirements, the Commonwealth should carefully consider key inputs and variables into the buildup of the methodology. CMS highlights two requirements for states to

consider when establishing their rate determination methods.[125]

Payments for waiver services must be consistent with:

1. *1902(a)30(A) of the Social Security Act: "Payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area"*
2. *42 CFR 447.200 – 205: "Plan must describe the policy and the methods used in setting payment rates for each type of service …"*

Of the various rate methodologies acceptable to CMS, Navigant recommends using one or more of the prospective methodologies. Regardless of the methodology selected, Navigant recommends using an independent model approach to build rates, using a buildup approach that includes specific rate components and assumptions for each service to calculate a prospective reimbursement rate. This type of independent rate buildup model can be tailored to meet the specific needs of the Commonwealth and its 1915(c) waiver programs. CMS has presented the independent rate model approach as one of the leading practices for state consideration.[126] This approach brings uniformity and transparency to reimbursement rates, as states can identify each rate component as a building block which individually impacts the overall rate determination. This approach allows for easier future modifications to rates, as each variable is clear, transparent, and adjustable. Figure 6.6 summarizes common inputs for the independent model approach.

[125] Centers for Medicare and Medicaid Services. Rate Methodology in a FFS HCBS Structure. February 2016. https://www.medicaid.gov/medicaid/hcbs/downloads/rate-setting-methodology.pdf
[126] Centers for Medicare and Medicaid Services. Rate Methodology in a FFS HCBS Structure. February 2016. https://www.medicaid.gov/medicaid/hcbs/downloads/training/rate-sufficiency.pdf

Figure 6.6 Common Inputs States Use for the HCBS Independent Model

1. ***Wage rates*** for direct service employees and supervisors, by type of employee (e.g., direct care, personal care aids, vocational trainers, job coaches, etc.)
2. ***Hours incurred per unit of service***, including additional hours necessary to cover time when direct service workers are not available to provide services (e.g., while in training, traveling between client locations, on vacation, paid holidays, etc.)
3. ***Supervisor span of control,*** or the average number of direct service staff that can be supervised by each shift supervisor
4. ***Employee benefits factor***, based on the percentage calculated by dividing total provider employee benefits expenses by total provider salaries and wages
5. ***Non-direct allocation rate components***, calculated for administration, non-program contracted services, and program support components, by dividing the cost of each component by total direct service employee and supervisor salaries and wages, including benefits
6. ***Multiple participant factor***, which is intended to adjust certain model generated rates to take into consideration that the provider is serving more than one consumer at a time (note: case management would assume a 1:1 client to case manager ratio, so Navigant does not expect to apply this factor)
7. ***Productivity factor***, which accounts for non-billable activities, such as time spent conducting screenings, transporting individuals, recordkeeping, program development, and employer time

States choosing an independent model approach often conduct a comprehensive payment methodology and reimbursement rate study to support rate development, and typically conduct a provider cost survey to collect financial information from providers. Navigant recommends Kentucky follow this approach and include the statewide engagement of providers through a survey to collect cost and wage information across service types. Navigant anticipates that the survey would allow the Commonwealth to obtain required financial data timely, without overburdening the provider community. To notify the Commonwealth's HCBS providers of the pending decision to issue the survey and conduct a payment and rate methodology study, the Cabinet released a memorandum in May 2018. Navigant has included a copy of the memorandum as Appendix F.

While Kentucky HCBS waiver provider cost and wage survey data would be a key part of rate development, there are also other data sources important for benchmarking / identifying rate component assumptions. These data sources include Bureau of Labor Statistics (BLS) wage and benefit data, health insurance benefit cost data from Agency for Healthcare Research and Quality (AHRQ)'s Medicaid Expenditure Panel (MEPS) data, inflation factors, and state-specific data on similar provider costs and wages. BLS data, for example, provides state-specific annual

wage data to benchmark against wage data collected via the provider survey, or to use as a proxy when provider wage data are not sufficient.

Select stakeholders also requested that the Cabinet consider incorporating Value Based Payment (VBP) methods into its payment design for HCBS providers to incentivize higher quality care and improve health outcomes. In January 2015, CMS set the Medicare quality and alternative payment model goals for 2018 to have 50 percent of FFS payments linked to alternative payment models and 90 percent of FFS payments linked to quality.

VBP methods have become widely used for hospital and physician services but are still relatively new to HCBS. To support broader adoption of VBP within HCBS, CMS launched the Medicaid Innovation Accelerator Program (IAP) for Value-Based Payment in 2017. Kentucky was one of ten states selected by CMS for this initiative; the Commonwealth's goals for program participation include:

- To learn more about VBP and ways to incentivize quality for HCBS
- To align financial incentives in VBP with overall state policy objectives for HCBS
- To create a clear vision and approach that can be effectively communicated to stakeholders
- To develop strategies to expand successful VBP for HCBS initiatives to new populations, programs, or providers

Participation in the IAP-VBP program better positions the Cabinet to be a well-informed purchaser of HCBS waiver services, with increased access to information about leading innovation and best practices developed and adopted by other states.

Anticipated Actions Related this Recommendation

Should the Cabinet elect to implement this recommendation, they would conduct a payment methodology and rate setting study to develop policies and methods used in establishing payment rates for all HCBS waiver services, as required in *42 CFR 447.200 – 205* and by Section 1902(a)30(A) of the Social Security Act. The results of the study should meet the following objectives:

Figure 6.7 Proposed Objectives of the Rate Setting Process

Consistent with other recommendations, Navigant recommends the Commonwealth consider establishing an advisory panel of external stakeholders to participate and advise throughout the rate study. The advisory panel membership should consist of a mix of providers, participants, caregivers, natural supports, and advocacy groups. The Commonwealth should seek the panel's input and guidance on:

- Provider survey design, analysis, and results
- Rate methodology options
- Independent model approach assumptions and input variables
- Fiscal impacts of proposed rates
- Final rate determinations

To complete the payment methodology and rate setting study, the Cabinet should consider completing the following six key tasks:

1. Conduct research on national payments and rate study methodology best practices
2. Facilitate an advisory panel that would provide feedback on the survey and key rate components
3. Collect cost and wage survey data from Kentucky HCBS waiver providers
4. Analyze provider survey data and other state and national data to identify / benchmark rate component assumptions
5. Review service definitions, utilization data, and determine fiscal impacts of rate changes
6. Develop a payment methodology, related financial modeling that includes considerations of state budget constraints, and proposed rates

Post-study, DMS would have a firm foundation and process in place for determining the amount the Commonwealth would pay for provider services, and a process by which to follow for future rate methodology updates.

Highlighted Cabinet Decisions to Proceed with this Recommendation

Should the Cabinet implement this recommendation, the Cabinet would need to address the following strategic or operational considerations:

- Will the Cabinet elect to undertake a rate methodology study?
- Will the Cabinet issue a provider survey to obtain cost and wage data from HCBS providers?
- Will the Cabinet endorse an independent model approach for the rate design?
- Will the Cabinet establish an advisory panel of stakeholders to provide input into the rate study?

Future Stakeholder Input

If the Cabinet proceeds with this recommendation, Navigant recommends the Cabinet consider establishing an advisory panel, including providers and participants, caregivers, natural supports, and advocates to obtain external stakeholder input and promote transparency for the methodology study and rate setting process. The Cabinet should seek the panel's feedback on key aspects of the study (e.g., development of the provider survey, claims analysis, fiscal impacts, etc.). See Recommendation 9 for further detail regarding the advisory panels.

In addition to considering establishing an advisory panel, Navigant recommends that the Cabinet continue to leverage the expertise and provide regular updates to the Commonwealth's MAC and TACs.

Lastly, during the 2017 Regular Session, the Kentucky House passed HCR 100, which called for a review of Supports for Community Living (SCL) reimbursement rates and the SCL provider tax.[127] The Program Review and Investigations Committee authorized a study of this topic. To meet the requirements of HCR 100, the Cabinet should continue to collaborate with the Legislative Review Committee (LRC), as required by the Legislature, to improve transparency and promote legislative support for payment methodology and rate design changes.

Recommendation 5 – Develop standard operating procedures using a standardized template across the Cabinet, to include as part of a training program for Cabinet staff responsible for administration and oversight of the 1915(c) waivers.

Recommendation 5 is considered the "living space" of the "Home" for Home and Community-Based Services, where the Cabinet conducts its day-to-day operations in administering and overseeing each of the 1915(c) waivers. Offering staff clear, specific standard operating procedures (SOPs) for monitoring and oversight tasks as part of a broader training program to facilitate the administration and oversight of the 1915(c) waivers would help the Cabinet's "living

[127] http://www.lrc.ky.gov/recorddocuments/bill/17RS/HC100/bill.pdf

space" to operate more seamlessly and consistently across operational areas.

Recommendation: Develop standard operating procedures to support waiver activities and assign all operational responsibilities pertaining to HCBS waiver oversight to the Division of Community Alternatives.

Recommendation Description: Navigant recommends for all operational responsibilities pertaining to HCBS waiver oversight, establishing SOPs to be owned, maintained, and operated by the DCA. A SOP would support staff's understanding and involvement in a process and support the Cabinet in maintaining institutional knowledge from staff in case of turnover. Each SOP would include, at a minimum:

- High-level description of the activity (e.g., 1915(c) waiver assurance monitoring, critical incident management and remediation, etc.)
- Specific action steps to complete tasks
- Associated timeframes for completion
- Responsible parties
- Links to other relevant documents (e.g., state administrative code, associated checklists, inventories or tracking tools)

For processes requiring coordination between DMS, DBHDID, and DAIL, Navigant recommends that procedures include clear delineation of responsibilities by Department and individual, to promote alignment and avoid duplication or uncoordinated tasks. Once developed, the Cabinet should leverage SOPs as part of a broad training program for Cabinet staff that would solidify and strengthen workflows across the Cabinet and assist with onboarding of new staff.

Recommendation Rationale: As indicated in Chapter 6: *Assessment Findings*, **s**everal departments within the Cabinet contribute to administering and operating HCBS waiver programs; however, over time each department has established unique approaches to some of the same administrative and oversight functions. These separate approaches often lead to stakeholder confusion and duplication of tasks. Multiple program administration processes lack defined procedures and consequently, these processes are carried out differently across Cabinet departments.

This recommendation reflects the need for the following, consistent with Navigant's formal assessment of the HCBS system:

- Establish SOPs to be owned, maintained, and operated by the Division of Community Alternatives to standardize HCBS monitoring and oversight efforts across Departments
- Enhance efficiency and customer service to stakeholders using consistent approaches that can be easily explained to participants, caregivers, and providers
- Incorporate SOPs into a training program for all staff with 1915(c) waiver administration responsibilities to increase staff adoption and accountability

Cabinet Goals Advanced by this Recommendation:

- Enhance quality of care to participants
- Establish procedures for all waiver management administration activities

Expanded Rationale for Recommendation

Navigant is making this recommendation to help the Cabinet address challenges related to today's operating procedures. The rationale for this recommendation is described below.

- **Establish SOPs to be owned, maintained, and operated by the Division of Community Alternatives to standardize HCBS monitoring and oversight efforts across Departments.** Developing and housing SOPs in a centralized business unit within DMS would allow for ease of administration and ongoing maintenance of procedures. The centralized business unit would maintain responsibility for all HCBS waiver program oversight, and thus would have responsibility to report findings to CMS to demonstrate the Commonwealth's compliance with waiver assurances and that operating procedures allow DCA to effectively oversee the waiver programs. DCA should develop a coordinated process to receive periodic input from SOP owners (e.g., annually) to assure that SOPs stay current and are in use by operational area teams as part of day-to-day waiver operations. SOPs will promote continuity of operations within DMS, and across the Cabinet for those activities that require Departmental coordination. See Recommendation 8 for more detail regarding the centralized quality management business unit.
- **Enhance efficiency and customer service to stakeholders using consistent approaches that are easy to explain to participants, caregivers, and providers.** As outlined in Chapter 6: *Assessment Findings*, Cabinet staff and external stakeholders described varying approaches to conducting waiver administration and oversight activities. The lack of operating procedures for these activities contributes to disparities and allows for misinterpretation of state regulations across the six waivers. More broadly across all administration activities, Navigant anticipates that SOPs would enhance staff efficiency and consistency to address this stakeholder concern and allow staff to readily and easily communicate with relevant external stakeholders regarding their concerns.
- **Incorporate SOPs into a training program for all staff with 1915(c) waiver administration responsibilities to increase staff adoption and accountability.** Cabinet leadership should consider incorporating newly developed SOPs into a training program to support broad adoption of enhanced oversight practices within the Cabinet. The training program should outline key roles and responsibilities, escalation processes, required SOP maintenance, and key resources available to support staff in responding to anticipated stakeholder concerns. Committing to such a training program would allow DMS to hold staff accountable for carrying out SOP steps and allow for ongoing constructive critique to processes as needed.

Implementing these recommendations would advance the Cabinet's goals to *enhance quality of care to participants* and to *establish procedures for all waiver management administration activities*.

Related National Trends and Best Practices

States are increasingly identifying need for more standardized ways of conducting operations, whether in a monitoring and oversight role or in service delivery. To meet these needs, several states have recently conducted thorough reviews of their current processes and implemented frameworks and timelines for developing and/or updating SOPs. Though not required, as a part of this process states often house approved SOPs on their State Medicaid website to improve transparency and support discussion with all stakeholders. Even if states do not elect to publicly post their SOPs, many often disseminate them internally throughout their departments to promote knowledge sharing and an understanding of roles and responsibilities within the program(s). States with well-documented, publicly available SOPs include:

- Arizona[128]
- Indiana[129]
- Tennessee[130]

Recently, CMS has increased the level of scrutiny of Medicaid agencies regarding the coordination of roles and responsibilities in program administration. In January 2017, CMS levied a corrective action plan (CAP) against the Kansas Department of Health and Environment (KDHE), the State's single state Medicaid agency. CMS declared that KDHE was out of compliance in their responsibility to administer and supervise the Medicaid State Plan, as well as supervising any State operating agencies and/or contractors that perform functions on the state Medicaid agency's behalf. CMS stated,

> *"The State has failed to establish clear roles and responsibilities for State employees who administer and operate the KanCare (Kansas Medicaid) program."*[131]

As a result, the State developed SOPs to more clearly outline specific roles, responsible parties, and associated timeframes to enhance accountability and promote transparency throughout KDHE.

To avoid similar audit findings from CMS and other federal oversight entities, and to support a more documented approach to program administration, the Cabinet should proactively develop, update, and finalize operational guidelines to demonstrate compliance to Federal statute and the Cabinet's responsibility to properly administer and supervise the Commonwealth's Medicaid

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[128] https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/400/404.pdf
[129] http://provider.indianamedicaid.com/ihcp/HoosierHealthwise/content/MCO_QA/Hoosier%20Healthwise%20and%20HIP%20MCE%20Policies%20and%20Procedures%20Manual%20MC10009.pdf
[130] https://www.tn.gov/content/dam/tn/tenncare/documents2/operationalprotocol.pdf
[131] http://www.kha-net.org/criticalissues/kancare/tools/kancareadministrativeresources/cms-letter-to-kansas-regarding-corrective-action-plan_137648.aspx

program.

Anticipated Actions Related to this Recommendation

Should the Cabinet elect to implement this recommendation, they should anticipate that development of SOPs across the Cabinet would require considerable staff time. To this end, the Cabinet must determine the extent to which they would balance staff time to develop SOPs versus staff performing day-to-day operations in the normal course of business. While the development of SOPs would increase efficiency and effectiveness in the long run, in the near-term the Cabinet must prepare to devote internal resources to meeting the Cabinet's goals for this recommendation.

Navigant recommends the Cabinet undertake four high-level tasks to complete the development of SOPs and content of a training program:

1. Quantify the number of processes requiring SOPs and determine who would be responsible for the development and maintenance of the documentation
2. Develop contents for a training curriculum to support the adoption of SOPs throughout the Cabinet for those with HCBS waiver monitoring responsibilities
3. Prioritize the review and approval of newly developed SOPs and training content
4. Determine timeline for implementation of new SOPs and training program

Outstanding Cabinet Decisions

Should the Cabinet implement this recommendation, the Cabinet would need to address the following strategic or operational considerations:

1. Which HCBS waiver-related processes would require an SOP and which staff would be involved in the SOP development process?
2. What is the best method for prioritization of SOP development, review, and approval?
3. What is the overall timeline for development of SOPs and a training program to support staff adoption of procedures?
4. How would the Cabinet share selected SOPs with external stakeholders?
5. How often would the Cabinet formally review and update SOPs and who would oversee this process?

Future Stakeholder Input

Should the Cabinet elect to implement this recommendation and identify select SOPs to share publicly, Navigant anticipates external stakeholders would have a clearer understanding of how DMS and sister agency staff complete their work in a consistent manner. As time allows in the timeline for SOP development, the Cabinet should consider receiving targeted feedback from both internal and select external stakeholder focus groups that review steps within SOPs impacting providers and/or participants, caregivers, or natural supports. If stakeholders have

questions or concerns regarding the steps or parties involved within the SOP, DMS should consider facilitating a question and answer session. To this end, the Cabinet should also consider making stakeholders aware of schedule for ongoing maintenance of SOPs, and clearly identify key contacts for stakeholders to contact in the event they have questions or concerns. The Cabinet should consider these steps as part of the ongoing stakeholder strategy outline in Recommendation 9.

Recommendation 6 – Update and enhance the case management approach for HCBS waivers, implementing updated tools, strengthened performance standards and training that better reinforces and supports case managers.

Case management is in many ways the lynchpin to support many facets of the HCBS system. Case managers are chiefly responsible to support person-centered planning, including identifying participants' personal preferences and community-based goals. Case managers also play a critical role in service coordination and monitoring, detecting abuse/neglect/exploitation of vulnerable participants, educating participants and their natural supports on Medicaid and non-Medicaid funded resources, and providing a liaison to providers and the Cabinet. A well-reinforced, best-in-class case management approach is a must for any high-functioning HCBS system.

Recommendation: Update and enhance the case management approach for HCBS waivers, implementing updated tools, strengthened performance standards and training that better reinforces and supports case managers.
Recommendation Description: Navigant recommends improving case management services offered to wraparound participants on 1915(c) waivers, by applying performance standards that drive how services are delivered. These performance standards, coupled with requirements set forth for person-centered planning defined in CMS' HCBS Settings Rule of 2014, would drive a foundational restructuring of case management support and oversight for both traditional, blended, and participant-directed case management services. Navigant recommends also delivering improved monitoring and training supports to assist all case managers so that they are adequately trained and prepared to holistically support participants with person-centered planning and address their community-based needs and goals.
Recommendation Rationale: As noted in the findings, current waiver service definitions and operational standards for case management systems across the Commonwealth lack clarity and do not consistently reference current state or federal policies resulting in ambiguity and diminishing effectiveness of case management services. To address these issues, Navigant recommends the following enhancements to the HCBS case management approach: • Better define case management services, re-define traditional and participant-directed case management services to align case management support across traditional and participant-directed service models.

- Develop a standard caseload size limit to help mitigate instances when caseloads may be too large for case managers to effectively service their caseload.
- Implement an approach to standardize the tools and templates used by case management providers to conduct person-centered planning; this will help address concerns that performance varies heavily and that person-centered planning activities are difficult for the Cabinet to efficiently monitor using a consistent approach.
- Offer comprehensive training using improved approaches to support case managers to perform required responsibilities in a manner that follows person-centered planning requirements and adheres to conflict-free case management regulations, while obtaining technical assistance from the Cabinet.
- Develop a coordination strategy to better link case management, DMS, and the Department of Community Based Services' (DCBS) child and adult protective services units to better address suspected abuse, neglect and exploitation (A/N/E) of waiver participants; this will support the Cabinet to meet CMS HCBS quality assurance requirements for resolving A/N/E.
- Develop performance standards to help unify the case management system around a core set of objectives; this will help address the current variation in perceived performance, addressing concerns that not all participants get equal support from their case management provider.

Cabinet Goals Advanced by this Recommendation:

- Enhance quality of care to participants
- Maximize consistency in definitions and requirements across waivers
- Optimize case management to support person-centered planning with participants and their representatives, monitor service delivery, and abide by conflict free case management regulations

Expanded Rationale for Recommendation

Navigant is making this recommendation to help the Cabinet address challenges related to today's case management services. The rationale for this recommendation is described below.

- **Better definition of case management services will help clarify the role of traditional and participant-directed case managers to align case management support across traditional and participant-directed service models.** The current definition of case manager (which applies to traditional services) and the current definition of support broker (which applies to participant-directed services models) need to be adjusted to better articulate the level of wrap-around and person-centered service planning support, monitoring, and issue resolution required of case managers across both models. Having a core definition of case management services applied to both traditional and participant-directed service delivery, will promote consistent levels of case management support to all waiver populations. Although individuals who choose traditional services will often require a certain degree of oversight and wrap-around, individuals who self-direct their care may also need hands-on case management support

and oversight, which the current approach may not adequately prescribe. Providing clearly articulated expectations across the person-centered service planning development, implementation, and monitoring cycle will provide clear guidance on the roles and responsibilities of case managers to guide their performance, encourage consistent case management services to all participants, and support Cabinet monitoring of this important HCBS component.

- **Developing a standard caseload size limit will help to mitigate instances when caseloads may be too large for a case manager to effectively service their caseload.** Internal and external stakeholders commented that case managers need a reasonably sized caseload to perform their responsibilities effectively. Navigant recommends that the Cabinet impose a caseload standard, establishing a framework for reasonable distribution of case managers to participants. A manageable assignment of cases to case managers is critical to drive improved performance of case management activities. This caseload standard would help to better manage resource distribution of case managers as participants identify available providers. Case weighting can also help when developing caseload size standards, recognizing that some participants require more case management supports and attention than others. A significant number of caseloads in the Commonwealth consist of 16 participants or less, which may be a sign that participants have high acuity or demand.

  A caseload standard would also help the Cabinet identify instances of case management overload and work with providers to reduce caseloads. Navigant suggests that caseloads with 50+ individuals become challenging to effectively manage when case managers conduct monitoring and make monthly contact. A caseload maximum standard will help to reinforce quality in case management delivery by promoting reasonable caseloads that allow case managers to perform their duties successfully.

- **Implement an approach to standardize the tools and templates used by case management providers to conduct person-centered planning will help address concerns that performance varies heavily and that person-centered planning activities are difficult for the Cabinet to efficiently monitor using a consistent approach.** There is wide-ranging opinion on whether the Cabinet should define tools and templates, including person-centered planning and case management documentation, or whether this should be left to case management providers to design. Cabinet staff are concerned that some provider-developed templates lack important components. Additionally, the variability in tools used across the Commonwealth makes it challenging for the Cabinet to consistently monitor case management provider performance and record keeping. Monitoring has been especially challenging considering the difficulties encountered by case management providers as they adopted the Medicaid waiver management application (MWMA).

  The Cabinet can manage the contents of case management tools and templates in two ways:

  - Developing a tool or template and requiring that case management providers use

that tool or template.

- Allowing case management providers to develop their own tools and templates, prescribing certain required elements, and potentially requiring that case managers submit their tools for review and approval. Tools can also be audited during provider site or desk reviews to ensure that case management tools and templates meet minimum standards.

Navigant anticipates that standardization would help to drive consistent, high-quality, person-centered planning and case management services across the Commonwealth. More attention to standardization would also promote the Cabinet's goal to *maximize consistency in definitions and requirements across waivers.*

- **Offer comprehensive training using improved approaches will support case managers to perform required responsibilities in a manner that follows person-centered planning requirements and adheres to conflict-free case management regulations, while obtaining technical assistance from the Cabinet.** The case management provider network changed considerably when implementing conflict-free case management. According to Navigant's assessment, many long-standing case management providers retained direct services and eliminated their case management services due to reimbursement considerations. Those entities that opted to become case management providers have received varied levels of training and are not always clear on the role and responsibilities of a traditional case manager.

  Many providers and other stakeholders believe that to optimize case management training practices, the Cabinet needs to include case management providers in training development and delivery, since they offer an understanding of the day-to-day challenges of conducting case management. Training is especially needed for case management providers who took on expanded service capacity post-conflict-free case management implementation. Navigant recommends using a train-the-trainer approach, using trainers with direct experience as case managers to implement a comprehensive training model. The Cabinet should offer this training model on a continual basis to support case managers as they navigate the requirements of person-centered planning, as established by the Cabinet and the HCBS Settings Rule of 2014 and help to offer solutions on how to mitigate conflict of interest in person-centered planning and monitoring. This training can support improved relations between case managers and the Cabinet, so that case management providers are comfortable to address any case-specific concerns directly with the Cabinet.

- **The Cabinet needs a coordination strategy to better link case management, DMS, and DCBS's child and adult protective services units to better address suspected A/N/E of waiver participants, so the Cabinet can meet CMS HCBS quality assurance requirements for resolving A/N/E**. It is critical to link 1915(c) waiver operations and service delivery to child and adult protective services housed in DCBS in order to uphold 1915(c) waiver assurances that require DMS to address critical incidents of A/N/E. Case managers are a key contributor to identification, reporting, and resolution

of suspected A/N/E, thus training and oversight of case management services should cover this topic. The Cabinet must effectively link 1915(c) administrative and oversight teams to DCBS protective services leadership to jointly address concerns from case managers, critical incident reporting, and other methods.

Navigant recommends developing memorandums of understanding or other formal inter-agency protocols to clarify coordinated approaches including:

- Receipt and assignment of A/N/E investigation, including timely notification of newly suspected incidents
- Roles and responsibilities, including limitations of DMS and protective service teams when investigating incidents and responding to founded incidents of A/N/E
- Information sharing and inter-agency communications terms and protocols, including how to handle confidential or protected health information of participants
- Defined terms for case closure, with protocols for how DMS will work with case managers to continue follow-up for victims of A/N/E who remain 1915(c) participants

An established coordination strategy with clear definitions of the roles and responsibilities of all parties who contribute to identification, reporting, investigation, and response of A/N/E will help to better protect participants by offering improved and holistic response when there is a founded incident of A/N/E. The strategy can also provide the reporting systems DMS needs to report to CMS and demonstrate adherence to health and welfare related quality assurances.

- **Define performance standards will help unify the case management system around a core set of objectives to help address the current variation in perceived performance, addressing concerns that not all participants get equal support from their case management provider.** Developing a uniform set of performance standards that reflect national and Kentucky-specific case management best practices can help mitigate stakeholder concerns about the strength of existing case management. A more uniform set of standards and performance objectives would inform a consistent approach to case management delivery and support the Cabinet in monitoring the effectiveness of case management services. Having a core set of case management performance standards would also help to inform the training and technical assistance that the Cabinet provides to case managers.

  Identifying performance measures that can also feed into the Commonwealth's HCBS quality improvement strategy would improve case management practice and improve the confidence that participants have in their case managers and the benefits of their case management services. This recommendation acknowledges that many case management providers have faced declining rates in recent years and need to make targeted investments to help advance any quality initiatives. Clear performance benchmarks that clarify the direction of systemic case management improvement will help providers focus on targeted areas for improvement and investment of training and

management resources.

Related National Trends and Best Practices

Case management services have evolved significantly within the last decade, due to several changes in how HCBS are delivered across the country. The HCBS Settings Rule of 2014 is a significant driver of this evolution; this Rule included CMS guidance on how to conduct person-centered planning to develop and monitor HCBS plans under the 1915(c) and 1915(i) waiver authorities. This CMS guidance marked a significant shift from past use of a medical model where case managers assessed participants and developed plans that may or may not have adequately incorporated participant input. Person-centered planning requirements have changed the culture to emphasize participant direction and autonomy and participant's personal preferences in service plan development and implementation. The person-centered planning requirements also drive service outcomes that reflect participants' goals for community-based living and community participation.

The growth of participant-directed service models has also influenced current case management practices. The recent proliferation in self-directed offerings across states has driven fundamental change in the role of a case manager, as participants and/or their designated representatives assume increased responsibility for self-management of their HCBS service planning and implementation. Whereas case managers were once the driver of the process, participants have assumed more responsibility, leading to the evolution of a case manager into a new role of facilitator, advisor, and consultant to a participant. In Kentucky and across other states, there are providers who leverage the same staff to deliver traditional case management while also offering case management services to individuals who self-direct. Staff are then challenged and must significantly adjust their practice styles to meet differing needs across traditional and participant-directed delivery models.

Another driver of case management implementation has been growth in more holistic care models where case managers are responsible to offer a single point of management, overseeing HCBS and managing other Medicaid-funded benefits. There are several models that have advanced holistic approaches, including Medicaid Health Homes and the proliferation of managed long-term services and supports (MLTSS) programs, in which HCBS services are included in comprehensive service packages managed by contracted entities. While models vary in their scope and federal requirements, there is a marked trend to develop case and care management models that facilitate access and coordination across a participant's total continuum of care. CMS has offered additional guidance in recent years allowing billable coordination of non-Medicaid funded services, including the provision of housing supports. This has increased the momentum toward more comprehensive coordination activities provided by case managers.

Also impacting the evolution of case management within HCBS waivers is an ever-increasing emphasis on quality measurement and improvement in all services, including case management. There is no single, universally adopted quality framework for HCBS, but in recent years there have been significant advances in measuring quality to improve outcomes. Several

of the HCBS quality frameworks included in the National Quality Forum's 2016 report: "Quality in Home and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement," measure the effectiveness and impact of case management. The National Quality Forum report included multiple domains that correlate to case management activities listed in Figure 6.8.

Figure 6.8 National Quality Forum HCBS Measurement Domains, Definitions and Example Measures Related to Case Management Practice[132]

NQF Domain	NQF Definition	Example Measures
Service Delivery and Effectiveness	"the level to which services are provided in a manner consistent with a person's needs, goals, and preferences that help the person to achieve desired outcomes."	• Percent responding yes to: Do the services you receive meet your needs and goals? (National Core Indicators for Aging and Disabilities) • Proportion of Individualized Care Plans with goals unmet. (MLTSS Measure – NY)
Person-Centered Planning and Coordination	"an approach to assessment, planning, and coordination of services and supports that is focused on the individual's goals, needs, preferences, and values. The person directs the development of the plan, which describes the life they want to live in the community. Services and supports are coordinated across providers and systems to carry out the plan and ensure fidelity with the person's expressed goals, needs, preferences, and values."	• Number and percent of waiver participants with reassessment performed and ISP/IPs updated when needs/condition changed. (MLTSS Measure – HI) • Percent of participants reporting they are the primary deciders of what is in their service plan. (MLTSS Measure – MN) • Percent responding yes to: Does your case manager help coordinate all the services you receive? (CMS Performance Outcome Measurement Project Case Management Survey)

[132] National Quality Forum. Quality in Home and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement. September, 2016. Available at: http://www.qualityforum.org/Publications/2016/09/Quality_in_Home_and_Community-Based_Services_to_Support_Community_Living__Addressing_Gaps_in_Performance_Measurement.aspx

NQF Domain	NQF Definition	Example Measures
Choice and Control	"the level to which individuals who use HCBS, on their own or with support, make life choices, choose their services and supports, and control how those services and supports are delivered."	• Percent responding yes to: Can you make changes to your budget/services if you need to? (National Core Indicators Adult Consumer Survey) • Percent of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care. (MLTSS Measure – KS) • Percent responding "true" to: I have the freedom to make my own decisions. (Participation Assessment with Recombined Tools-Enfranchisement)
Caregiver Support	"as the level of support (e.g., financial, emotional, technical) available to and received by family caregivers or natural supports of individuals who use HCBS."	• Percent responding yes to: Do you get enough information to take part in planning services for your family member? (National Core Indicators Adult Family Survey, National Core Indicators Family/Guardian Survey) • Percent responding "not at all difficult" to: How difficult is it to get affordable services in [person's] local area or community that could help you care for [person], like delivered meals, transportation, or in-home health services? (Caregiving in the United States 2015 Survey)

Anticipated Actions Related to this Recommendation

Should the Cabinet move forward with this recommendation, they should anticipate the following high-level steps:

1. The Cabinet would need to establish caseload standards to assure that case managers have an appropriately sized caseload. This would likely need to be defined in waiver-related KAR. The Cabinet would need to develop and implement monitoring procedures to regularly screen for and address instances where caseloads are excessive.
2. The Cabinet would need to select performance standards, likely under the advisement of a diverse advisory panel, including case management providers.
3. Upon selection of standards intended to support monitoring and quality improvement, the Cabinet would need to select minimum requirements for case management tools, and select a method for case management tool standardization, implementing one of the following solutions:
    a. Develop standardized tools for mandated use by case managers.
    b. Develop processes and procedures for the review and approval of all provider-developed tools and templates that support case management and person-centered planning activities.
    c. Proceed with a blend of standardized forms and tools, allowing case management providers the ability to independently develop certain tools and documents subject to Cabinet review and approval.
4. Case managers would require a robust series of targeted training to help support performance according to defined standards and using updated tools, templates, and forms for person-centered planning and case management activities. Navigant recommends using a “train the trainer” model, so that training is delivered with the support of current providers, who demonstrate willingness and capability to help train other providers in their region. This training would help support case managers to work with real-world challenges.
5. To better support case management providers, the Cabinet would need to develop policies and procedure to better define the following processes and anticipated DMS activities:
    a. Reporting suspected fraud, waste and/or abuse of Medicaid services to DMS.
    b. Reporting suspected A/N/E of all participants, with clear understanding of how case managers and waiver providers would cooperate with DCA staff during an investigation with child or adult protective services workers.
6. DMS would need to update its internal monitoring tools and practices to accurately reflect updated performance management standards and expectations.

Highlighted Cabinet Decisions to Proceed with this Recommendation

Should the Cabinet implement this recommendation, the Cabinet would need to address the following strategic or operational considerations:

- What would the maximum caseload standard be, and would this vary across waivers?
- What tools or templates would the Cabinet develop to use on a mandatory basis statewide?
- What process would the Cabinet implement to review and approve any provider-developed materials, and what would the requirements be for reviewing any tools and templates a provider changes?
- How would the Division of Community Alternatives within DMS better collaborate with DCBS to address suspected A/N/E of child and adult waiver participants? Does this collaboration merit a formal agreement?
- Who would serve on an advisory panel for developing case management standards?
- How would the Cabinet re-define support broker services to better clarify that support brokers have case management responsibilities in addition to their roles supporting participant-directed service delivery?
- What modifications would be needed to the tools and methods used to monitor case management delivery and record keeping?
- What enhanced quality and performance standards would target case management delivery, and what tools or methods would be needed to measure those standards?

Future Stakeholder Input

Like other recommendations, if the Cabinet opts to move forward with this recommendation, Navigant suggests leveraging an advisory panel to advise Cabinet leadership throughout implementation. The panel should have a diverse representation of external stakeholders well positioned to inform case management design and implementation. Potential representatives could include:

- Case management providers
- Participant delegates from multiple waivers
- Caregiver delegates
- Direct service provider delegates
- Designees from child and/or adult protective services
- A designee from Kentucky Protection and Advocacy
- A designee from the Kentucky Commonwealth Council for Developmental Disabilities

In addition, there would be ample opportunity to provide input on go-live activities via the public comment inbox, pre-established channels including the MAC and TACs and potentially through satisfaction surveys and individual comment periods (e.g., comment period prior to the release of a standardized tool).

Recommendation 7 – Streamline participant-directed service (PDS) delivery by reducing operational disparity between fiscal management agency (FMA) operations and strengthening program policies and procedures.

Recommendation 7 includes adjustments to the Commonwealth's PDS design. PDS plays an important role in Kentucky's HCBS system, promoting participants' autonomy and self-management of waiver services, while providing many participants with a way to obtain needed services in the absence of available traditional providers. Kentucky's PDS program lacks clearly defined policies, and would benefit from more participant friendly policies, with clear guidelines stakeholders can more readily understand. Additionally, Navigant recommends the Cabinet adopt clear performance objectives and requirements for FMA providers.

Recommendation: Streamline PDS delivery by reducing operational disparity between FMA operations and strengthening program policies and procedures.

Recommendation Description: Navigant recommends strengthening Kentucky's PDS program through a blend of policy clarifications. Navigant recommends the Cabinet better define several program elements, including:

- *Who is eligible to self-direct*: While all 1915(c) waiver participants should be offered the option to participate in PDS, participants should be educated and make an informed decision about whether PDS is the appropriate model for them and understand the administrative and management requirements of the model.
- *Who is eligible to be a PDS employee*: Navigant recommends the Cabinet clarify whether they would change existing PDS policy allowing parents and guardians to act as PDS employees. Additionally, the Cabinet should clarify which criminal offenses disqualify an individual from becoming a PDS employee.

Navigant also recommends strengthening Kentucky's PDS program through a blend of program design improvements, including:

- *Updating employee background check policies and implementing a PDS employee registry*: Navigant recommends the Cabinet consider ways to streamline its requirements for PDS employees to ease access to services for participants recruiting workers. Navigant also recommends developing a PDS employee registry to mitigate duplicate background checks for employees who have already submitted background checks.
- *Strengthening FMA contracts and oversight*: Navigant recommends the Cabinet develop strengthened FMA contracts with clear performance standards and minimum requirements for all FMA providers.

Recommendation Rationale: There are several ways in which the Commonwealth's current

PDS programs for 1915(c) waivers could be easier for participants to navigate, while improving the effectiveness of the model. Additionally, the Cabinet seeks strategies that will help them to better monitor this model due to its expansive use, to ensure that individuals who elect for PDS have equal opportunity to benefit from waiver-delivered HCBS and advance toward their person-centered plan goals. Navigant recommends the following updates to PDS design and operations:

- Develop a tool that educates participants about PDS requirements, and simultaneously allows the participant and his or her case manager to review these requirements and identify the necessary supports to assist with self-management of budget and employer authorities.
- Update and clarify a formal policy that considers when having a parent/legal guardian/legal representative as an employee is necessary to keep the participant in a community-based setting, while providing criteria that clarifies when the Cabinet considers it appropriate to employ a parent/legal guardian/legal representative.
- Clarify criminal background requirements for PDS workers will help to address current stakeholder confusion, with the potential to relax restrictions that inhibit individuals from identifying providers as they recruit employees.
- Revise the current rigor of health and training requirements and implementing a centralized database or registry that helps to track employee background checks and screenings, reducing waste and inefficiencies that overly tax participants.
- Introduce defined performance expectations for FMAs to promote the necessary employer and administrative supports are available to participants regardless of where they live in the Commonwealth.

Cabinet Goals Advanced by this Recommendation:

- Enhance quality of care to participants
- Maximize consistency in definitions and requirements across waivers
- Design services that address participants' community-based needs, including for populations who are under-served or not served by today's waivers

Expanded Rationale for Recommendation

Navigant is making this recommendation to help the Cabinet address challenges related to today's PDS programming. The rationale for this recommendation is described below.

- **Develop a tool that educates participants about PDS requirements, and simultaneously allows the participant and his or her case manager to review these requirements and identify the necessary supports to assist with self-management of budget and employer authorities.** Although PDS has many benefits, the model requires participants to manage employer and budget authorities, which come with a significant number of tasks and administrative responsibilities. Navigant did not identify strong systems to inform participants of these requirements. Navigant therefore recommends the Cabinet develop a training tool that depicts the requirements and

allows case managers to help participants self-assess whether they are willing and able to manage PDS requirements, either independently or with the support of a representative, caregiver, or their case manager/support broker.

Navigant anticipates that this type of solution would improve the ability of participants to make informed decisions, while allowing case managers/support brokers to better understand where additional support, training, and coaching may be needed to assist participants in developing the skills and abilities to manage these responsibilities long-term. Addressing this issue would help participants who choose PDS to be setup for success with the model and advances the Cabinet's goal to *enhance quality of care to participants*.

- **Update and clarify a formal policy that considers when having a parent/legal guardian/legal representative as an employee is necessary to keep the participant in a community-based setting, while providing criteria that clarifies when the Cabinet considers it appropriate to employ a parent/legal guardian/legal representative.** As described in Chapter 5, many parents, legal guardians and legal representatives act as PDS employees. During the assessment, the Cabinet expressed the need to better manage this trend, citing instances where community members had called to inquire about "how to be paid to provide care to their child." Cabinet staff and external stakeholders have raised concerns that while some families have leveraged this opportunity to improve their support systems and the level of care to waiver participants, others may accept PDS funds without advancing a participant's person-centered goals.

  Navigant recommends that the Cabinet clarify whether they would continue to allow parents and guardians to act as PDS employees and to address widespread public unrest about a potential change in policy. While other states do not permit parents or guardians to act as PDS employees, the Commonwealth would need to carefully consider that most, if not all these states have upheld that policy since PDS was first introduced. Cabinet leadership should carefully consider how to approach a change in policy and consider how it would impact current waiver participants who employ a parent or guardian as their PDS worker, as opposed to applying the policy to future participants.

  One solution used by other states is to develop policy that stipulates specific requirements that allow employment of a parent/legal guardian/legal representative. These requirements can span several circumstances. Examples from other states include allowable use of a parent/legal guardian/legal representative when:

  - The participant lives in a rural or remote location where they may be unable to identify alternative employees
  - The participant has a behavioral health concern that would make it difficult for a previously unknown employer to meet their care needs
  - The parent/legal guardian/legal representative has had to significantly reduce or cannot reasonably maintain paid employment due to the extent of their caregiving

responsibilities to maintain the participant in the community

This type of policy could benefit the Commonwealth by recognizing that some participants depend on their current arrangement and/or may not be able to identify alternative employees to meet their HCBS needs, while also addressing the Cabinet concern that the PDS option is occasionally misused to the employee's financial benefit and does not support progress towards participants' person-centered service plan goals.

- **Clarify criminal background requirements for PDS workers will help to address current stakeholder confusion, with the potential to relax restrictions that inhibit individuals from identifying providers as they recruit employees.** During operational reviews conducted with Cabinet staff, staff familiar with the PDS employee approval process indicated that criminal background restrictions needed to be better clarified and communicated to participants. Conversely, participants have complained that while the PDS model allows flexibility in hiring, there are many restrictions that inhibit their ability to recruit individuals they deem strong candidates. While certain criminal background elements like violent crimes, abuse of vulnerable children or adults and other felonies may present high-risk to the health, safety, and welfare of participants, there are other criminal charges that may present less risk, particularly if the employee under consideration is an unpaid caregiver or natural support to the participant. Clearly identifying specific conviction types that would disqualify an individual from being paid as a PDS employee, as well as the statute of limitations will likely improve participants' ability to recruit and retain PDS providers, which in turn supports the Cabinet's goal to *diversify and grow the provider network.*

  Direct care workers have reported needing several background checks within a year to serve multiple participants. Each background check takes time and costs money for PDS participants and/or their potential employees. During focus groups, many waiver participants indicated they struggle to manage the costs of recruiting staff and obtaining required background checks. Waiver participants also reported inefficiencies, such as requiring the same PDS employee to obtain a background check for each participant they work with within a year. Navigant recommends that the Cabinet consider implementing a PDS employee registry to support criminal background tracking, which would streamline the background check process and eliminate duplicative administrative processes, while quickly identifying workers who were confirmed as ineligible.

- **Revise the current rigor of health and training requirements and implementing a centralized database or registry that helps to track employee background checks and screenings will help reduce current inefficient and duplicative requirements that overly tax participants.** In addition to confusing and inefficient, duplicative criminal background screenings, there are also inefficient, duplicative health and training requirements to onboard new employees. These requirements differ across waivers, but in some waivers require multiple health screenings and training requirements – all of which cost money for prospective employees while extending the time to be cleared for

payment as a provider. This dynamic becomes even more challenging when considering that the current approach does not include use of a registry to identify when a recruited employee may have recently met these requirements. Navigant recommends the Cabinet revisit PDS employee health screening and training requirements to balance the need to ensure the health and welfare of participants with concerns that current standards impede employee recruitment and service obtainment. Additionally, the Cabinet requires the participant or prospective employee to pay for these screenings and trainings; Navigant recommends the Cabinet consider this when revisiting the requirements, as a participant may have to hire multiple PDS employees to staff their person-centered plan and may struggle to identify prospective employees willing to bear these costs prior to employment.

- **Introduce defined performance expectations for FMAs will promote the necessary employer and administrative supports are available to participants regardless of where they live in the Commonwealth.** Per Navigant's assessment, FMAs in the Commonwealth operate with varying levels of technological and administrative infrastructure to process documents and perform administrative responsibilities. These differences in technological and administrative capability creates a disparate level of FMA support across the Commonwealth, resulting in inequitable services and supports to PDS participants. PDS participants are currently common law employers of PDS employees. Participants report not having a clear understanding of their responsibilities as common law employers or understanding of the documentation required to participate in PDS without FMA and case manager support. Participants reported varying degrees of support provided by FMAs and case manager regarding PDS employment.

  As there are currently few standards for FMA providers, Navigant recommends formally defining the expected standards for FMA operation that reinforce participant-friendly practices that enable participant success with the PDS model. Standards should encourage use of technology and efficient execution of administrative and payroll related supports.

Related National Trends and Best Practices

In its short history and accelerated growth through the 1990s and early 2000s, there have been vulnerabilities and challenges within the PDS framework, as described in Figure 6.9.

Figure 6.9 Risks and Challenges of PDS Programs[133]

Risk	Risk Description	Strategies to Mitigate Risk
Participant Risk	• Balance risk and respect related to participants' decisions regarding their own lifestyle, health, and welfare • Mitigate harm to participants	• Offer minimal PDS eligibility criteria to allow most participants to select PDS and retain control of decision-making • Conduct PDS employee background checks to determine qualified employees • Use person-centered planning to consider participant preferences and needs, and develop back-up plans to ensure the participant's needs are met
Program Risk	• Determine the risk-sharing relationship between the participant and the agencies supporting PDS • Identify personal care services fraud schemes	• Use individualized budgets to tie the participants' PDS budget to their functional assessment and person-centered service plan, while tailoring their budget to an individual's needs, preferences, and goals
Systematic Risk	• Develop a comprehensive community infrastructure with the capacity to minimize risk and institute timely and appropriate response to emergency situations • Unnecessary or duplicative work for PDS employees and participants	• Use person-centered planning to create back-up plans that can mitigate risk in emergency situations • Develop a PDS employee database that tracks employee information and recent background checks
Administrative Risk and Liability	• Compliance with financial management, U.S. Department of Labor, and Internal Revenue Service requirements	• Offer information and assistance in support of self-direction. Arrange for a system of supports that is responsive to participants' needs and desired assistance

Navigant's recommendations encompass several nationally supported best practices listed below:

Determining Eligibility for PDS: Overall, there has been a national trend over the last three decades to expand the PDS option to more participants. Studies have shown that PDS programs (1) reduce the unmet needs of Medicaid participants who require personal care

[133] National Council on Disability. The Care for Medicaid Self-Direction: A White Paper on Research, Practice, and Policy Opportunities, May 2013. Available at: https://ncd.gov/rawmedia_repository/23720a02_e755_42f4_b366_dff166ba0c96.pdf

services; (2) result in positive health outcomes; (3) improve quality of life for participants and their caregivers; (4) may result in increased Medicaid personal care costs, which can be partially offset by savings in institutional and other long-term care costs; (5) need not cost more than traditional programs, if states carefully design and monitor their programs.[134] Due to these positive results, CMS has encouraged states to offer waiver participants the opportunity to direct some or all of their waiver services.

Parents, Spouses and Legal Guardians/Representatives as PDS Employees Policy: CMS first allowed relatives to be PDS employees in 1999. Studies have shown that the paid family caregiver model may increase flexibility and individual choice to remain at home, as well as increase the ability to meet the needs of individuals in rural areas, those with unique service delivery needs, or who have specific faith or cultural preferences.[135]

However, despite these benefits, states face several challenges when implementing and monitoring family members or other natural supports who act as PDS employees including:

1. Oversight responsibility to monitor the quality of care and to establish training, qualifications, or credentialing requirements for family caregivers.
2. Substitution of paid for unpaid help by family caregivers raises budgetary considerations for the state due to the potential for reimbursing family caregivers for services that would have been willingly provided in the absence of payment.
3. The blurred line between family caregiver and paid support presents challenges for interpreting labor laws given that family caregivers may provide care both on and off the clock.[136,137]
4. Some states limit the number of hours to encourage participants to develop a wider support system, lessen fatigue among providers, and ensure the availability of a back-up plan. [138]

Criminal Background Checks for PDS Workers: According to the 2013 National Inventory Survey on Participant Direction, 89 percent of 1915(c) waivers require background checks for paid PDS workers; however, there is no uniform protocol for screening and disqualifying

[134] Mathematica Policy Research. Case Study: Cash and Counseling Demonstration Finds Large Favorable Effects, Leading to Policy Changes. August 2007. Available at: https://www.mathematica-mpr.com/our-capabilities/case-studies/controlling-their-own-care
[135] Center for Health Care Strategies, Inc. Trends and Challenges in Publicly-Financed Care for Individuals with Intellectual and Developmental Disabilities. September 2012. Available at: http://www.chcs.org/media/IDD_Service_Delivery_Systems_082812.pdf
[136] Foster, L, SB Dale, and R Brown. How caregivers and workers fared in Cash and Counseling. 2007.
[137] Newcomer, R. J., T. Kang, and P. Doty. Allowing spouses to be paid personal care providers: spouse availability and effects on Medicaid-funded service use and expenditures. 2012.
[138] Center for Health Care Strategies, Inc. Trends and Challenges in Publicly-Financed Care for Individuals with Intellectual and Developmental Disabilities. September 2012. Available at: http://www.chcs.org/media/IDD_Service_Delivery_Systems_082812.pdf

candidates across states.[139] Background checks for PDS workers present a unique set of challenges because PDS programs are designed to offer more choice and risk-taking on the part of the participant. Under these circumstances, some states make background checks and disqualifications optional, particularly for family members.[140] According to a 2010 AARP report, six states exempt family members or other relatives from criminal background check requirements completely (i.e., Alabama, Alaska, Delaware, Florida, South Carolina and Utah).

The types of convictions that preclude employment vary considerably across states. While most states and territories list the offenses that preclude employment, some consider only felonies as a basis for disqualification, while others include certain misdemeanors. A few states disqualify only applicants with a history of offenses against dependent or vulnerable individuals or fraud-related offenses. In addition, 13 states have provisions whereby certain convictions would no longer disqualify a provider after a certain period.[141]

Overall it is challenging to predict the likelihood of committing a crime or the risk of harm to a Medicaid participant. It is also challenging to determine the rate of recidivism of individuals previously convicted of crimes.

In addition to setting clear expectations for criminal background checks, there are state examples of how to manage this information. The 2013 National Inventory Survey on Participant Direction reported that 43 percent of PDS programs make a worker registry available to participants to assist them in locating personal assistance workers. Of these worker registries, 71 percent are publicly available.[142]

Financial Management Services: The 1915(c) waiver authority forbids the direct disbursement of Medicaid funds to participants, instead requiring that Medicaid funds flow to a Financial Management Service (FMS) entity that accepts Medicaid funds and reimburses providers on the participant's behalf. There are certain core FMS supports that must be made available to participants, as stipulated by CMS. At a minimum, the FMS must provide the following:

- "Assist participants in verifying support worker citizenship status;
- Collect and process timesheets of support workers;
- Process payroll, withholding, filing, and payment of applicable federal, state, and local employment-related taxes and insurance;

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[139] National Resource Center for Participant-Directed Services. Facts and Figures: 2013 National Inventory Survey on Participant Direction, September 2014. Available at: http://www.appliedselfdirection.com/sites/default/files/NRCPDS%20Facts%20Figures%202013.pdf
[140] AARP Public Policy Institute. Safe at Home? Developing Effective Criminal Background Checks and Other Screening Policies for Home Care Workers, September 2010. Available at: https://assets.aarp.org/rgcenter/ppi/ltc/2009-12.pdf
[141] AARP Public Policy Institute. Safe at Home? Developing Effective Criminal Background Checks and Other Screening Policies for Home Care Workers, September 2010. Available at: https://assets.aarp.org/rgcenter/ppi/ltc/2009-12.pdf
[142] National Resource Center for Participant-Directed Services. Facts and Figures: 2013 National Inventory Survey on Participant Direction, September 2014. Available at: http://www.appliedselfdirection.com/sites/default/files/NRCPDS%20Facts%20Figures%202013.pdf

- Maintain a separate account for each participant's budget;
- Track and report disbursements and balances of participant funds;
- Process and pay invoices for goods and services approved in the service plan; and
- Provide participant with periodic reports of expenditures and the status of the participant – directed budget"[143]

Participants may decline these supports and elect to self-manage these tasks, but the 1915(c) waiver authority requires states make these supports available when offering participant-directed opportunities.

Anticipated Actions Related to this Recommendation

Should the Cabinet elect to accept this recommendation, they should anticipate conducting the following activities:

- Develop a participant self-assessment tool based on allowable employer and budget authorities established in the 1915(c) waiver, train case management providers on use of the tool to educate participants on PDS requirements, and identify where additional support, training, and coaching would be needed to assist participants with meeting requirements.
- Implement an evidence-based approach to identify disqualifying crimes and the statute of limitations for disqualification. This review of evidence-based approaches should consider the various 1915(c) waiver target populations and the necessity for background checks of PDS employees who are also natural supports.
- Draft and release updated policies to clarify Cabinet positions on specific PDS components.
- Consider "grandfathering" any changes in PDS policies. Additionally, the Commonwealth may implement a review or appeals process that grants PDS employee candidates the opportunity to demonstrate they are qualified despite the results of their background check or that the background check was inaccurate.
- Consider mechanisms to assist participants with up front PDS costs, such as paying for background checks for PDS employees, and providing tools, such as PDS employee databases, to prevent duplicative activities (e.g., background checks).
- Develop and implement updated FMA requirements including reviewing current FMA contracts, drafting new or revised contracts, developing FMA monitoring tools and templates, and training staff to monitor FMA activities and outcomes.
- Conduct public education on new PDS policies to support smooth implementation and

[143] United States Centers for Medicare and Medicaid Services, Application for a §1915(c) Home and Community Based Waiver: Instructions, Technical Guide and Review Criteria, January, 2015.

offer participants and other stakeholders the opportunity to ask questions.

Highlighted Cabinet Decisions to Proceed with this Recommendation

Should the Cabinet implement this recommendation, the Cabinet would need to address the following strategic or operational considerations:

- Will use of a participant self-assessment for PDS be mandated for use by case managers?
- Who is eligible to be a PDS employee, including parents and legal guardians, and what types of criminal background checks will be required?
- Will the Cabinet pursue implementing a registry for prospective PDS employees?
- What FMA requirements would be developed and how would this be monitored?

Future Stakeholder Input

Stakeholders would have the opportunity to review and provide comments through the stakeholder and public comment input process described under Recommendation 1, as part of the waiver standardization, waiver application amendment, and waiver-related KAR promulgation process.

In addition, as with other recommendations, Navigant recommends the Cabinet consider leveraging an advisory panel of external stakeholders to vet PDS policies and program design. The advisory panel input would not be limited to this recommendation but should also consider implementation of other recommendations.

Recommendation 8 – Consolidate HCBS waiver operations and oversight under one quality management business unit within DMS to centralize decision-making authority and responsibility.

Recommendation 8 is considered the “roof” of the “Home” for Home and Community-Based Services. Operational and programmatic oversight responsibilities are currently spread across the Cabinet, with DMS, DBHDID, and DAIL each implementing disparate processes by waiver which, in some cases, have created duplication of efforts. The Cabinet should consider consolidating HCBS waiver operations and oversight under one quality management business unit within DMS to centralize decision-making authority and responsibility.

Recommendation: Consolidate HCBS waiver operations and oversight under one quality management business unit within DMS to centralize decision-making authority and responsibility.
Recommendation Description: Navigant recommends the Cabinet consolidate leadership of waiver operations and administration currently spread across DMS, DBHDID, and DAIL, by creating a single business unit within DMS that is responsible for decision-making related to provider and service monitoring and oversight. The business unit should focus on overall quality management, accountabilities for delivering quality care, and creation of consistent

and accurate processes for HCBS waiver administration, while reducing duplication of effort. Navigant recommends structuring operational areas within the quality management business unit according to their administrative function. Navigant recommends that this unit be housed in DMS and use designated operating agencies where applicable to drive high-quality service delivery using consistent approaches across all waivers.

Recommendation Rationale: DMS, as the single State Medicaid Agency, ultimately bears responsibility for the oversight and management of all 1915(c) waivers in Kentucky. Centralized quality management into a single structure will support:

- Consolidation of operational oversight responsibilities into a single defined management team housed within DMS to conduct HCBS waiver oversight will increase uniformity in overall monitoring, maximize inter-agency communications related to monitoring, and centralize accountability.
- Centralization of managerial oversight and cross-waiver trending within DMS, including data management, operational tracking, and CMS reporting, will improve DMS' ability to conducting trending, use that trending to inform future monitoring activities, and report efficiently to CMS.
- Improved consistency in monitoring approaches, including the delivery of provider training, technical assistance, and application of recoupment and corrective action across waivers will offer more fairness across different providers types and improve relations between providers and the Cabinet.
- Reduction in inefficient monitoring practices like high-volumes of on-site technical assistance and extensive second-line review allows for re-deployment of limited staff resources to address under-resourced monitoring components to support overall HCBS delivery.

Cabinet Goals Advanced by this Recommendation:

- Enhance quality of care to participants
- Establish procedures for all waiver management administration activities

Expanded Rationale for Recommendation

Navigant is making this recommendation to help the Cabinet address challenges related to today's 1915(c) waiver operations and oversight. The rationale for this recommendation is described below.

- **Consolidation of operational oversight responsibilities into a single defined management team housed within DMS to conduct HCBS waiver oversight will increase uniformity in overall monitoring, maximize inter-agency communications related to monitoring, and centralize accountability.** The Cabinet will benefit from a single decision-making authority for HCBS waiver oversight, which is best housed in DMS as the primarily accountable party to CMS. Moving the management and decision-making authorities into a single department will reduce differences in monitoring approaches by waiver that exist today. Additionally, a single, consolidated management

structure to oversee 1915(c) waivers overall, allows for a clearer line of communication up and down the decision-making structure when a policy needs to be interpreted, or leadership makes a decision that informs how field staff proceed with their monitoring activities and direct contact with providers. Today, it takes significant effort to align and coordinate across multiple managing parties housed across DMS, DAIL, and DBHDID. A centralized management structure offers clearer overall leadership for internal and external stakeholders allowing for more efficient communication flow from management to staff throughout the entire quality management team. This supports management's ability to make staff aware of important information, critical updates, and executive decisions in a timely, uniform fashion. It also provides a clear source of decision-making authority to external stakeholders as they address monitoring issues.

- **Centralization of managerial oversight and cross-waiver trending within DMS, including data management, operational tracking and CMS reporting, will improve DMS' ability to conducting trending, use that trending to inform future monitoring activities and report efficiently to CMS**. While centralizing operations and oversight to a single quality management business unit will help the Cabinet to bolster leadership over quality management, it is still critical to have the needed staff resources to conduct field operations required within monitoring. There is a significant level of effort in conducting annual and event-based on-site reviews, thus Navigant recommends a *delegated* model of monitoring, where a centralized team in DMS manages overall Cabinet resources by tracking overall monitoring activities and assigning field visits, including those related to annual certification, critical incident investigation, and other on-site monitoring activities to DAIL and DBHDID teams for review and follow-up. Sister agencies would be responsible to report their findings back to DMS, who would then retain final decision-making on how to respond to reported findings and determine follow-up steps to ensure regulatory compliance among providers.

  The recommended delegated monitoring approach allows the Cabinet to continue using the breadth of knowledge and provider-facing experience housed in both sister agencies, without undergoing an extensive re-organization across departments. A delegated method also allows for clear delineation between departments to better align roles and responsibilities, equipping DMS with the necessary level of purview and oversight to adequately report to CMS and manage the broad HCBS delivery system. This method will also support provider relations with the Cabinet, providing a single source of decision-making, to promote improved accountability between providers and the Cabinet.

- **Improved consistency in monitoring approaches, including the delivery of provider training, technical assistance, and application of recoupment and corrective action across waivers will offer fairness across different provider types and improve relations between providers and the Cabinet.** Navigant recommends the Cabinet apply a uniform monitoring approach to all providers across all waivers, both in terms of how monitoring is conducted and how much provider support is offered. The

Cabinet should provide all providers equal opportunity to receive technical assistance and training, to promote high quality service delivery that adheres to existing program rules and regulations. Ultimately, the success of participants is dependent on the success of providers in delivering high-quality services and supports regardless of the department conducting on-site reviews or the waiver the provider participates with.

Similarly, Navigant recommends that the centralized quality management approach include a consistent application of corrective action and punitive action when a provider fails to comply with program rules and requirements. This is important for program integrity, offering providers transparency to understand what support is available to help them succeed in service delivery, while also understanding what violations or non-compliance will result in corrective and/or punitive action. The current approach is unclear to providers and Cabinet staff are often not positioned to enforce important program rules, which undercuts the Cabinet's ability to uphold quality standards and ensure HCBS providers serve participants well.

- **Reduction in inefficient monitoring practices like high-volumes of on-site technical assistance and extensive second-line review allows for re-deployment of limited staff resources to address under-resourced monitoring components to support overall HCBS delivery.** Navigant recommends examining certain monitoring practices used currently, to identify where the Cabinet can more effectively deploy limited staff resources to support HCBS quality management. Some of the Cabinet's current practices entail heavy use of staff resources with unclear return on the investment. Among these practices, SCL providers are allowed ongoing on-site technical assistance visits, a resource not available to providers on other waivers. High volumes of on-site technical assistance require a heavy amount of statewide travel, with increased likelihood that providers will get individualized information leading to systemic confusion about program rules and requirements. Navigant suggests increased use of more efficient technical assistance mediums including webinars and group trainings, which allow providers an opportunity to request feedback and receive updates, while reducing the time and resources used to respond at the individual provider level.

  Additionally, Navigant recommends reducing the rates of second-line monitoring. In certain instances, DMS conducts a near total re-review of all monitoring activity conducted by a sister operating agency, which is an inefficient use of resources that has led to provider frustration when one department puts forth one set of findings, and DMS follows up with a different set of findings on the same review. Navigant recommends that the centralized quality management team conduct a standard quality control review across monitoring segments sufficient to ensure consistency and accuracy, at no greater than 15-20 percent of reviews conducted, based on resource availability.

  Addressing these inefficiencies in today's monitoring practices will allow the Cabinet to re-assign resources to address certain areas Navigant identified as under-resourced, largely related to event-based monitoring. Two of the areas Navigant would highlight for

an infusion of staff resources would include critical incident investigation and follow-up, and corrective action plan development and follow-up. The Cabinet may wish to use a mixture of announced and un-announced visits to conduct follow-up related to correction action plan and critical incident monitoring. Navigant identified that there is limited follow-up to corrective action plans, which is another monitoring area where the Cabinet can provide targeted technical assistance to those providers with observed deficiencies who demonstrate need for it.

The Cabinet may also consider expanding their current monitoring practices to conduct reviews at the site-specific level, as opposed to the provider-level, which may be needed for certain provider types. Per the assessment, the Cabinet currently considers providers to have been reviewed if a single site has received an annual monitoring visit, which may lead to unidentified issues at an alternative site that did not receive an annual visit.

Implementing these recommendations would advance the Cabinet's goals to *enhance quality of care to participants* and to *establish procedures for all waiver management administration activities.*

Related National Trends and Best Practices

Medicaid program management and 1915(c) waiver oversight structures vary nationally, based on the delivery system under which the program operates and the broad objectives of the programs. Many states effectively manage their waiver programs using multiple departments, while other states choose to consolidate many (or all) waiver responsibilities under the single state Medicaid agency. States can succeed using both approaches; however, in Navigant's experience, the common elements for success include: (1) a single, decision-making authority that maintains primary responsibility for the program(s); and (2) clear delineation of monitoring task assignment, decision-making authority, and roles and responsibilities across parties so all staff expectations are clear. Without these two elements, states run a significant risk for non-compliance with Federal and state regulations, duplication of work, and unnecessary operational inconsistencies across programs.

Two states Navigant has worked where these common elements were a focal area, include:

1. The State of *Arizona,* which recently incorporated the Department of Behavioral Health into the Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid agency. This administrative simplification reduced the amount of duplicated effort across agencies and allowed for more streamlined processes to be developed and implemented.
2. The State of *Arkansas* is currently consolidating its HCBS provider licensure and certification to a single unit called the Division of Provider Services and Quality Assurance (DPSQA). DPSQA will be a "one stop shop" for waiver providers, creating efficiency and consistency, reducing unnecessary redundancy, improving interactions with providers, and improving health outcomes.

Regardless of implementing a singular approach or delegated approach, centralization of key

operational and oversight should help drive performance improvement across all operational areas and allow for a focused approach to support a quality improvement strategy, as described in Recommendation 10.

Anticipated Actions Related to this Recommendation

Should the Cabinet elect to implement this recommendation, they should anticipate that operation of a quality management and oversight business unit would require significant planning and dedicated resources. Implementation of this business unit is critical to the success of many of Navigant's other recommendations, as the newly developed business unit would be primarily responsible for administering the program with which all other recommendations apply.

Navigant recommends the Cabinet undertake seven high-level tasks to complete the implementation of a quality management and oversight business unit:

1. Develop a workplan and timeline to execute implementation
2. Determine operational areas to include within the new business unit, along with anticipated roles and responsibilities for each area
3. Align staff within the business unit to focus primarily on their assigned operational areas across all waivers, along with delineation of responsibilities for departments outside of DMS, vendors, and other entities as needed
4. Develop standard operating procedures for each operational area to promote consistency in operations across HCBS waivers, as indicated in Recommendation 5, leveraging staff's experience and intimate knowledge of the needs for each waiver
5. Develop an escalation process for operational, policy, and quality management issues and identify accountable parties with decision-making authority
6. Revise position descriptions, as necessary to reflect updated responsibilities for Cabinet staff
7. Develop performance metrics to benchmark progress regarding this recommendation (e.g., number of SOPs the Cabinet intends to implement, number of staff transitioning, etc.)

Highlighted Cabinet Decisions to Proceed with this Recommendation

Should the Cabinet implement this recommendation, the Cabinet would need to address the following strategic or operational considerations:

1. Will the Cabinet elect to implement a single quality management and oversight business unit within DMS?
2. What stakeholders need to be apprised of implementation details throughout the timeline?
3. What operational areas would the business unit include?

4. Which staff would DMS assign to each operational area and what would be their role?
5. Should staff transitioning to the new unit be co-located to the same floor or building?
6. What financial impacts should the Cabinet consider with staffing the new business unit?
7. What roles and functions would remain with departments outside of DMS?

Future Stakeholder Input

As with any transition, DMS must prepare to clearly communicate decisions, the impact of decisions and timing of implementation to impacted stakeholders throughout the process. With the proposed restructuring outlined in this recommendation, DMS must consider both internal and external stakeholders to be consulted throughout the process to better understand their considerations on the recommended changes. DMS should consider developing a broad stakeholder strategy, as outlined in Recommendation 9, to include how the implementation of the quality management and oversight business unit would support the other recommendations the Cabinet would be implementing. The stakeholder strategy should include anticipated points at which stakeholders can anticipate involvement in key details and/or milestones in the development of this business unit.

Recommendation 9 – Implement an ongoing, formal stakeholder engagement process to engage all types of stakeholders who may be affected by the Cabinet's HCBS policy and operations and to improve the use of advisory committees, including but not limited to the Technical Assistance Committees (TACs) and Medicaid Advisory Committee (MAC).

Recommendation 9 is considered to be the front yard of the "Home" for Home and Community-Based Services. Implementing this recommendation would enable the Cabinet to anticipate and plan for the equivalent of future home maintenance, repairs, and improvements.

Medicaid programs and policies impact a variety of stakeholders, such as those described in *Chapter 2: Assessment Background and Methodology*. Medicaid programs and policies also affect schools, providers of non-Medicaid health and social services, communities, special interest organizations and associations, advocacy groups, and taxpayers. Likewise, Medicaid policymaking and program administration involves a wide range of government entities, including the Medicaid agency and its sister state agencies, the Federal Centers for Medicare and Medicaid Services, state legislators, and state gubernatorial administration.

Medicaid policymaking is best done with input from various stakeholders and with clear and open communication about anticipated changes. For HCBS waiver participants and their natural supports, stakeholder engagement is particularly important. Navigant's assessment findings reveal that the Cabinet's HCBS stakeholder engagement activities have been minimal and targeted a narrow group of stakeholders.

Recommendation: Implement an ongoing, formal stakeholder engagement process to engage stakeholders who may be affected by Cabinet HCBS policy and operations and improve the use of advisors including but not limited to the MAC, TACs, and other standing committees.

Recommendation Description: Navigant recommends the Cabinet develop a long-term strategy for ongoing, meaningful stakeholder engagement including a full range of stakeholders. External Stakeholders should be involved, informed, and encouraged to provide their insights and recommendations to DMS and the Cabinet. Navigant recommends implementing strategies, including improved communications via written and in-person engagement, along with optimization of how the Cabinet engages MAC, TACs, and other boards and organizations in program design, evaluation, and decision-making. Finally, Navigant encourages the Cabinet to improve the representation of waiver participants, their natural supports, and other stakeholder types beyond providers into TACs, to further assure diversity in stakeholder input and engagement. Key elements of Navigant's recommendation are further described below.

- **Development and implementation of a stakeholder engagement strategy.** The stakeholder engagement strategy should set forth common goals, roles (e.g., advisory) and responsibilities, stakeholder subgroups, lines of communication, and information exchange. The strategy should also define both internal and external stakeholders. Then, the Cabinet should develop a stakeholder inventory and a communication plan that identifies each stakeholder subgroup, the group's information needs and desires, and the potential means of communicating to that stakeholder subgroup. This inventory would inform the stakeholder engagement strategy. The strategy should be relatively straightforward and easy to sustain. The Cabinet should evaluate the plan periodically to ensure it is working for the Cabinet and its external stakeholders.
- **Reliance upon formal committees or other formal groups to advise Cabinet activities.** Rapid-cycle stakeholder engagement would be necessary for the successful implementation of the recommendations outlined in this report. Specifically, the Cabinet would need to rely upon one or more multi-stakeholder groups to serve in an advisory capacity. The composition and protocols governing the MAC and TACs is established in the KAR, so any modifications to the role, representatives, or approach to developing agendas for the MAC and TACs would be subject to the regulations. Thus, the Cabinet should assess the feasibility of relying upon the MAC and the TACs or consider the alternative of forming short-term, task focused advisory panels comprising a range of stakeholders. The Cabinet should determine how many advisory boards it needs, as well as the focus and meeting frequency of each advisory board. When making these decisions, the Cabinet should consider the resource demands on both committee members and the Cabinet, and the need for differing perspectives.

Recommendation Rationale: Historically, the Cabinet's approach to HCBS stakeholder engagement has been characterized as reactive rather than proactive in nature, and it has engaged a limited number of stakeholders representing a limited subset of the HCBS stakeholder groups. Stakeholder engagement activities have lacked a disciplined, strategic approach. Navigant anticipates that implementation of a strategic and inclusive stakeholder

engagement strategy would provide information that would drive improvements in participant care and/or quality of life.

Implementing a formal, ongoing stakeholder engagement strategy will enhance Kentucky's HCBS programs in the following ways:

- The Cabinet will better leverage stakeholder engagement as a means to inform policy development and program operations.
- Engagement efforts will reach a broader audience of internal and external stakeholders to maximize stakeholder engagement, including improved engagement of participants and their caregivers.
- Improved stakeholder engagement will increase public understanding and, in turn, public confidence in the Cabinet's HCBS-related decision-making process.
- A thoughtful approach will promote an engaged stakeholder culture, which CMS encourages (and in some cases requires).
- An ongoing strategy offers the Cabinet opportunity to build on previous stakeholder engagement activities, which have already demonstrated value.

Cabinet Goals Advanced by this Recommendation:

- Implementation of this recommendation would advance all ten of the Cabinet's goals.

Expanded Rationale for Recommendation

Navigant is making this recommendation to help the Cabinet address challenges related to today's stakeholder engagement. The rationale for this recommendation is described below.

- **The Cabinet will better leverage stakeholder engagement to inform policy development and program operations.** Although the Cabinet has employed stakeholder engagement to inform policy decisions and program design, the interactive sharing of ideas and concerns and the collaborative development of solutions has occurred only with a small number of stakeholders. As noted in *Chapter 6: Assessment Findings*, the Cabinet also underutilizes formal advisory bodies and committees.

  Navigant recommends leveraging existing committees and stakeholder panels to complement Governor Bevin's *Red Tape Reduction* initiative by avoiding unnecessary development of additional processes to conduct program administration. According to information provided by internal stakeholders, the MAC has not historically focused on HCBS waiver programs. Although the MAC receives a monthly "Waiver Dashboard" report, the MAC and TACs do not appear to have significant discussions regarding HCBS program performance. The degree of HCBS waiver participant involvement in the MAC and TACs is unclear but appears to be very limited.

  Taking a more concerted approach to engaging these entities, including timely updates and early vetting of new concepts and proposed changes to program design could re-position engagement of the MAC and TAC as advisors who offer subject matter expertise to the Cabinet. This improves upon the current dynamic, in which the Cabinet

is more often defending itself against complaints and/or responding to provider questions. Using the opportunity to obtain early feedback can also support the Cabinet in developing policy that reflects stakeholder input.

- **Engagement efforts will reach a broader audience of internal and external stakeholders to maximize stakeholder engagement, including improved engagement of participants and their caregivers.**

  Historically limited formal stakeholder engagement practices have, in some cases, resulted in legislators and Cabinet leadership relying on anecdotal feedback provided by a limited number of stakeholders when forming opinions or making decisions. The perspectives of a small number of highly active stakeholders may have provided limited perspective, while other stakeholders were silent. The Cabinet and legislature have, at times, made program-related decisions without broad appreciation for how those decisions impacted the full breadth of program stakeholders, especially participants. A broad and inclusive stakeholder engagement strategy can help the Cabinet to avoid circumstances like the stakeholder engagement sessions to discuss 1915(c) waiver redesign in late 2015. After these sessions, the Cabinet received complaints from stakeholders who reported they felt excluded, did not have equal opportunity to provide input, and that the stakeholder segment was overly comprised of providers and lacked perspective from participants and their caregivers.

- **Improved stakeholder engagement will increase public understanding and, in turn, public confidence in the Cabinet's HCBS-related decision-making process.**

  Navigant observed significant opportunity to improve relations between the Cabinet and external stakeholders, particularly to improve stakeholder confidence that the Cabinet is transparent and deliberate in the use of stakeholder engagement as a program design tool. Non-provider stakeholders tend to be less accustomed to and more distrustful of the Cabinet's input and decision-making process. A clear strategy using thoughtful methods to engage stakeholders will help to overcome the perception that stakeholders do not have an actual voice and that system changes are made in the best interest the Cabinet, as opposed to in the best interest of those who rely on HCBS to remain in the community. Through continued engagement and a pattern of consistent validation of stakeholder input reflected by thoughtful Cabinet decisions and transparent information sharing, the Cabinet can build a better dynamic with stakeholders and demonstrate improved understanding and appreciation for stakeholder needs and perspectives.

- **A thoughtful approach will promote an engaged stakeholder culture, which CMS encourages (and in some cases requires).**
  The participation of waiver participants in HCBS program decisions is key to successfully managing and improving HCBS waivers. A defined strategy will ensure that the Cabinet is planning for and optimally executing optional, and in some cases required, stakeholder engagement activities, including public comment periods for substantive changes to a 1915(c) waiver application, changes to KAR, and other federally expected

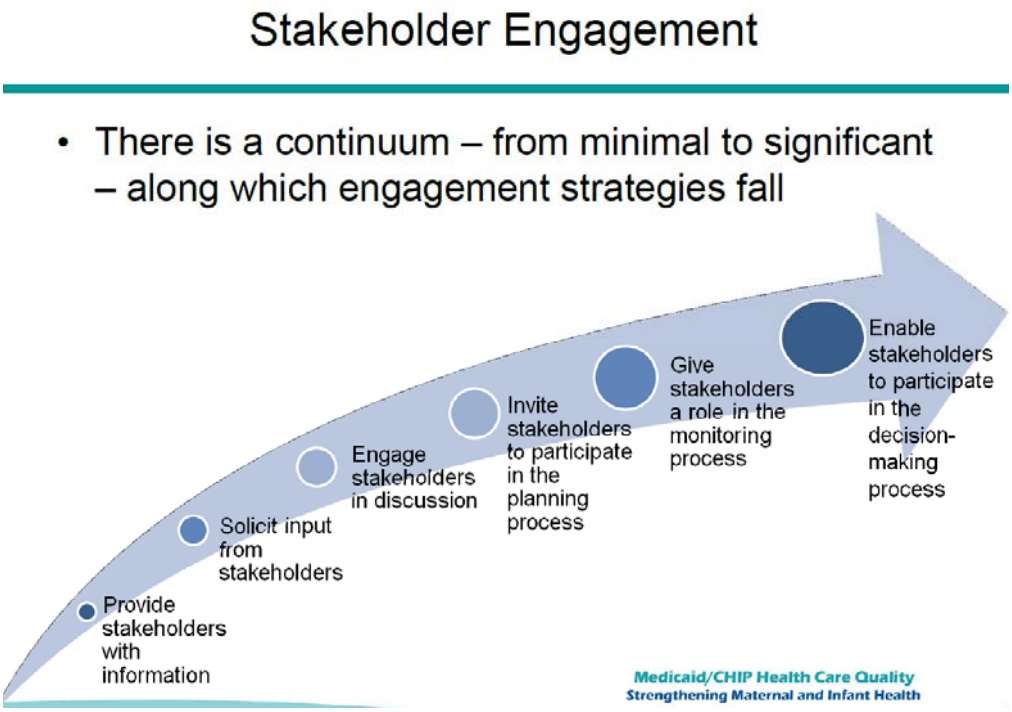
engagement practices.

- **An ongoing strategy offers the Cabinet opportunity to build on previous stakeholder engagement activities, which have already demonstrated value.** The Cabinet launched a broad stakeholder engagement process in the fall of 2017 by administering focus groups for four key stakeholder constituencies: participants, caregivers, provider managers and executives, and direct support professionals. The Cabinet then continued its stakeholder engagement efforts by holding town hall meetings in the spring of 2018. Stakeholders had positive perceptions of these engagement activities and provided valuable feedback for the Cabinet's and Navigant's consideration. These activities have helped to demonstrate the value and importance of structured approaches to broad-based stakeholder engagement in Kentucky. Participants and their natural supports are not accustomed to engaging with the Cabinet, and the Cabinet is developing and testing approaches to improve outreach, engagement, and information sharing with non-provider stakeholders. A thoughtful strategy will also position the Cabinet to target stakeholder segments they struggle to reach, like individuals who are on waiver waiting lists.

Related National Trends and Best Practices

CMS describes stakeholder engagement as essential and includes specific requirements for public notice in the HCBS Settings rule. CMS has described a continuum of stakeholder engagement strategies, from minimal to significant as illustrated in Figure 6.10.

Figure 6.10 CMS Framework for the Continuum of Stakeholder Engagement Strategies[144]



CMS not only defines the stakeholder engagement process, it also offers a definition of stakeholders as "those who pay for, provide, regulate, receive, measure, monitor, or otherwise interact with/influence the health care outcomes you want to improve" and are further identified as "internal and external."[145] Further, CMS provides seven core principles of authentic engagement:

1. Careful planning and preparation
2. Inclusion and demographic diversity
3. Collaboration and share purpose
4. Openness and learning
5. Transparency and trust
6. Impact and action
7. Sustained engagement and participatory culture[146]

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[144] QI 201 Learning Session #2: Engaging Stakeholders and Developing a QI Road Map, October 29, 2013, Medicaid/CHIP Health Care Quality, Strengthening Maternal and Infant Health presentation.
[145] QI 201 Learning Session #2: Engaging Stakeholders and Developing a QI Road Map, October 29, 2013, Medicaid/CHIP Health Care Quality, Strengthening Maternal and Infant Health presentation.
[146] QI 201 Learning Session #2: Engaging Stakeholders and Developing a QI Road Map, October 29, 2013, Medicaid/CHIP Health Care Quality, Strengthening Maternal and Infant Health presentation.

Other states' practices fall within the stakeholder engagement spectrum CMS defined. In compliance with *42 CFR Section 431.12*, states with Medicaid programs have advisory councils or committees like Kentucky's MAC. The composition of states' MACs is mostly providers and provider representatives, with a few slots designated for Medicaid recipients or their representatives. A few states also include legislative representatives. Similar to Kentucky's TACs, contiguous states also use technical advisory committees for subject-specific issues, such as pharmacy and therapeutics, drug utilization, and durable medical equipment. Illinois and Pennsylvania use permanent subcommittees including Consumer, Health Equity, Fee-for-Service, Long-Term Services and Supports (LTSS), Quality Care, Managed Care Delivery System, and Public Education.[147] [148]

In other states, the scope of responsibility of the MAC and its respective subcommittees ranges from advisory to specific duties, such as reviewing access to and utilization of medically necessary health care services and reviewing data to develop data-based recommendations to improve program implementation and access and track progress in addressing gaps or service deficiencies.[149]

Regarding LTSS, many states have created special committees, subcommittees, or work groups. The committees vary in their length of existence; some are permanent, while others are short-term, and disband once a task is completed. For example, Ohio created the Unified Long-Term Care Systems Advisory Workgroup to assist with its integrated care delivery system design and implementation.

The stakeholder engagement methods used by other states are like those used by Kentucky and included public meetings, video conferencing, statewide conference calls, surveys, discussion circles at statewide committee meetings, focus groups, periodic meetings with key advocacy or provider organizations, email, listservs, and websites.[150]

The Center for Health Care Strategies (CHCS) has provided technical assistance sessions and briefings to guide state officials through the use of stakeholder engagement to improve systems of care, especially for dual eligibles. CHCS notes the following key best practices: anticipate the questions from stakeholders, listen to stakeholders, and include advice from an advocate. In one brief, advocates advised:[151]

- Trust the process
- Engage narrowly and broadly

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[147] Pennsylvania Department of Human Services, Information for Advocates and Stakeholders. Available online at: http://www.dhs.pa.gov/communitypartners/informationforadvocatesandstakeholders/index.htm
[148] Illinois Department of Healthcare and Family Services. Medicaid Advisory Committee (MAC). Available online at: https://www.illinois.gov/hfs/About/BoardsandCommisions/MAC/Pages/default.aspx
[149] Illinois Department of Healthcare and Family Services. Subcommittee Health Equity. Available online at: https://www.illinois.gov/hfs/About/BoardsandCommisions/MAC/access/Pages/default.aspx.
[150] Tennessee Department of Health. Upcoming Events. Available online at: https://www.tn.gov/health/calendar.html
[151] Lind, Alice and Suzanne Gore, Center for Health Care Strategies, Inc., "Engaging Consumer Stakeholders to Improve Systems of Care for Dual Eligibles", Technical Assistance Brief, Dec. 2010. Available online at: https://www.chcs.org/media/TCDE_StakeholderBrief_122010.pdf

- Get input from local and state advocates
- Include real participants
- Share your process
- Provide a variety of opportunities for stakeholders to participate
- Include stakeholders from the beginning (design, implementation, evaluation)
- Share drafts of proposals and other documents
- Be responsive to concerns raised
- Consider evaluation from the beginning

Anticipated Actions Related to This Recommendation

Should the Cabinet elect to implement this recommendation, they should conduct the following steps to develop and execute the HCBS stakeholder engagement strategy:

- Develop a comprehensive stakeholder engagement strategy and communication plan to help assure that all stakeholder engagement activities are well coordinated.
- Follow the steps outlined below to assess the potential of relying upon the MAC and the TACs to formally advise the Cabinet during implementation of the Phase I recommendations.
    - Evaluate the governing regulations to identify potential opportunities to rely upon the MAC and TACs to facilitate the Cabinet's stakeholder engagement strategy.
    - Hold dialogue with the agenda setters for the MAC and TACs regarding the importance of engaging 1915(c) waiver stakeholders, and whether the MAC and TACs could support this engagement.
    - Once the two steps outlined above are complete, consider where changes to standing processes and governing regulations are needed and determine the degree to which the standing committees can serve in advisory roles to support implementation of Phase I recommendations.
    - Determine where additional advisory panels might be needed to enable broad-based stakeholder engagement, develop charters, and carefully define the scope of responsibility and duration for which the panel would be in place.
- Conducting reviews of other standing committees to identify opportunities for engagement including:
    - Formal committees, such as the House Bill 144 Commission, or the Kentucky Council for Autism Spectrum Disorders
    - Committees and panels from other state entities, such as the Protection and Advocacy for Persons with Developmental Disabilities (PADD) board, or the Commonwealth Council for Developmental Disabilities (CCDD).

The Cabinet sends designees from DMS to present departmental updates to many of these other state-run standing committees but does not typically seek targeted proactive input or present ideas for consideration. Navigant has encouraged the Cabinet to take a more proactive approach to leveraging other state-run standing committees, whose members have vested interest in 1915(c) programming, by soliciting targeted feedback on specific policies areas and show a willingness to participate in constructive dialogue.

Highlighted Cabinet Decisions to Proceed with this Recommendation

Should the Cabinet implement this recommendation, the Cabinet would need to address the following strategic or operational considerations:

- Will the Cabinet develop and execute a communications plan and stakeholder engagement strategy? If so, would it pertain specifically to HCBS waiver programs or to all Medicaid programs?
- What means of communication would the Cabinet use and how and when would the Cabinet interact with stakeholders to support the Phase I recommendations?
- What Cabinet departments and staff (e.g., communications staff, legislative relations staff, sister agency staff) should be involved in development and execution of the communication plan and stakeholder engagement strategy? And how would the Cabinet inform and/or involve the Governor's office in these activities? What means of communication would the Cabinet use and how and when would it interact with stakeholders in executing its stakeholder engagement strategy? This activity may require development of, for example, new Cabinet web pages
- What would be the role of the MAC, the TACs, and other standing committees that address Medicaid issues? If the Cabinet determines that existing committees would not satisfy the Cabinet's needs, would the Cabinet form temporary HCBS advisory panels or pursue another option? If the Cabinet forms temporary HCBS advisory panels, how many panels are needed, what is the membership of the panels, and what roles would the panels serve?
- Are there best practices employed in other parts of the Cabinet, or in other Commonwealth Cabinets that can be replicated to support a 1915(c) waiver specific approach?

Future Stakeholder Input

Navigant recommends that the Cabinet undertake stakeholder engagement activities as it implements each recommendation. As outlined in each recommendation, Navigant recommends that a variety of stakeholder engagement methods be employed, including but not limited to:

- Public reporting by the Cabinet, published electronically
- Town halls or other public meetings where external stakeholders can receive updates and provide comments

- Focus groups, surveys, and other methods to solicit input about external stakeholder experience and opinions
- Email comment box to which stakeholders can submit comments at any time
- Briefings for legislators and their staff
- Social media postings and email blasts to key associations and membership groups
- Newspaper editorials and articles profiling key developments
- Development of a predictable rhythm and mode(s) of routine communication that stakeholders can anticipate

Implementation of the ten Phase I recommendations would be complex and resource intensive. As described in Chapter 7, the Phase I recommendations are interdependent, so the implementation activities must be appropriately sequenced, and simultaneous implementation of many recommendations is highly likely. Thus, messaging to stakeholders must be considered carefully, so that messages are clear, appropriately sequenced, and not so voluminous as to overwhelm stakeholders with new information. For these reasons and, due to the limited capacity of stakeholders and the Cabinet to coordinate and participate in formal advisory committees, Navigant recommends that the Cabinet seek advisory panel approaches that are not duplicative of one another or of existing bodies, as discussed above.

Recommendation 10 ─ Implement a quality improvement strategy (QIS) for the 1915(c) waivers to increase emphasis on improving service outcomes and participant experience.

Recommendation 10 is part of the *future plans* for the "Home" for Home and Community-Based Services. Implementing this recommendation would enable the Cabinet to anticipate and plan for the equivalent of future home maintenance, repairs, and improvements. Navigant anticipates that the development and implementation of a deliberate and proactive QIS would drive cultural change throughout the program and would improve the participant experience.

Recommendation: Implement a QIS for the 1915(c) waivers to increase emphasis on improving service outcomes and participant experience.
Recommendation Description: Navigant recommends that the Cabinet develop and execute a comprehensive HCBS QIS that sets forth a plan for achieving the Cabinet's goals. The Cabinet has defined its overarching HCBS program goals, as outlined in Chapter 1.2 and should take the appropriate steps to evaluate current performance to establish baselines and identify performance gaps. Next, the Cabinet should establish performance targets to close performance gaps and then develop and implement interventions designed to close selected gaps as a means of achieving performance targets. The Cabinet should build existing operational processes to support and enable this quality improvement process. Paramount to these efforts would be access to complete and accurate data, as well as the ability to analyze

that data and generate timely standard and ad hoc reports.

Recommendation Rationale: Today, the Cabinet's approach to assuring HCBS quality of care is focused heavily on compliance and resolution of ad hoc issues and concerns as they arise. In some regards, the quality management approach is, like stakeholder engagement, characterized by a reactive rather than a proactive stance. While the Cabinet does measure program performance in some areas, the measurement and reporting activities are not part of a disciplined continuous quality improvement cycle. Navigant anticipates that implementation of an informed QIS would drive improvements in participant care and/or quality of life.

Recommended improvements to incorporate a QIS into the 1915(c) waiver program operations are outlined below:

- The Cabinet would benefit from re-orienting its quality management activities from the current compliance focus to one that recognizes the importance of both regulatory compliance *and* quality improvement to promote improved participant outcomes and other performance improvements.
- Implementing a disciplined continuous quality improvement cycle with defined operational elements including data aggregation, measurement, and reporting activities will promote consistent, rigorous quality management approaches that are institutionalized within Cabinet operations and culture.
- Implementing a continuous quality improvement approach that encompasses all waivers and intersects with other parts of the Medicaid delivery system can maximize the impacts of quality improvement in HCBS, as opposed approaching specific waiver programs or populations individually.
- Developing a QIS that not only meets CMS requirements and but also reflects national best practices related to continuous quality improvement will position the Cabinet to achieve compliance with minimum CMS performance requirements *and* to achieve the Commonwealth's quality improvement goals.

Cabinet Goals Advanced by this Recommendation:

- Enhance quality of care to participants
- Maximize consistency in definitions and requirements across waivers
- Curb preventable increases in total spend for HCBS programs

Expanded Rationale for Recommendation:

Navigant is making this recommendation to help the Cabinet address challenges related to today's quality management infrastructure and processes. The rationale for this recommendation is described below.

- **The Cabinet would benefit from re-orienting its quality management activities from the current compliance focus to one that recognizes the importance of both regulatory compliance *and* quality improvement to promote improved participant outcomes and other performance improvements**. As described in Findings 45 and

47, today's formal HCBS quality management activities and culture are heavily focused on compliance rather than on quality improvement. Stakeholders internal and external to the Cabinet reported that the Cabinet is focused heavily on compliance, particularly compliance with documentation and administrative requirements. Cabinet HCBS staff spend much of their time addressing individual inquiries from participants and their natural supports, as well as from providers. Thus, the focus is on resolving the inquiries (which require attention in the near-term), rather than on establishing long-term goals to achieve defined program performance. Like many states, Kentucky currently focuses its HCBS quality management resources on compliance and procedural matters and does not embrace its CMS-approved comprehensive QIS or another continuous QIS as much as it could. In effect, long-term planning and the quality improvement cycle have taken a back seat to compliance management.

- **Implementing a disciplined continuous quality improvement cycle with defined operational elements including data aggregation, measurement, and reporting activities will promote consistent, rigorous quality management approaches that are institutionalized within Cabinet operations and culture.** Generally, limited program-wide performance data are available and, when such data are reported, they are often reported using raw numbers rather than relative figures (such as a utilization rate). Also, data are often reported as a point-in-time figure rather than being trended over time. Thus, available data are not reported in a frequency or format that enables effective use of quality improvement cycles. As described in Findings 45-47, currently, the Cabinet does not have the data analyses or processes in place so that the Cabinet can:
    - Conduct timely program-wide performance data (including participant assessment data and, ideally, Medicare data for dually eligible participants) are readily available to Cabinet staff.
    - Summarize program-wide data in a manner the enables Cabinet staff to observe overarching trends and to "drill down" to observe differences among various geographies, waivers, subpopulations, etc. so that the Cabinet can begin to understand potential root causes of performance patterns and variation.
    - Review historical performance, identify and prioritize gaps in care, design interventions or quality improvement projects (QIPs), establish performance targets, and deploy interventions or QIPs.
    - Aggregate and analyze program data to observe comparisons and trends over time and compare to performance targets or minimum performance thresholds.

  Developing the capabilities to achieve the bullets above will require some front-end investment, and, if desired, the Cabinet can phase in implementation over time. In the long-term, these investments should enable the Cabinet to achieve greater administrative efficiencies and data capabilities.

- **Implementing a continuous quality improvement approach that encompasses all**

waivers and intersects with other parts of the Medicaid delivery system can maximize the impacts of quality improvement in HCBS, as opposed to approaching specific waiver programs or populations individually.

As described in Finding 1, among other findings, the Cabinet's current approach to waiver management, including quality management, reflects its longstanding approach to separately managing and operating the waivers. Thus, approaches to quality management are not always aligned across waivers. To date, the Cabinet has wide ranging quality goals among its six HCBS waivers and instead should establish a core set of two to three key goals or performance targets it wishes to achieve. Several stakeholders asked that the Cabinet do more to recognize and share best practices and take a more holistic approach to monitoring. Stakeholders noted an opportunity to improve quality in HCBS across the Commonwealth but, when asked, often struggled to identify measures and targets the Cabinet should consider, indicating to Navigant that the Cabinet must take steps to drive quality improvement and lead the way as a purchaser.

Likewise, HCBS waiver quality management is not aligned with the quality strategy in place for Kentucky Health Partnership, the Commonwealth's Medicaid managed care program. The HCBS waiver quality activity today focuses primarily on HCBS services and does not consider the participants from a holistic perspective that includes LTSS and non-LTSS care services such as physician visits. Some opportunities may exist to align quality management by, for example, developing a set of core measures that is common across all HCBS waivers and, potentially, across the entire Kentucky Medicaid program.

Developing a QIS that not only meets CMS requirements and but also reflects national best practices related to continuous quality improvement will position the Cabinet to achieve compliance with minimum CMS performance requirements *and* to achieve the Commonwealth's quality improvement goals. CMS requires states to establish quality assurance systems to meet assurances for their HCBS waivers. Best practices indicate that continuous quality improvement requires infrastructure and processes that extend beyond those required by CMS. Historically, the Cabinet has had limited capability to evaluate the status quo, identify gaps in care, develop performance targets to achieve via closing some of those gaps, implement interventions to close those gaps, and re-measure those performance areas. Frequent measurement enables rapid cycle improvement, and transparency helps to engage and engender the trust of stakeholders, at least as long as the state agency is making progress toward closing performance gaps. Critical to the success of any state hoping to assure compliance or achieve a program improvement goal is access to complete and accurate data, as well as the ability to analyze that data and generate timely standard and ad hoc reports.

Related National Trends and Best Practices

In its national quality strategy, CMS sets forth the "Triple Aim" and its related goals, which apply

to Medicaid as well as other CMS-financed healthcare programs. Figure 6.11 lists the Triple Aim and associated goals.

Figure 6.11 CMS's Triple Aim and Goals[152]

Triple Aim	Goals
Better Care	• Patient Safety • Quality • Patient Experience
More Efficient Care (Reduce Per Capita Cost Through Improvements in Care)	• Reduce unnecessary and unjustified medical cost • Reduce administrative cost through process simplification
Improve Population Health	• Decrease health disparities • Improve chronic care management and outcomes • Improve community health status

States are encouraged to consider these aims and goals as they set for their quality improvement goals and strategies. In addition, CMS outlined its *Meaningful Measures Framework* in 2017, as a guide for states as they identify high priority areas for quality measurement and improvement.[153] Its purpose is to improve outcomes for patients, their families and providers while also reducing burden on clinicians and providers. States are encouraged to use this framework as they build comprehensive QIS plans.

Figure 6.12 Continuous Quality Improvement Cycle

Continuous quality improvement (PDCA), illustrated in Figure 6.12, is also a business practice commonly adopted and widely accepted in healthcare administration and health services research to achieve program goals. Each phase builds upon the previous, until the cycle repeats:

***PLAN*:** Determine the change or improvement

DO: Conduct a pilot test of the change

CHECK: Gather data about the pilot change to determine how successful the change is

ACT: Implement the change on a broader scale[154]

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[152] CMS. CMS Value Based Purchasing, Health System Transformation Initiatives. September 22, 2015. Available at: https://cdn.ymaws.com/www.traumacenters.org/resource/collection/D888237A-0B81-4795-BA8B-044FB24E5252/Richard_Wild-_CMS_Value_Based_Purchasing,_Health_System.pdf

[153] CMS. Meaningful Measures Framework. Available at:https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/CMS-Quality-Strategy.html

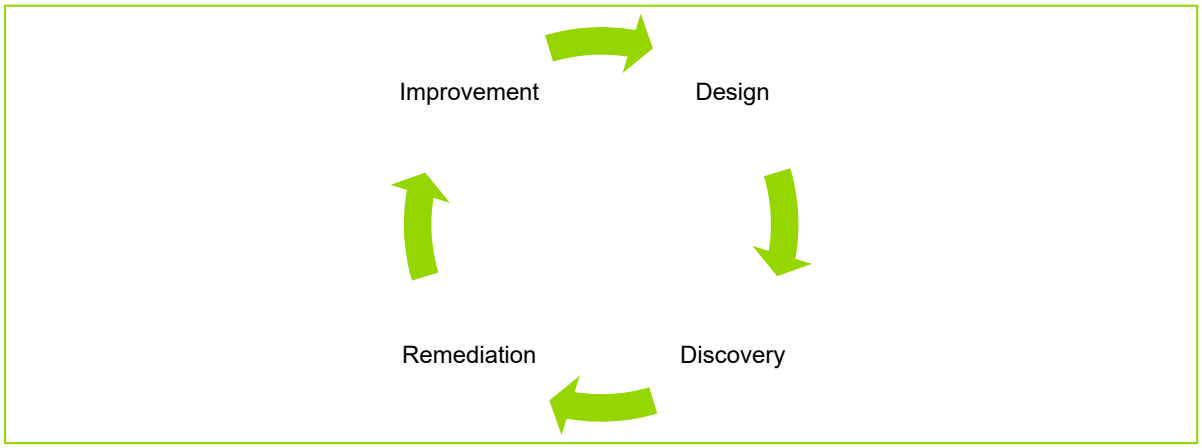
[154] AHRQ. Health Information Technology, Plan-Do-Check-Act Cycle. Available at: https://healthit.ahrq.gov/health-it-tools-and-resources/evaluation-resources/workflow-assessment-health-it-toolkit/all-workflow-tools/plan-do-check-act-cycle

Literature and practice reveal that a key to success in this process is focusing on a few key goals. Establishing too many goals and related measures tends to spread limited resources too thinly across the many goals, confusing providers, participants, and other external stakeholders and, ultimately, reducing the likelihood of achieving even one of the many goals. Using the PDCA model, States are encouraged to select a limited number of goals and plan each phase accordingly to determine continuous improvement towards those goals.

For states operating HCBS waiver programs, CMS requires that states develop and identify performance measures across six CMS waiver assurances; however, these measures are typically more compliance focused and process oriented than they are focused on measuring health, well-being, or functional status of waiver participants.[155]

Similar to the PDCA model, CMS has adapted a continuous quality improvement cycle to HCBS program management; as illustrated in Figure 6.13 below.

Figure 6.13 CMS's Continuous Quality Improvement Cycle to Monitor Compliance with Waiver Assurances[156]



CMS requires states to establish quality assurance systems to meet assurances for their HCBS waivers, and states must develop and measure performance indicators in a series of CMS-defined areas and establish a quality assurance system to do so for each HCBS waiver. CMS also conveys an expectation that, when waivers are managed and monitored similarly, that discovery and improvement activities are the same, and that the state will achieve some administrative efficiencies by consolidating quality improvement activities. CMS stipulates that a state's continuous quality improvement process must consist of:

- **Discovery:** monitoring and data collection activities that identify whether and to what

[155] State Health Access Data Assistance Center. Quality Measurement for Home and Community Based Services (HCBS) and Behavioral Health in Medicaid. December 2016. Available at: https://www.macpac.gov/wp-content/uploads/2017/06/Quality-Measurement-for-HCBS-and-Behavioral-Health-in-Medicaid.pdf
[156] CMS. Modifications to Quality Measures and Reporting in §1915(c) Home and Community-Based Waivers. March 12, 2014. Available at: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/downloads/3-cmcs-quality-memo-narrative.pdf

extent the state addresses compliance with the assurances

- **Remediation:** activities designed to correct identified problems at the individual, provider, or system level
- **Improvement:** a state must implement a QIP when the performance indicator falls below a threshold of 86 percent, unless the state provides justification accepted by CMS that a QIP is not necessary

CMS also requires states to submit an evidentiary report on all waiver performance measures approximately 18 months prior to the waiver renewal date.

While this CMS-mandated process does, in many regards, mirror the continuous quality improvement cycle illustrated in Figure 6.13 and discussed above, CMS applies this framework to assure that states are complying with waiver assurances, and actively remediating any noncompliance issues with waiver assurances. State adoption of this CMS framework is necessary, but it is not sufficient to achieve robust continuous quality improvement culture and infrastructure. Similarly, adoption of the CMS framework is not enough to achieve program goals related to outcomes and participant experience that exceed those reflected in the waiver assurances.

Anticipated Actions Related to this Recommendation

Should the Cabinet elect to implement this recommendation, they would put in place a comprehensive QIS that would drive cultural and operational change within the Cabinet, as well as in the way the Cabinet interacts with external stakeholders. The Cabinet's quality management activities would focus on systems improvement as opposed to solely on compliance. Ultimately, these quality management activities would improve the participant experience through improved quality of care and quality of life.

The Cabinet should conduct the steps indicated below to develop the HCBS QIS. While undertaking these steps, the Cabinet should engage stakeholders to aid in identifying gaps, establishing goals, and designing and implementing interventions. The process should be transparent, and all key documents should be published online as soon as possible after they are finalized. The steps are:

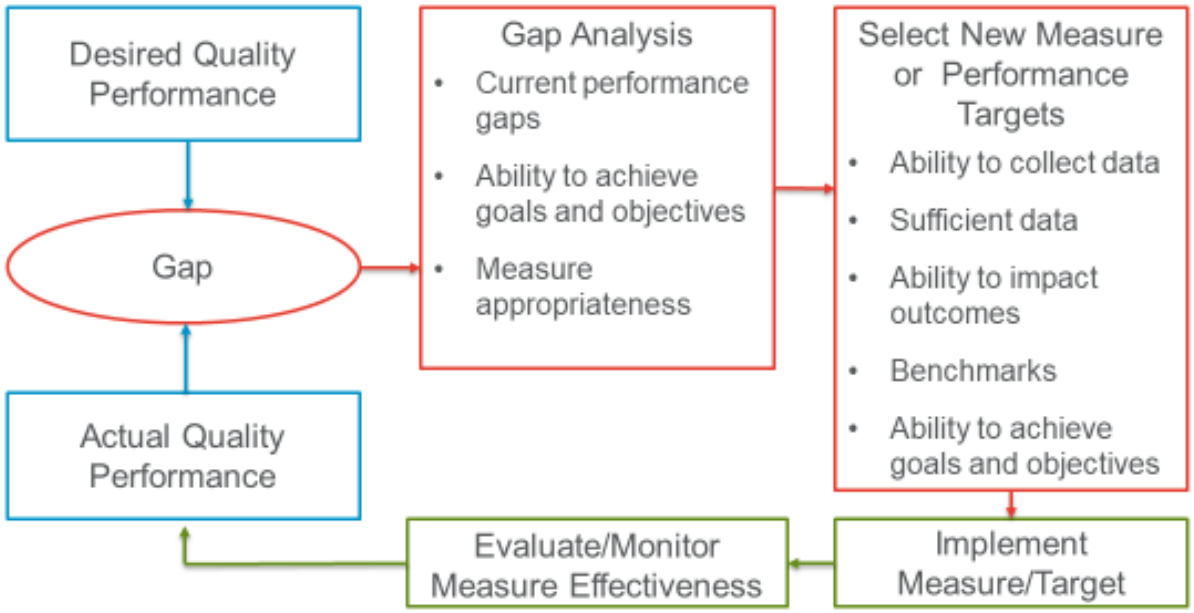
- Assess the current delivery system, service utilization patterns, and other available data points that are currently tracked (e.g., performance measures listed in the AARP LTSS Scorecard) to identify gaps
- Evaluate gaps to determine which can be closed or narrowed through effective interventions
- Select limited (up to three) areas of focus and establish measurable goals along with quality measures the Cabinet would use to track performance and progress in achieving those goals
- Determine cost and feasibility of collecting data and calculating identified performance

measures

- Update waiver applications, if necessary, to reflect new quality initiatives or updates to the waiver performance measures
- Update applicable information systems and create new policies and procedures to collect identified performance measures
- As appropriate, submit a draft QIS to CMS, then revise the draft as needed after receiving feedback from CMS
- Design interventions to close identified gaps and achieve goals
- Plan for and then implement the interventions to drive desired performance improvements
- Establish feedback loops to share performance data with sister operating agencies, providers, and other stakeholders as needed, to implement and maintain interventions and achieve established goals
- Continuously measure performance and modify interventions as needed to achieve established goals
- Report results publicly on a routine schedule (e.g., annually, quarterly)

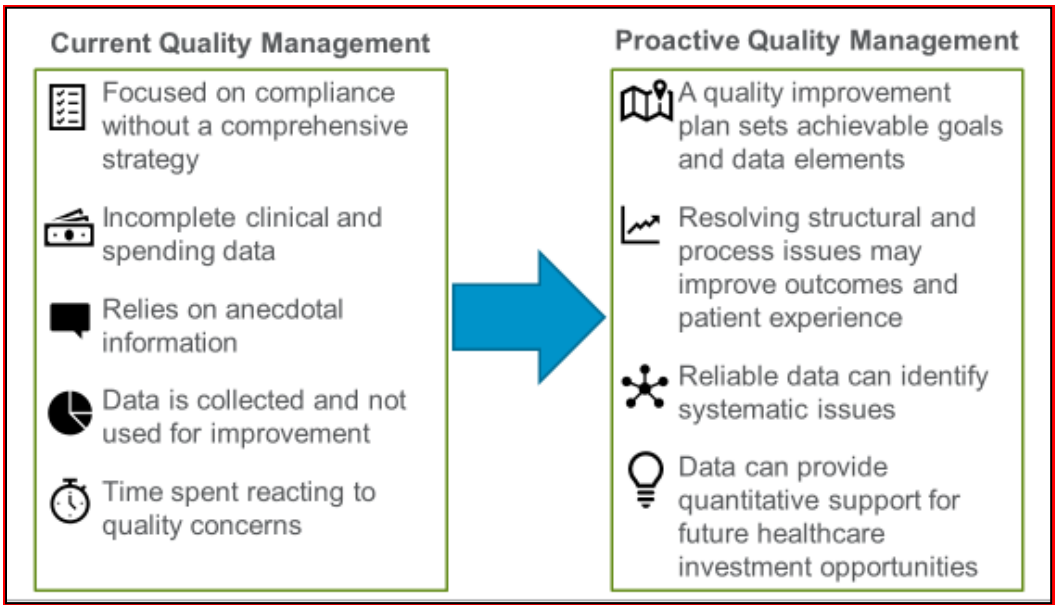
This approach is illustrated in Figure 6.14 and its successful implementation would require cultural change within and outside the Cabinet. It would also require sufficient resourcing of data analytics staff and tools, as well as experts and stakeholders who are well positioned to staff and advise the Cabinet in identifying gaps, designing interventions, and interpreting results. The end goal is that the Cabinet would be well-positioned to proactively use data to observe the HCBS programs in real time and, through implementation of the QIS, to anticipate and positively influence the future of the programs.

Figure 6.14 Recommended Approach to Developing and Maintaining a Sustainable QIS



In summary, Figure 6.15 illustrates how the Cabinet's current approach to quality management differs from the recommended proactive approach to quality management.

Figure 6.15 Kentucky's Current Approach to Quality Management Versus a Proactive Approach to Quality Management



Highlighted Cabinet Decisions to Proceed with this Recommendation

Should the Cabinet implement this recommendation, the Cabinet would need to address the following strategic or operational considerations:

- How are the current waiver programs performing, and what gaps in quality or access exist?
- What focus areas and measures would the Cabinet select?
- With what frequency would the Cabinet measure performance?
- What performance measures are tracked and reported today?
- What means would the Cabinet use to create transparency (e.g., dashboards, public reports)?
- If the Cabinet elects to implement value-based payment for HCBS services, to what measures would it tie the value-based payments?
- What resources (e.g., data) would be necessary for the Cabinet to successfully implement the QIS?

Future Stakeholder Input Related to the Recommendation

A disciplined approach to quality improvement, like that outlined above, would be new for all stakeholders. As such, stakeholder engagement should be extensive and take a variety of forms, such as:

- Improving Cabinet directed transparency through routine public reporting about service use, spending, and other baseline performance under the current waiver configuration
- Seeking stakeholder input regarding current performance gaps or focus areas where quality improvement is needed and would help improve participant care and/or quality of life
- Engaging stakeholders in designing interventions that more aptly address selected performance gaps
- Engaging stakeholders through other established outreach (e.g., town halls, email comment box, etc.) to address QIS initiatives and solicit relevant feedback
- Briefing legislators and their staff regarding performance on QIS initiatives and anticipated barriers, should they exist

As indicated in Recommendation 9, the Cabinet should also consider how it could rely upon existing advisory groups (such as the MAC and TACs) or specially convened, short-term advisory panels to provide insights and advice on technical and design issues.

Recommendation 11 – Conduct a future assessment of the need for waiver reconfiguration, once aforementioned recommendations are implemented and

reviewed for effectiveness.

Recommendation 11 is part of the "*future plans, remodel and additions"* to the "Home" for Home and Community-Based Services. The first ten recommendations address areas for improvement in design, administration, and operation of the existing 1915(c) waivers and do not suggest any change to the number of waivers or the populations served. Navigant's final recommendation in this report focuses on making future plans to improve the waiver programs. Navigant recognizes that it would be premature to recommend waiver design and configuration innovations without first addressing the foundation upon which DMS has built its HCBS program. Navigant recommends Kentucky invest in improvements in the administration, oversight, and operations of today's 1915(c) waivers before considering innovative reforms that may put additional stress on the delivery system. The eleventh recommendation is to conduct an assessment in the future to determine whether a change in the number or types of waivers might be warranted. Navigant refers to this as waiver reconfiguration.

Recommendation: Conduct a future assessment of the need for waiver reconfiguration, once aforementioned recommendations are implemented and reviewed for effectiveness.

Recommendation Description: Navigant recommends that the Cabinet conduct future analysis of the Commonwealth's waiver configuration. Navigant recommends the Cabinet first implement Recommendations 1 through 10, which are referred to as the Phase I recommendations. Upon completion of Phase I recommendation implementation, the Cabinet should initiate work on the Phase II recommendation.

Phase II would employ a Kepner-Tregoe Model analysis, a systematic method to problem solving and decision-making that allows decision makers to objectively consider multiple options to achieve the goals set forth earlier in this report. This systematic approach would determine the reconfiguration options most likely to achieve redesign goals while considering the unintended negative outcomes and minimizing risk. The approach and options considered would be discussed in a Phase II Assessment Report.

In Chapter 7: *Next Steps*, Figure 7.1 illustrates Navigant's recommended two-phased approach to implementing the recommendations. Navigant recommends the Cabinet complete implementation of the Phase I recommendations by approximately December 2019, so the Cabinet can initiate Phase II in early 2020 with the assessment of HCBS waiver reconfiguration options.

Recommendation Rationale: Navigant's rationale for Recommendation 11 is based on several factors outlined below:

- Kentucky has never conducted a comprehensive assessment of its current HCBS waiver configuration so does not have the information necessary to determine whether the current configuration is well-suited to achieve the Commonwealth's goals for its HCBS program.
- An assessment of the optimal configuration of HCBS waivers would be conducted using more readily accessible and available HCBS waiver program data, reflective of programs with improved operations to better evaluate factors that drive participant outcomes influenced by waiver configuration.
- Allowing for time to improve existing programs helps to avoid implementing too much change at once, which could pose substantial risks to the program, its participants, and other stakeholders.

- An appropriately timed future assessment would allow for better focus and data collection related to potential eligibility and service enhancements for subpopulations in future waiver configuration.

Cabinet Goals Potentially Advanced by this Recommendation

- Enhance quality of care to participants
- Diversify and grow the provider network
- Curb preventable increases in total spend for HCBS programs
- Design services that address participants' community-based needs, including for populations who are under-served or not served by today's waivers

Expanded Rationale for Recommendation

Navigant is making this recommendation to help the Cabinet address challenges related to today's HCBS waiver configuration. The rationale for this recommendation is described below.

- **Kentucky has never conducted a comprehensive assessment of its current HCBS waiver configuration so does not have the information necessary to determine whether the current configuration is well-suited to achieve the Commonwealth's goals for its HCBS program.** As described in Recommendation 1, the Commonwealth's six HCBS waivers were developed separately over time to address the needs of specific groups of participants. These waivers were not part of a holistic strategy to design an HCBS program that would best meet the needs of Kentuckians who live with disabilities. Since the Cabinet has not comprehensively assessed the HCBS waiver programs, they do not know whether the waivers offer the most impactful menu of services, cover the people who have the greatest needs, or are configured to maximize operational efficiency and effectiveness. Furthermore, Federal regulations afford the Cabinet substantial flexibility to define the populations and services covered under the HCBS program.
- **An assessment of the optimal configuration of HCBS waivers would be conducted using more readily accessible and available HCBS waiver program data, reflective of programs with improved operations to better evaluate factors that drive participant outcomes influenced by waiver configuration.** Much of the data necessary to evaluate the current waiver program configuration (e.g., assessment data, Medicare claims data for waiver participants who are dually eligible for Medicare and Medicaid) are not readily available today. Furthermore, any evaluation using data that is readily available today would lead to conclusions about historical performance of the waivers and would not reflect the improvements anticipated to result from implementation of the Phase I recommendations. After implementing the ten Phase I recommendations, the Cabinet would be better positioned to evaluate innovations using more readily available data. For example, several Phase I recommendations, including introducing standardized methods for participant assessment, individualized budgeting, and HCBS rate setting, would equip DMS leadership with improved data and

information. Also, the Cabinet would be able to better assess the likely impact of any waiver reconfiguration, as reconfiguration would potentially entail significant change for stakeholders and the Cabinet. Employing the recommended two-phased approach would enable the Commonwealth to better assess the current waivers – when they are operating more efficiently and effectively and when better data are available -- before considering changes to the number, or configuration, of the waivers.

- **Allowing for time to improve existing programs helps to avoid implementing too much change at once, which could pose substantial risks to the program, its participants, and other stakeholders.** Through Navigant's work in other states, Navigant has observed that innovative ideas and large system changes are more successful when the delivery system is equipped to seamlessly transition from present state to future reforms. Such transitions are more likely to be seamless when reforms are built atop a stable foundation and system infrastructure. Phasing-in changes should support long-term success in improving HCBS waiver programs and quality of services.
- **An appropriately timed future assessment would allow for better focus and data collection related to potential eligibility and service enhancements for subpopulations in future waiver configuration**. Despite the wide range of participant needs that are served through the Commonwealth's HCBS waivers, stakeholders expressed a need for waivers to serve additional subgroups and cover different services. For example, during the Fall 2017 focus groups and the Spring 2018 public comment period, stakeholders voiced frustration with waiver waiting lists, expressed concern that some of the waiver participants' needs were not well addressed by the menu of services in their waivers, and expressed the hope for an Autism-specific 1915(c) waiver. Stakeholders also expressed interest in a waiver targeting populations with Serious Mental Illness (SMI), a population that may be underserved in the Commonwealth today. To date, these populations have not been thoroughly considered due to the amount of resources dedicated to assessing the current waiver configuration and performance.

The Commonwealth should approach and implement waiver configuration in a manner that allows the Commonwealth to achieve the desired results, rather than simply achieving few results quickly (but perhaps not the desired results). Recommendation 11 offers the Cabinet the opportunity to ultimately to assess whether waiver reconfiguration is in the best interest of all stakeholders, especially participants.

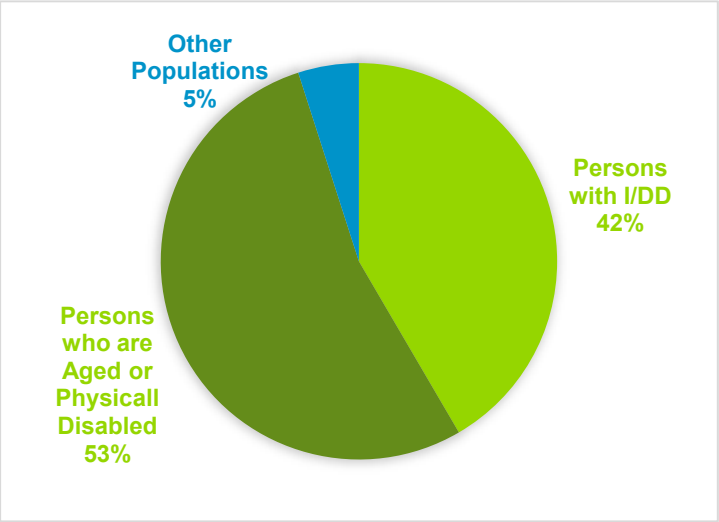
Related National Trends and Best Practices

All 50 states and the District of Columbia administer at least one 1915(c) waiver. States have control over the number of waivers and target populations their 1915(c) waivers serve. The number of 1915(c) waivers offered by states ranges from one to 11, depending on the number of populations targeted.[157] The target populations vary widely state to state depending on each

[157] Kaiser Family Foundation. Medicaid Home and Community-Based Services: Results From a 50-State Survey of Enrollment, Spending, and Program Policies. 2018. Available at: https://www.kff.org/report-section/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies-report/

state's population's needs. Over half of 1915(c) waiver participants are seniors and/or nonelderly adults with physical disabilities. The second largest group comprises individuals with intellectual or developmental disabilities. The smallest target populations include children who are medically fragile or technology dependent, people who have mental health disabilities, people with HIV/AIDS and people with traumatic brain injury (TBI) as shown in Figure 6.16.

Figure 6.16 Medicaid 1915(c) Waiver Enrollment by Target Population, 2014[158]



States frequently reconfigure their 1915(c) waivers by developing, amending, and consolidating their 1915(c) waiver programs or moving HCBS under another Medicaid authority. According to a 2018 Kaiser Family Foundation report, 16 states plan to consolidate multiple 1915(c) waivers or move HCBS to another Medicaid authority, including 1115 waivers and state plan authority. States most often pursue these reforms for children with I/DD (ten states) and adults with I/DD (seven states). Three states, Michigan, New York, and Virginia, are planning to consolidate 1915(c) waivers into a single 1115 waiver, while other states are moving certain services from 1915(c) waiver authority to State Plan authority. For example, South Carolina and Utah are phasing out their 1915(c) waivers for children with autism and instead offering those services under their Medicaid State Plan[159].

States are also considering 1915(c) waiver redesign in a constantly evolving HCBS policy environment. The implementation of CMS' HCBS Settings Rule and Department of Labor direct care worker minimum wage and overtime rules have required states to update their policies and regulations to come into compliance with these federal requirements. Additionally, states have more redesign options at their disposal than ever before, including 1915(i) HCBS State Plan Option and 1915(k) Community First Choice Option that can impact waiver configuration and services. Likewise, some states are turning to managed care programs to deliver and managed HCBS. All these options can provide more flexibility to states, but all introduce trade-offs for states and their stakeholders. This wide range of choices also has the potential to cause choice

[158] Kaiser Family Foundation. Medicaid Home and Community-Based Services: Results From a 50-State Survey of Enrollment, Spending, and Program Policies. 2018. Available at: https://www.kff.org/report-section/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies-report/
[159] Kaiser Family Foundation. Medicaid Home and Community-Based Services: Results From a 50-State Survey of Enrollment, Spending, and Program Policies. 2018. Available at: https://www.kff.org/report-section/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies-report/

fatigue, when too many options hinder a state's ability to make a decision.

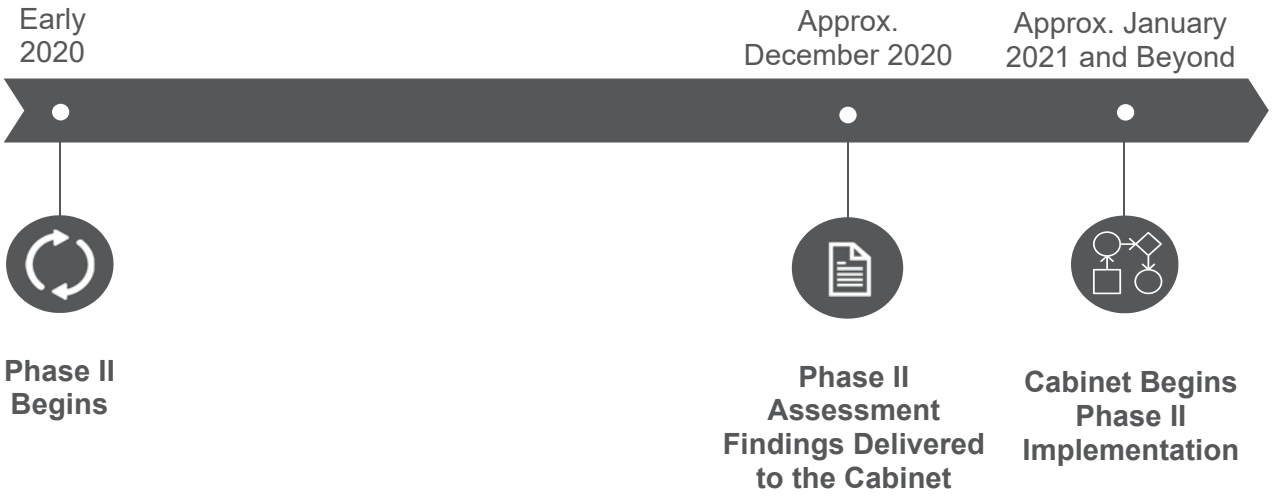
Anticipated Actions Related to this Recommendation

Should the Cabinet elect to implement this recommendation, they would be leaving the current waiver configuration intact until the Phase II assessment process is complete. In other words, between now and 2021, the Cabinet would *not* be:

- Increasing the number of waivers or adding new waivers
- Decreasing the number of waivers or eliminating existing waivers
- Consolidating waivers into a "super-waiver" or any other merged waiver

Should the Cabinet elect to proceed with Recommendation 11, Navigant recommends that the Cabinet initiate the waiver reconfiguration study in early 2020 and that the study be completed by approximately December 2020. This timeline is reflected in Figure 6.17. Important to consider is that implementation of the Phase I recommendations may extend through most or all of 2019. In such a case, only limited data may be available to assess the current waiver configuration post-Phase I recommendation implementation. Likewise, internal and external stakeholders may have had limited experience with the changes from the Phase I recommendations about which to provide feedback. Thus, the Cabinet should carefully consider the timing of this Phase II assessment when they determine whether and how they will be implementing the Phase I recommendations.

Figure 6.17 Recommended Timelines for Conducting Phase II Activities



Given Navigant's prior experience with waiver reconfiguration in other states and the Commonwealth's experience with Kentucky's 1915(c) waiver redesign process to date, Navigant recommends Phase II involve the activities listed below.

- Conduct national scan and best practice research for 1915(c) waiver design
- Conduct detailed claims, utilization, and financial analysis and stakeholder engagement

process to:

  - Evaluate waiver program performance overall
  - Identify unserved and underserved populations
  - Target service allocation and the ability of services to meet community-based needs
  - Identify gaps in access and quality under the existing 1915(c) waivers after implementation of Phase I recommendations

- Identify reconfiguration options and evaluate waiver reconfiguration options including but not limited to:
  - Using the Kepner-Tregoe Model of analysis in which options are systematically evaluated relative to program redesign goals to maximize success and minimize risk
  - Considering impact of reconfiguration options on federal funding and considering options for which enhanced federal funds might be available
  - Modeling the anticipated impact of waiver configuration options on waiver enrollment, service use, and resulting budget and fiscal implications for DMS and its sister agencies
- Conduct discussions with CMS to inform them about the assessment process and to seek CMS advice regarding national best practices and federal requirements
- Develop preliminary recommendations for 1915(c) waiver reconfiguration and publish report for public consumption
- Conduct stakeholder engagement process to gather feedback regarding preliminary recommendations from full range of stakeholders using a variety of approaches, considering those outlined under the “Future Stakeholder Input” subheading below
- Issue final report and recommendations, also for public consumption

The above listing of activities is not exhaustive but offers the Cabinet an overview of the key tasks required to complete implementation of Phase II and is consistent with the approach the Commonwealth employed during Phase I.

Should the Cabinet elect to reconfigure its HCBS waivers, they would need to undertake further actions not detailed in the list above. These actions might include: notifying all stakeholders of the Cabinet’s decision, modifying waiver applications, conducting a formal public input process that complies with CMS’s requirements for waiver modification (in accordance with *42 CFR 441.304(f)*), conducting further stakeholder engagement activities, and updating KAR and manuals, among other actions.

Finally, the Cabinet will also need to consider the appropriate delivery model for future delivery of the existing waiver configuration or a reconfigured set of waivers. The Commonwealth’s HCBS waiver programs are currently operated using a fee-for-service (FFS) framework. Several

populations, including HCBS waiver participants are excluded from the managed care approach used in other parts of Kentucky's Medicaid program. As discussed in earlier chapters, managed long-term services and supports (MLTSS) models are increase nationwide, and may offer an Cabinet tools and method not available in FFS, to continue driving program outcomes while continuing the momentum of system improvements completed during Phase I. However, Navigant would caution that MLTSS takes considerable time and resources, along with strategic planning, which must include all stakeholders. The Cabinet will need to continue considering available staff and budget resources as they consider future changes, including changing delivery models. Navigant's experience with other states has shown that it benefits the state to stabilize its fee-for-service programs before making a significant change to a new delivery system. Thus, Navigant agrees with the Cabinet's stance as expressed during the assessment that it will take considerable time and system improvement before MLTSS becomes a palatable option for the Commonwealth, as they consider all available program models and waiver authorities at their disposal.

Highlighted Cabinet Decisions to Proceed with this Recommendation

Should the Cabinet implement this recommendation, the Cabinet would need to address the following strategic or operational considerations:

- Is available data and information sufficient to evaluate the effectiveness of the current waiver configuration post-implementation of Phase I recommendations? And to model projected impact of waiver reconfiguration options? If so, how are Kentucky's existing waivers performing after implementation of Phase I recommendations selected by the Cabinet?
- What are the Cabinet's goals for the HCBS waiver programs in 2020 and future years?
- Will a reconfiguration need to be budget neutral, or will budget and other resources be sufficient to allow for increased spend for HCBS?
- Which waiver program configuration options would be considered during the assessment, and what service menu and populations would be covered under each configuration option?
- How does the Cabinet anticipate the new waiver configuration would impact waiver program participation by participants and by providers, as well as participant service use and spending?
- When would any waiver reconfiguration be implemented, and would the transition to the new configuration be phased in over time? Will a future implementation be conducted using the existing fee-for-service method, or will a managed care approach be used?
- Will the HCBS waiver programs be reconfigured based upon the findings set forth in the waiver reconfiguration assessment?

Future Stakeholder Input

Stakeholder engagement during Phase II will resemble the stakeholder engagement activities leading up to and throughout Phase I. Phase II is anticipated to draw the same, or more, stakeholder interest and involvement as Phase I. Therefore, the Cabinet should continue to make efforts to be as transparent as possible, invest in stakeholder engagement, and offer several opportunities and mechanisms for external stakeholders to provide feedback. As such, stakeholder engagement should be extensive and take a variety of forms, such as but not necessarily limited to:

- Public reporting by the Cabinet about service use, spending, and other performance under the current waiver configuration
- Opportunities for all stakeholders to suggest possible waiver configuration options for consideration
- Public release of preliminary recommendations, as well as final assessment report
- Town halls or other public meetings where external stakeholders can comment on preliminary Phase II recommendations
- Email comment box to which stakeholders can submit comments at any time during or leading up to the Phase II assessment process
- Reliance on existing advisory groups (such as MAC and TACs) or specially convened, time-limited external stakeholder advisory panels to provide insights and advice on technical and design issues
- Legislative briefings to educate legislators and their staff regarding stakeholder input received, along with related federal requirements, waiver configuration options, and the benefits and risks of the various options

Chapter 7: Next Steps

This chapter outlines next steps the Cabinet should take to determine whether and how they would implement the recommendations set forth in Chapter 7. The next steps outlined below do not fully account for Cabinet activities unrelated to the 1915(c) waivers. Thus, the Cabinet should consider these recommended next steps in the broader context of other Cabinet initiatives (such as the 1115 waiver implementation) and the impacts those initiatives would have on participants and their caregivers and natural supports, on providers, on Cabinet staff and vendors, and on other stakeholders.

7.1 Immediate Action Steps for the Cabinet

Navigant recommends that the Cabinet undertake the following steps upon receipt of this report:

1. Determine if, and how to act upon Navigant's recommendations. For each of Navigant's eleven recommendations, the Cabinet has three options:
   i) Accept the recommendation in its entirety, as proposed by Navigant;
   ii) Accept the recommendation with the Cabinet's modifications (e.g., implement a recommendation only for a particular subpopulation, phase the implementation over time, etc.); or
   iii) Reject the recommendation in its entirety.
2. Prioritize accepted recommendations, if Cabinet resources are limited and do not allow for adoption of all recommendations in the near-term.
3. Determine the timeline for implementation of each accepted recommendation, considering carefully the sequencing of and interdependencies of implementation activities, including those samples outlined in Figure 7.2.
4. Notify stakeholders of the Cabinet's decisions using a variety of communication and stakeholder engagement strategies so that internal and external stakeholder groups are made aware of the Cabinet's decisions.
5. Develop a detailed workplan to manage the implementation activities.
6. Initiate implementation activities in accordance with above-mentioned workplan.
7. Identify performance metrics to benchmark the Cabinet's progress regarding each recommendation. (e.g., number of SOPs the Cabinet intends to implement, anticipated participation in stakeholder engagement activities, etc.).

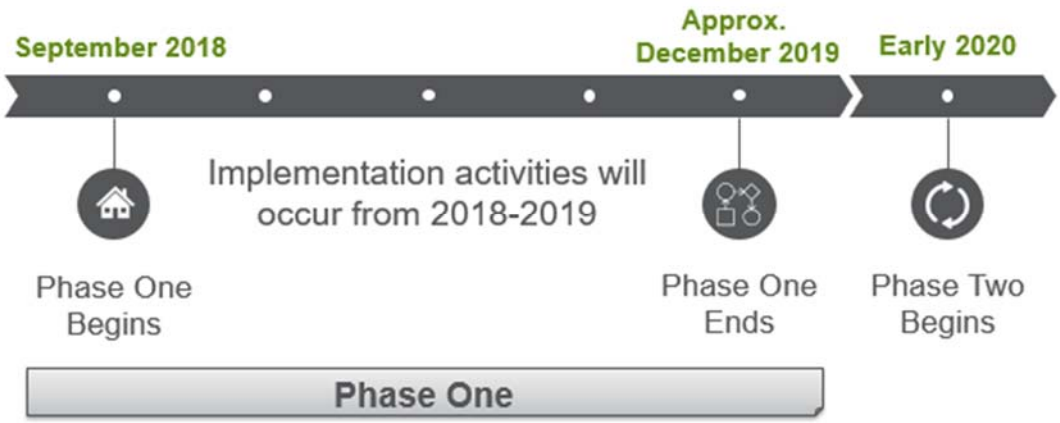
7.2 Sequencing and Timing Considerations Related to Phase I and Phase II Recommendations

Navigant recommends the Cabinet first implement Recommendations 1 through 10, which are referred to as the Phase I recommendations. These Phase I recommendations address areas

for improvement in design, administration, and operation of the existing 1915(c) waivers and does not suggest any change to the number of waivers or the populations served.

Upon completing implementation of selected Phase I recommendations, the Cabinet should then consider initiating Phase II to assess the need for waiver reconfiguration. Figure 7.1 illustrates a proposed timeline for this recommended two-phased approach to implement Navigant's recommendations. Navigant proposes the Cabinet complete implementation of selected Phase I recommendations by approximately December 2019, so the Cabinet can initiate Phase II in early 2020. The Cabinet may have competing priorities and resource constraints that pose challenges to implementing all ten Phase I recommendations within the timeline proposed. As such, the Cabinet should carefully consider which recommendations are most feasible to complete and will have the greatest impact on their goals, as outlined in Chapter 1.2: *Assessment Goals*.

Figure 7.1. Two-Phased Approach for Implementation of Phase I and Phase II Recommendations



Implementation Considerations for Phase I Recommendations

Whether the Cabinet accepts all ten Phase I recommendations, or a subset of the recommendations, the Cabinet must carefully sequence implementation in way that recognizes the interdependencies that exist among recommended changes. For example:

- Many Phase I activities will need to be documented in waiver applications that must be submitted to CMS for review and approval, which may take up to six months for approval.
- Development of a universal assessment tool would impact the development of the individualized budgeting methodology.
- Changes to payment and rate methodology would impact the development of an individualized budgeting methodology reflective of utilization costs.
- Improved functional assessment data obtained via electronic storage would help inform the selection of quality improvement strategy measures and would vastly improve the

Cabinet's ability to measure outcomes.

This is only a small sample of identified inter-dependencies that will need to be considered by the Cabinet when selecting Phase I recommendations for improvement and planning a coordinated implementation. Many recommendations are interdependent, and the Cabinet will need to consider whether any recommendations partially implemented or not selected, may in turn influence the ability to advance those recommendations that are selected.

Navigant recognizes there are existing resource constraints within the Cabinet and specifically DMS, which is actively undertaking additional initiatives outside of improving 1915(c) waiver programs. These initiatives include work related to implementing the 1115 Kentucky Health waiver program, updating DMS' Medicaid Management Information Systems (MMIS), all while managing the demands of day-to-day operations on existing staff and program resources. Given these constraints, the Cabinet can modify the extent to which it implements recommendations, including a longer timeline with phased improvements, or piloting significant changes on a smaller, more focused scale as needed to promote success with whatever changes are selected for implementation going forward.

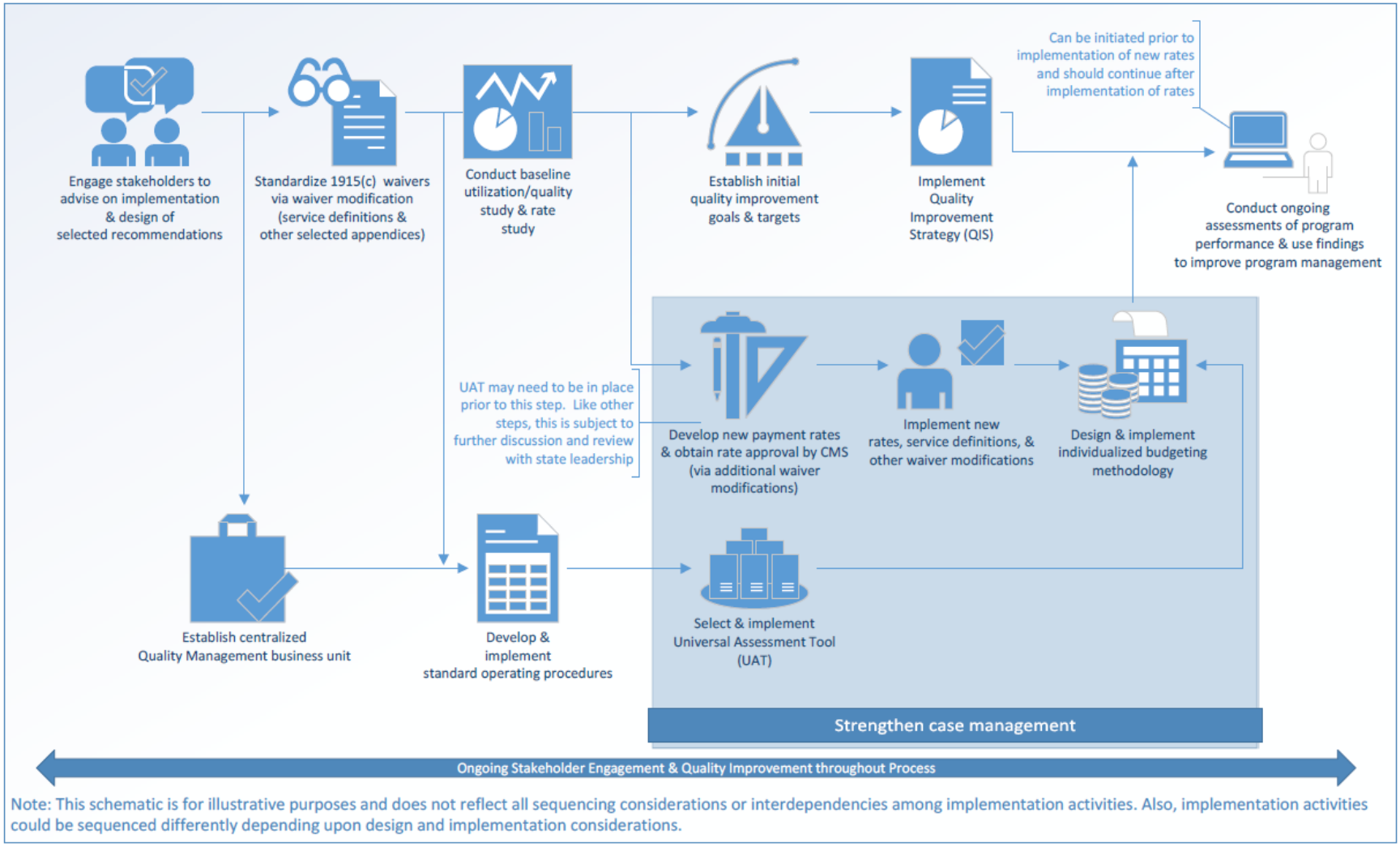
Navigant would highlight certain recommendation components that offer early opportunities for improvement that can be feasibly implemented with minimal interdependency, including:

- Standardizing terms and definitions within 1915(c) waivers, and training internal and external stakeholders on updated terms, definitions and new more consistent approaches across waivers.
- Centralizing quality management of current program operations to better align responsibilities across DMS, DAIL and DBHDID using standard operating procedures to ease operational processes and overall organization.
- Updating quality management practices across services and waivers related to annual certification, desk reviews, critical incident investigation and the development, issuance and monitoring of corrective action plans all monitored using defined performance standards that can be shared with internal staff, Cabinet leadership and the Legislature to monitor operational outcomes.
- Optimizing case management by improving Cabinet oversight of person-centered tools and templates, while offering improved technical assistance and training to case management providers.
- Clarifying PDS-related policy and implementing new PDS tools and participant supports to improve the PDS delivery model
- Completing a study to develop a rate methodology informed by providers' reported costs.
- Begin the process of incorporating ongoing quality improvement processes into the Cabinet's management and oversight approach.

- Enhancing stakeholder engagement practices through a thoughtful engagement strategy to obtain meaningful stakeholder input into program design and decision-making.

To guide sequencing efforts, Figure 7.2 illustrates some of the key sequencing considerations and interdependencies among the recommended Phase I implementation activities.

Figure 7.2. Key Sequencing Considerations for Implementation of Phase I Recommendations



Note: This schematic is for illustrative purposes and does not reflect all sequencing considerations or interdependencies among implementation activities. Also, implementation activities could be sequenced differently depending upon design and implementation considerations.

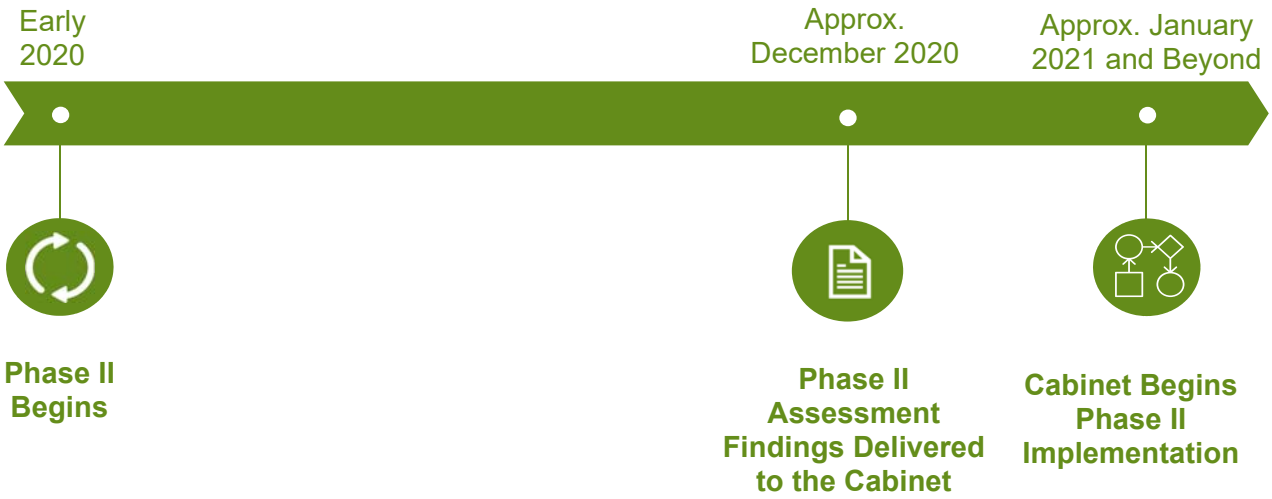
To assist the Cabinet in understanding related implementation activities for each recommendation, Appendix G includes a listing of key implementation activities involved for each of the Phase I recommendations. This listing of activities is not exhaustive but offers the Cabinet an overview of some of the key tasks required to complete implementation. As the Cabinet develops its implementation workplan, it should carefully consider Figure 7.2 and Appendix G.

Upon implementation of Phase I recommendations, the Cabinet must identify performance metrics to determine the success of progress towards each recommendation (e.g., number of SOPs the Cabinet intends to implement, anticipated participation in stakeholder engagement activities, etc.). Identifying such metrics will enable the Cabinet to track continued progress and course correct, where appropriate.

Implementation Considerations for Phase II Recommendations

Should the Cabinet elect to proceed with Recommendation 11, Navigant recommends that the Cabinet initiate the waiver reconfiguration study in 2020, following the implementation of Phase I improvements, completing the study within that calendar year, ending approximately in December 2020. This proposed timeline is reflected in Figure 7.3.

Figure 7.3. Recommended Timelines for Conducting Phase II Activities



Given Navigant's prior experience with waiver reconfiguration in other states and the Commonwealth's experience with the 1915(c) waiver redesign process to date, Navigant recommends conduct of Phase II involve the activities listed below.

- Conduct national scan and best practice research for 1915(c) waiver design
- Conduct detailed claims, utilization and financial analysis and stakeholder engagement process to evaluate performance of existing 1915(c) waivers after implementation of Phase I recommendations
- Identify delivery system design and evaluate waiver reconfiguration options

- Conduct discussions with CMS
- Develop preliminary recommendations for 1915(c) waiver reconfiguration
- Conduct stakeholder engagement process to gather feedback regarding preliminary recommendations
- Issue final assessment report and recommendations

The above listing of activities is not exhaustive but offers the Cabinet an overview of the key tasks required to complete implementation of Phase II and is consistent with the approach the Commonwealth applied in conducting the Phase I assessment. See Recommendation 11 for additional activities for DMS consideration as part of Phase II.

Appendix A

1915(c) Home and Community-Based Services Waiver Project - *Internal Structure and Administration Assessment*

Commonwealth of Kentucky
Cabinet for Health and Family Services

Summary of Key Interview Themes

Based on Interviews with Cabinet Staff

August 15, 2017

Preliminary Draft – For Discussion Purposes Only

navigant.com/healthcare

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Table of Contents

1 Introduction 2
1.1 Overview of Report 2
1.2 Summary of 1915(c) HCBS Waiver Project 2
1.3 Interview Methodology 4
2 Key Interview Themes 5
2.1 Internal Communication 7
2.2 Coordination Between Departments 8
2.3 Provider Communication 9
2.4 Policy Regulations 10
2.5 Crisis Escalation 11
2.6 Participant Education 13
2.7 Technology 14
2.8 Operating Procedures 15
2.9 Internal Training 15
2.10 Staffing Resources 16
2.11 Prior Authorization 17
2.12 Participant Directed Services 18
2.13 Quality 19
3 Conclusion 20

1 Introduction

1.1 Overview of Report

In April 2017, the Commonwealth of Kentucky Department of Medicaid Services (DMS) contracted with Navigant Consulting Inc. (Navigant) to assess the potential for operational efficiencies and cost containment within Kentucky's 1915(c) waivers. For the initial phase of the project, Navigant will complete two evaluations to inform the solutions assessment:

1. Internal Structure and Administration Assessment
2. 1915(c) Waiver Assessment

To begin the *Internal Structure and Administration Assessment,* Navigant conducted interviews with leadership and program staff within multiple departments of the Commonwealth of Kentucky Cabinet for Health and Family Services (the Cabinet). The intent of the interviews was to learn about the 1915(c) home and community-based services waiver (HCBS Waiver) programs, their goals, internal operations and opportunities for improvement.

In this report, we summarize the key themes that we identified during the interview process. We defined "key themes" as recurring items noted by multiple interviewees, representing strengths and items that pose significant risks to regulatory compliance and/or service delivery to the HCBS population. Navigant will use these themes as a foundation for our recommendations to improve operational efficiency and cost containment within Kentucky's HCBS Waivers.

1.2 Summary of 1915(c) HCBS Waiver Project

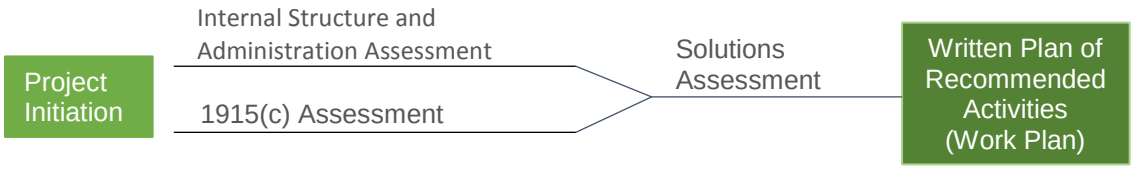
The Commonwealth requested that Navigant assess the state's six 1915(c) waivers in a two-phase approach. In the first phase, Navigant will evaluate the HCBS waiver programs and the subsequent phase will be to assist DMS to implement recommendations based on the assessment. For the first phase of the 1915(c) HCBS Waiver Project, we will complete two evaluations as follows:

- *Conduct Internal Structure and Administration Assessment of the State's HCBS Waiver programs:* Navigant will review the operational processes within the Cabinet for Health and Family Services (the Cabinet) for administering the waivers to identify areas for refinement

- *Assess the 1915(c) HCBS Waiver Programs for redesign*: Navigant will review the current HCBS waivers in Kentucky and evaluate the options for redesign of the programs to meet the Cabinet's goals

These assessments will be used to inform the solutions assessment and the activities we recommend for implementation in the second phase of the project as demonstrated in Figure 1 below.

Figure 1. Overview of Phase I of 1915(c) HCBS Waiver Project

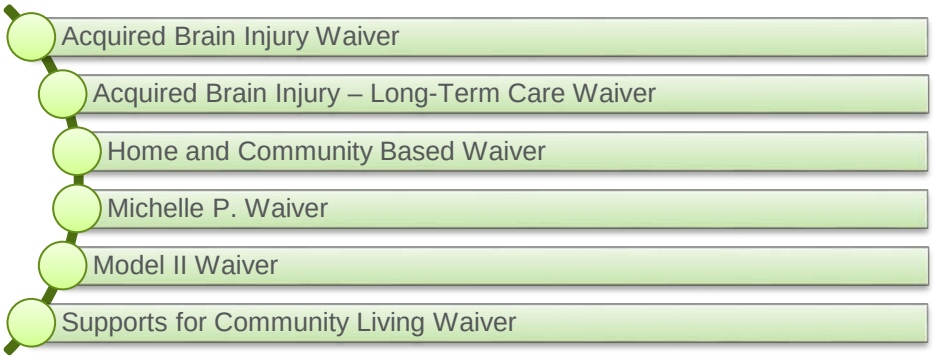


The interviews of staff across the Cabinet is one step in the *Internal Structure and Administration Assessment*, as Navigant continues to work with the Cabinet to assess and evaluate the HCBS Waiver programs for redesign. To identify and evaluate the operational processes for each waiver, we first conducted the interviews of Cabinet staff, as outlined and summarized in this report. Based on the information collected through the interviews, we will examine the work flows related to the administration and operation of HCBS services through each of the waivers to identify those for refinement or redesign. The themes we identified through the interviews are focused on the actionable steps the Cabinet can take to:

- Enhance inter-departmental coordination;
- Drive efficiency;
- Improve monitoring of service delivery; and
- Improve customer service to participants and providers.

Kentucky currently operates six 1915(c) HCBS Waivers as outlined in Figure 2 below.

Figure 2. Kentucky Current HCBS Waivers



The overall goal of the 1915(c) HCBS waiver project is to optimize the Kentucky waiver programs, eligibility processes, service offerings, and overall quality in care and service delivery. Through the internal structure assessment and HCBS waiver evaluation, we will work with the Cabinet and DMS to achieve these goals.

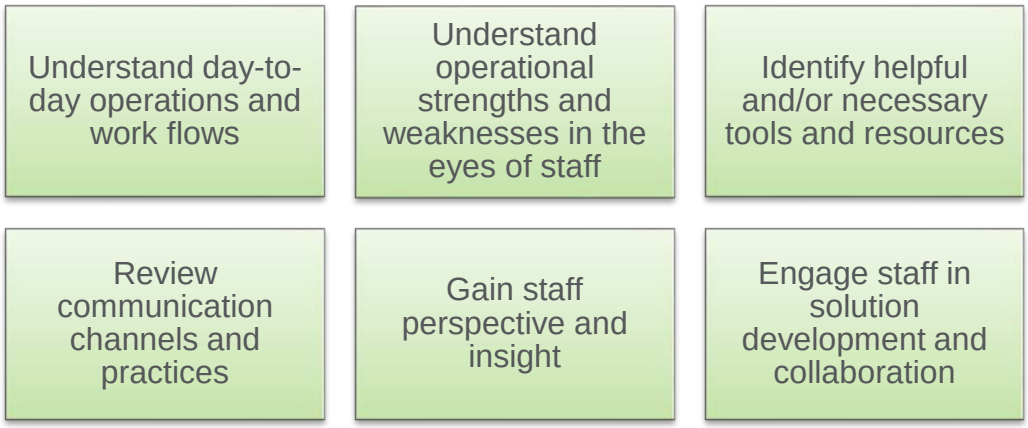
1.3 Interview Methodology

Navigant conducted over 30 interviews with staff from the following departments and organizations to collect and understand operational information and staff perspective related to Kentucky's HCBS Waivers:

- Department of Medicaid Services
- Department of Behavioral Health, Developmental Disabilities and Intellectual Disabilities (DBHDID)
- Department of Aging and Independent Living (DAIL)
- The Cabinet's Office of the Ombudsman
- Kentucky Protection and Advocacy

Navigant approached the interviews with six overarching goals, outlined in Figure 3, but tailored questions for each department or organization, to adequately assess the key HCBS Waiver-related processes. We conducted interviews in 90-minute increments where at least two Navigant consultants participated in each interview with one staff member. Prior to interviews, we sent the proposed questions to all interviewees so they may review and consider their responses. As a part of each interview, Navigant gained an understanding of each staff member's current roles and responsibilities and how the tasks fit his or her operational area.

Figure 3. Goals of Staff Interviews



We focused on the operations in the interviews to better understand daily operations of the waivers across agencies and departments. Some of the topics covered include:

- Standard operating procedures and current-state work flows
- Tools and technologies used or needed;
- Internal and external communication patterns;
- Staff training and development needs;
- Identified best practices and opportunities for improvement; and

- Goals for the future of HCBS Waivers and any redesign efforts.

To protect anonymity of interview participants and elicit honest feedback from staff, Navigant did not include individual staff comments in this report. This report does not reflect the views of each person interviewed, rather, it reflects Navigant's observed trends in feedback provided, and represents a culmination of the input across all interview participants. All interviewees were assured confidentiality prior to each interview.

2 Key Interview Findings

For the interviews with Cabinet staff, we focused on areas of opportunity, however, interviewees described several strengths and best practices, that they wish to see continue and/or sought to highlight as best practices that may benefit other departments or elements of HCBS administration. Some of these highlights include:

- DBHDID's Supports Intensity Scale (SIS) assessor team has been highly successful and the State's SIS assessment process has been nationally recognized.
- DMS recently obtained final approval of their Transition Plan from the Centers for Medicare and Medicaid Services (CMS), one of the earliest states to obtain this approval. The process to obtain approval included conducting successful stakeholder engagement efforts statewide that are considered advances in how the Cabinet engages with invested stakeholders.
- The deployment of the *College of Direct Supports* to direct care staff working within the Supports for Community Living Waiver has helped to disseminate required trainings throughout the State, allowing DBHDID to develop provider trainings and monitor delivery and compliance from central office.
- Conflict-free assessment has been successfully implemented in the Home-and Community-Based (HCB) Waiver, and has started to improve screening and eligibility practices for the waiver.
- The ABI branch has implemented a prioritization methodology for escalations that has helped to assign staff resources and organize incoming escalations.
- DMS staff, in partnership with CMS, successfully caught up several years of backlogged 372 reports, after completing training on reporting.
- DAIL has implemented standardized inquiry acknowledgements and response times for external inquiries, to improve customer service.
- The Cabinet has successfully managed several large-scale crises that included the closing of a significant provider, with successful transition of care for all impacted members using an all-hands approach to assist participants.

Interviewees demonstrated commitment to their assigned duties, and contributed many suggestions for ways to improve operations and administration of the State's 1915(c) waivers. The successes of the Cabinet are demonstrative of the team's ability to innovate and problem-solve. Continuing to encourage, promote, and share best practices will only serve to propel momentum and contribute to the future success of these programs.

Based on the interviews Navigant conducted, we identified 13 key themes for areas of opportunity, as displayed in Figure 4.

Figure 4. Overview of Key Interview Themes and Areas of Opportunity

Internal Communication	*Communicate more frequently and effectively with staff within Departments.*
Coordination Between Departments	*Define and streamline the inter-departmental efforts to optimize collaboration.*
Provider Communication	*Provide clear, concise and accurate guidance to providers*
Regulatory Compliance	*Streamline and consistently apply monitoring efforts.*
Crisis and Escalations	*Assign and improve coordinatation of roles and responsibilities for escalations*
Participant Education	*Provide easier access to information and issue resolution, to participants through enhanced program education.*
Technology	*Improve the use of technology to achieve efficiencies and improve operations.*
Operating Procedures	*Standardize and formally document procedures to improve operational integrity.*
Internal Training	*Provide further training and development to staff to sharpen their skills and knowledge on pertinent policies.*
Staffing Resources	*Evaluate the staffing level to determine if it is sufficient to accomplish the work required across departments.*
Prior Authorizations	*Refine the PA process to ensure it is not strictly oriented to the medical model.*
Participant Directed Services (PDS)	*Adjust PDS to ensure the program is participant-friendly, and free of fraud, waste or abuse.*
Quality	*Expand efforts to improve quality in service delivery and participant experience.*

In the following sections, we provide a description of each of the key themes along with the information we obtained through the interviews and the solutions suggested by staff related to each topic.

2.1 Internal Communication

Improve communication, both within departments and between departments.

Communication Within Departments (DAIL, DBHDID and DMS)

Interview Comments*:* Cabinet staff voiced concerns about lack of communication within and across departments. The inconsistent communication contributes to staff frustration, causing several undesired effects. Staff is generally unaware of the specific tasks and responsibilities of their colleagues, both outside of and within their own department. Staff described struggling when addressing issues raised by others within the Cabinet, indicating that they often have difficulty identifying the appropriate contact person to help with the issue at hand.

Several staff indicated that departmental monthly staff meetings have been discontinued. When asked what type of content they would like presented in staff meetings, interviewees requested broader education on policy changes from the Federal level, updates on changes at the State level, operational updates, and general staff and personnel information sharing. Most interviewees who noted an absence of a monthly staff meeting, subsequently requested resuming this type of in-person or telephonic communication. Other suggestions included emails and newsletters that quickly summarize important information and serve as a record for future reference. Interviewees noted a strong desire for macro-level guidance, as opposed to the task-specific information that is often disseminated today.

Staff Suggestions:

- Resume staff meetings - hold meetings on a regular basis, not just for problem-based reasons
- Have systems and protocols in place to share updates, policy and procedural changes in a timely fashion
- Develop a desk guide to identify subject matter experts and “point-people” for specific processes, for use across branches and departments
- Provide more training on federal policies that drive state policy and or decision-making, so staff can have a holistic understanding of programs

Communication Between Departments (DAIL, DBHDID and DMS)

Interview Comments*:* Staff members report lacking an overall understanding of relevant activities occurring in other departments, particularly activities that directly impact their work or end-to-end processes to which they contribute. Staff advised that policy decisions come from a variety of sources and are prone to misinterpretation, depending on the chain of individuals relaying information. A structure is needed so that appropriate staff demonstrate understanding of information and are prepared to communicate this information accurately before relaying information across departments. In addition, interviewees frequently complained that the rationale behind decisions is rarely shared, making it difficult to understand why a policy or procedural change has been made. Interviewees seemed to understand that all parts of the

Cabinet may not always agree, but suggested that Cabinet leadership communicates many directives with an authoritative tone, which discourages staff from contributing their professional point of view. This method by which messages are delivered ultimately drives inter-departmental discord.

Navigant observed a lack of tracking and monitoring to organize communications and the litany of questions and escalations that occur throughout the operations of HCBS waivers. When issues arise, departments do not appear to use tracking or monitoring tools to track the progress of outstanding issues or inquiries, outcomes and close-outs, or to define appropriate intervals between meetings (e.g., regular standing meetings, or defined maximum response times). Thus, it is challenging to assess the effectiveness of coordination efforts or identify when an issue has been properly addressed and closed out. Interviewees used the term “black hole” or “vacuum” to describe what happens when they escalate questions or concerns – often they are never made aware if an issue has been closed, or if further work needs to performed to close out an inquiry.

Staff Suggestions:

- Develop inter-department protocols around communication and formalize inter-departmental governance
- Implement standard response times and track inter-departmental inquiries and resolutions
- Provide guidance when issuing decisions, so staff understand the rationale, as opposed to giving blanket direction with no additional explanation

2.2 Coordination Between Departments

Implement changes to the coordination and collaboration processes for the operating agencies, to improve the multi-disciplinary approaches and solution development between DMS, DBHDID and DAIL.

Interview Comments: Staff across DMS, DBHDID and DAIL cited numerous examples that demonstrate a lack of appreciation for multi-disciplinary input and contribution to problem-solving. The current relationship strains open dialogue and inhibits shared problem solving. This results in an environment where staff perceive an imbalance in which departments can influence decisions, and believe decisions are not made using a holistic approach with consideration for the value of the medical-model, social-model and person-centered principles. All three of these frameworks play a role in optimal HCBS delivery, and each department’s disciplinary view of a policy or operational element, is valuable.

Numerous operating agency staff indicated that DMS takes an authoritative approach and can be over-prescriptive when giving guidance to the operating agencies. DAIL and DBHDID staff repeatedly echoed belief that they are provided insufficient autonomy to determine their operational needs to achieve their contractual obligations. Conversely, DMS staff indicated a lack of appreciation or understanding for the necessity of compliance with the Federal regulatory framework, and fiscal responsibility from operating agencies. When further probed,

interviewees acknowledged that there is often a sense of "turf" that leads to decisions that do not meet shared needs across departments. These tendencies inhibit holistic decision-making, and is counter-productive. It is critical that all departments develop a shared appreciation for the perspective of their sister agencies, and include each other in critical decision making that will impact waiver design and operations.

In addition, the current unstructured communication protocols lack the appropriate tracking and monitoring to keep staff up-to-date when a policy decision update has occurred or when a policy issue has been resolved. In current state, Cabinet staff learn about policy decisions at times from external parties – this hampers the Cabinet's ability to present as a unified team, and promotes negative practices including "answer shopping" and confusion.

Another area of concern is the timing of contract updates and finalization. Operating agency staff indicated that contracts have historically not been finalized and provided until near the end of each fiscal year. This timing of contract updates and finalization is problematic for operating agencies. This places operating agencies at a severe disadvantage to uphold their contractual responsibilities and plan for needed resources to deliver against contract terms. Those interviewees with visibility to the contract between DMS and each operating agency, indicated that responsibilities are sufficiently clarified, but indicated that shifting responsibilities and expectations tend to create operational issues including backlogs and uncompleted tasks.

Staff Suggestions:

- Expand those included on decision-making teams to ensure that all departments contribute to decision-making
- Provide additional training to inter-departmental leadership on person-centered principles with consensus building about how this framework fits into waiver regulations, including how it will be prioritized against medical-model principles
- Align points of entry for external inquiries across departments to better coordinate responses, so that departments convey consistent messages and reduce the likelihood of an inquirer to obtain multiple answers to the same question
- Develop cross-departmental protocols to share updates, policy and procedural changes in a timely fashion
- Finalize and disseminate the annual DMS contract with operating agencies at the beginning of the state's fiscal year, to ensure that operating agencies have clarity on their deliverables

2.3 Provider Communication

Improve the dynamic between the Cabinet and providers, to drive service delivery and provider engagement.

Interview Comments: Staff from each department indicated that strengthening communication with providers is a significant area of opportunity for the Cabinet. Staff described a large disconnect between the provider community and the three agencies administering Kentucky's HCBS Waivers. The relationship was described as unhealthy, one where providers are often confused and frustrated, or under-value their partnership with the Cabinet. There is also a

sense that the Cabinet can be usurped by providers, which undermines program integrity. Staff expressed concern regarding the disconnect between provider communication with the Cabinet and provider communications with State leadership. Per interviews, HCBS services are heavily politicized. Interviewers detected a heavy emphasis on providers in decision making, which can negatively impact program integrity, and diminish the authority of the Cabinet to assure compliance with state and federal regulatory requirements.

In addition, it was apparent from interviews that each department takes a different approach to technical assistance versus enforcement and penalizing, precision of auditing, and when to recoup payment or penalize providers. This discrepancy is problematic for all impacted parties, including for providers trying to adhere to regulations. Several interviewees mentioned recent *Supports for Community Living Letter #A-49* correspondence recently released by the Cabinet to Supports for Community Living Waiver providers clarifying documentation expectations, as a positive example of how transparent guidance improves the auditing process.

Staff repeatedly voiced a concern about differing standards and expectations being communicated to providers that deliver services under more than one HCBS Waiver. This further complicates a system where providers are accountable to inconsistent policies across programs. The level of confusion and frustration appears to undercut the entire auditing process, and many interviewees who play a role in first or second line monitoring described feeling limited in their ability to drive compliance, and/or that providers sought discrepancies to avoid penalties.

Staff Suggestions:

- Develop auditing guidelines that provide clarity on when a soft warning or technical assistance is appropriate, versus when recoupment or penalty is appropriate
- Train first and second line reviewers together, annually to drive shared understanding of regulatory requirements and how to interpret findings
- Implement thresholds when technical assistance has been exhausted and a provider must comply with a requirement or face recoupment
- Clearly communicate expectations and any changes in writing to all providers, with a specific deadline for when a change must be made
- Formalize governance process when providers seek overturning of a recoupment or negative finding
- Provide more authoritative actions to the Cabinet to ensure regulatory compliance, beyond a voluntary moratorium

2.4 Policy Regulations

Streamline policies across waivers to align with federal requirements, and make definitions and standards as consistent across waivers as possible.

Interview Comments: One key frustration that interviewees came back to on a consistent, and frequent basis is the inconsistency that exists in Kentucky regulations governing each HCBS waiver. Waiver regulations are highly specified to each waiver across a plethora of program

elements, including service definitions, qualified provider definitions, allowable services and service authorization standards, person-centered plan development and documentation standards, etc. It was apparent to interviewers that staff across the Cabinet rely heavily on regulations, even more so than the 1915(c) waiver applications themselves, even though the waiver applications represent the State's agreement with CMS.

The inconsistency across regulations is a significant impediment to two needed improvements.

- *First, providers who serve multiple waivers are at a severe disadvantage when attempting to comply, due to the high degree of differentiation across regulations.* Dissonance across regulations has caused high levels of confusion, administrative burden, and frustration across providers, creating a challenging dynamic for day-to-day waiver operation.

- *Second, the high level of specificity across waiver regulations, contributes immensely to the siloed approaches that exist in the Cabinet departments today.* The variance across waivers, and inconsistency in approaches, creates an environment where a staff member could not reasonably be expected to understand the nuances across waivers. This results in a required level of specialization among staff and discourages cross-training. The burden of these requirements appears to have played a significant role in why each waiver is operated at such an exclusive level.

Interviewees also expressed concern with the heavy hand that political dynamics and stakeholder demands play in regulatory design. While certain components of waiver design should be vetted with stakeholders, current regulations codify policy and procedure, making it very challenging for Cabinet departments to adapt internal processes, achieve efficiencies, and maximize their monitoring efforts.

Staff Suggestions:

- Standardize regulations across all six waivers to be as consistent as possible, particularly geared to reducing confusion for providers who deliver services for more than one waiver
- Revise regulation to allow the Cabinet more ability to adjust operations without going through the legislative process
- Ensure regulations are consistent with content of 1915 (c) waiver applications before submitting waiver applications for CMS approval

2.5 Crisis Escalation

There is a lack of clarity on how to respond to crisis and escalations, and staff spend a large amount of time "fire-fighting."

Interview Comments: Many of the staff interviewed advised that they spend large portions of their work time responding to a variety of crises. Interviewees made it clear there is a significant investment of Cabinet resources into "fire-fighting," some of which is likely preventable.

Interviewees described a lack of clarity around who the point people are for crisis and critical incident management. The state of confusion is further exacerbated by the multiple referral sources that drive escalations into the system, with lacking definition on how escalations are prioritized and/or assigned.

One area of concern mentioned by multiple departments is the management of critical incidents and resolving escalations in a manner that coordinates departments operating the waiver, and incorporates parts of the Cabinet who do not directly contribute to waiver operations, such as Adult Protective Services. Interviewees described recent critical incidents involving other Cabinet units, including Public Guardianship, Adult Protective Services, the Office of the Ombudsman, etc., where several of these escalations directly impacted the health and safety of the participant. The system was described as dis-jointed, lacking lead agency designation and assignment of responsible parties for investigation, action and resolution activity. It takes a well-coordinated system with clearly defined standards – that considers the roles, responsibilities and restrictions of each involved unit of the Cabinet – to meet the end goal of upholding the health, welfare and safety of vulnerable participants. Interviewees expressed concern that cases "fell through the cracks" and that discord existed in this response system due to a lack of shared understanding of roles and responsibilities.

At the same time, interviewees recapped recent events when the Cabinet pulled together with an "all hands-on deck" approach, to resolve significant participant issues, including the closure of a large provider and relocation of participants. It was apparent that all departments have the personnel and expertise to react appropriately, and could maximize their efforts using a whole team approach.

<u>Staff Suggestions</u>:

- Develop a protocol for assigning the priority-level of an escalation, and establish procedures for standardized response that correspond to priority levels.
- Improve tracking and monitoring of escalations, on a platform that is easily reviewed so that relevant staff know when an issue is resolved, and the nature of the resolution.
- Develop inter-departmental protocols for assigning and transferring "lead agency" designation and coordinating across departments during critical incidents that require response from multiple parts of the Cabinet
- Train across departments on the role and limitations of relevant parts of the Cabinet, including DMS, DAIL, DBHDID, Protection and Permanency, Public Guardianship, and any other necessary branch or department.
- Consider a standardized review or standing meeting to review escalations and critical incidents.
- Develop a standardized protocol for when and how status updates on escalations with be communicated to Kentucky executive and legislative leadership, Office of the Ombudsman, and other frequently referring parties.

2.6 Participant Education

Customer Service to participants needs improvement.

Interview Comments: The Division fields calls from participants and caregivers daily, related to issue resolution, waitlist and eligibility questions, denials, complaints, etc. None of the interviewees identified single points of entry for participant inquiries, and multiple interviewees described their department as the point of entry for questions and concerns. Several mentioned that participants are transferred multiple times, and complain that they did not receive a response or follow-up, and will beg not to be transferred. Interviewees described this process with great frustration, and were sometimes even emotional when discussing the difficulty that participants face in obtaining timely answers to waiver-related questions and concerns.

Staff admits that the process of answering participants often varies from call to call. Interviewees believe that participants have issues or questions about HCBS Waiver services, they should be able to easily reach the appropriate party and receive a quick and informative response. Many interviewees who field calls complained that the volume of calls distracts from other work, and would prefer a unit who focuses on this area. This was especially needed for Supports for Community Living and Michelle P Waiver related personnel, who field a heavy volume of waitlist inquiries in addition to common questions and concerns.

While certain staff indicated that they enjoy the customer service interface, others indicated that they answer calls but do not feel comfortable in a customer service, call center-like role. It is important to ensure that staff resources who answer inquiries have skills in communications and customer service, but not all Cabinet employees are well-suited for this function, which appears to be shared unilaterally across all staff today. Ideally, participant-facing staff are willing to embrace this function and be proficient at delivering information regarding waiver services quickly and reliably.

Staff Suggestions:

- Assign incoming call intake to targeted staff with customer service skills, with incoming call-flow directed to assigned staff so that all staff phones do not ring throughout the day.
- Develop clear definition and public awareness of which line an external party should call for waiver assistance, with improved options/prompts that better direct incoming calls. This would include directing calls to a central line that avoids “answer shopping” between departments.
- Identify additional resources for the Supports for Community Living and Michelle P. Waivers, to assist with volume of incoming waitlist inquiries.
- Identify a desk resource to list the appropriate contacts for specific topic areas or subject matters that represent common inquiries.
- Develop consistent, defined requirements around acknowledgment of incoming contacts, and response times.
- Provide customer service training, particularly training for how to deal with difficult or upset callers.

- Develop a system that tracks when inquiries have been resolved, and the nature of the response, to avoid mixed messaging, duplicate response, or unanswered inquiries.

2.7 Technology

Staff wish to leverage technology where possible, to achieve efficiencies and better track and monitor data.

Interview Comments: The Cabinet has numerous technology solutions to coordinate and administer HCBS services. Interviewees described an assortment of different methods and databases across waivers and departments. Some of these data tracking methods were described as "desk-specific" and data tracking and reporting often goes unchecked when assigned staff changes. The effective use of software and technology systems to track and coordinate activities across the departments provides for more efficient hand-offs, prevents duplication of effort, and facilitates management reporting and metrics. The interviewees identified the MWMA as a primary platform. MWMA is a web-enabled case management application designed to support the Commonwealth's HCBS Waiver programs. Interviewees describe MWMA as a system jointly used by DMS in close collaboration with DAIL and DBHDID. MWMA is intended to automate and ease access to intake, assessment, eligibility determination, service plan, case management, incident management, timesheet, and reporting functions performed by HCBS Waiver service providers.[1]

Interviewees described the implementation of MWMA as challenging. Per staff, the implementation did not involve the appropriate end-user and upper management from DMS, DAIL and DBHDID and thus has been in "fix-it" mode since its implementation. While trainings and technical assistance address problems when they arise, the system may need significant adjustments to allow all users to use it effectively. For example, staff pointed out that technical difficulties frequently occur while uploading assessments into MWMA. For instance, Supports Intensity Scale (SIS) assessments cannot be automatically uploaded. Interviewees advised that solution development is constrained by the implementation budget, and thus issues raised appear to go unaddressed.

Staff Suggestions:

- Standardize data collection templates and formats across functions, and potentially across departments.
- Implement a formal change management process, so that changes to a tool or system are formally vetted, and cannot be made based strictly on individual preference.
- Conduct a holistic assessment of MWMA to identify end-user issues across all departments, prioritizing updates based on end-user impact and available budget for

[1] Kynect. *Frequently Asked Questions (FAQ) Medicaid Waiver Management Application.* October 28, 2015. Available online: http://chfs.ky.gov/NR/rdonlyres/88254543-473F-433A-BDBD-E91C058EABA5/0/MWMAFAQS_102815.pdf

implementation. Consider work-arounds when budget does not exist to resolve an end-user issue that negatively impacts a workflow.

- Consider implementing technology solutions that enhance the ability to conduct desk review and remote oversight activity, to reduce the demand of statewide travel to provider locations.

2.8 Operating Procedures

The lack of standardization in operations and approaches poses significant challenges to day-to-day operations.

Interview Comments: The Cabinet does not use a standardized approach to document roles and responsibilities (i.e., standard operating procedures). Many of the staff interviewed stated they had little or no written guidance for their day-to-day tasks. This has created a mix of uncoordinated procedural documentation unique to each department and, in DMS especially, can be desk specific to an individual, meaning staff completing the same work activities may be doing it differently person to person. Multiple interviewees described how difficult this makes onboarding new staff, and advised that they did not have time to develop individual desk references or update them when procedures change.

Staff Suggestions:

- Develop standard operating procedures that clearly define step-by-step processes, performance standards and assigned parties across all workflows.
- Create a central repository where staff can easily access standard operating procedures.
- Designate who will be responsible for maintaining and updating standard operating procedures, as well as what the process would be for disseminating any changes and training staff when needed.

2.9 Internal Training

Enhance training and development for employees, to ensure tools are available to optimize employee performance.

Interview Comments: Staff from each of the departments indicated that there is a great opportunity to improve the training program across the Cabinet. There is currently no overall, programmatic approach to training, resulting in a lack of subject matter and policy expertise.

Staff Suggestions:

- Identify a curriculum of required internal training and refresher training across departments.
- Promote external opportunities for training and development.

- Put more emphasis on training and development needs as a component of existing performance review processes.
- Establish a program for onboarding new staff, and cross-training them early in their time with the Cabinet.
- Promote more cross-training of staff, as well as interdepartmental trainings, so staff between departments are better coordinated and receive consistent training information.

2.10 Staffing Resources

Consider the staffing resources needed to adequately administer and operate HCBS Waiver programs, and work to maintain these resources.

Interview Comments: Staff from DMS and DAIL indicated a lack of available staff to properly execute operational responsibilities for the waivers. This was not an area of concern highlighted by DBHDID. Staff in DMS and DAIL described frequent changing of responsibilities from their core responsibility, concerns with the dependence on temporary staff who are less skilled and not as invested in the end work product, and the feeling of always trailing behind as work gets backlogged. Interviewees described an inability to perform at maximum accuracy or effectiveness due to the volume of their workload, and few identified where efficiencies in task flows or operational procedures were implemented to better manage demanding work volumes.

Numerous interviewees mentioned that access to leadership is limited, describing that leadership staff are often in meetings, off-site or generally inaccessible. Time management is critical to ensure that managers have adequate time to a) interface with staff and b) execute their contributions to work flows, approvals, sign-offs, etc. While most interviewees indicated that their manager was supportive and helpful, this lack of desk time and office hours creates regular delays in work activity and flow processes. Many of the staff interviewed are also responsible for heavy travel schedules, that further restrict access to managers, creating the potential for further disconnect and limited collaboration.

Staff Suggestions:

- Examine where staff may be currently spending time on less skilled tasks, and identify ways to transition this work to temporary workers, to avoid using temporary staff for work that requires a higher level of skill or training, to perform tasks proficiently.
- Identify solutions to overcome backlogs that don't require employees to exclusively focus on a backlog, to the detriment of other required tasks, which results in a succession of backlogs.
- Implement standing office hours for managers, to ensure that employees have access to managers and can move work forward that requires management approval, signature or collaboration.
- Examine work methods and approaches that reduce travel time incurred by staff, which has contributed to turnover.

- Consider staff resources when finalizing the deliverables and contract requirements expected of operating agencies.

2.11 Prior Authorization

Tailor the prior authorization process to HCBS as much as possible, and identify a process for the sister agencies to resolve PA related concerns with DMS/CareWise.

Interview Comments: One recurrent theme that emerged throughout interviews was the difficulty staff have in finding a healthy balance between medical model and social model/person-centered principles of HCBS delivery. This imbalance seemed most impactful in the prior authorization process. Per interviewees, the prior authorization process is conducted by CareWise, a third-party contractor of DMS. Interviewees suggested that CareWise takes a very clinical, medical model approach to prior authorization that is driven by clinical eligibility definitions defined in State regulation. The challenge noted by interviewees was twofold:

- First, operating agencies who are charged with upholding person-centered planning principles, expressed concern that the PA process does not adequately account for mitigating circumstances and non-medical determinants that may impact the appropriateness of services.

- Second, there is a lack of interface or engagement between CareWise and operating agencies. Interviewees report that in the past, meetings were held between parties to discuss complex cases where mitigating circumstances needed to be considered. Staff reported that these conferences have ceased, and DMS instructed operating agencies not to have further contact with CareWise. This impedes the Cabinet's ability to ensure holistic consideration prior to service plan approval, which should include both clinical elements but also person-centered definitions included in the Federal HCBS Final Rule.

Staff Suggestions:

- Develop a process that allows for multi-disciplinary input when a prior authorization discrepancy occurs, or there are mitigating circumstances required.
- Cross-train CareWise and relevant Cabinet staff on the prior authorization process, methodology, as well as person-centered principles so that all parties build consensus around parameters for approving HCBS.
- Improve the approval process, as well as ongoing monitoring and oversight of exceptional supports for SCL participants for whom exceptional supports are approved, to ensure enhanced payments result in enhanced service delivery.

2.12 Participant Directed Services

Evaluate Participant Directed Services (PDS) across waivers to ensure participant access to services and program integrity, and to address potential fraud, waste and abuse.

Interview Comments: One service type interviewees frequently cited as problematic was PDS. Interviewees reported that this segment of service delivery has grown rapidly in recent years, particularly with the advent of the Michelle P. Waiver. DAIL monitors PDS across all waivers, and has since the program was first implemented. Interviewees across the board expressed concerns about the varying interpretations of allowable PDS worker and qualification requirements. Interpretation of rules and requirements about eligibility differs from waiver to waiver, and concern exists that the Cabinet may be taking an overly restrictive approach. Among the disparities:

- There is disagreement about who is appropriate and in-appropriate to self-direct services;
- Budgets are disparate across waivers and several interviewees believe certain participants are given unnecessarily high budgets compared to others who are arduously penalized;
- There is confusion about who can be a PDS worker;
- There is disagreement about the required qualifications to be a PDS worker;
- Tax withholdings and payroll are applied inconsistently among fiscal management service (FMS) agencies, with the burden of correcting tax errors falling to the participant when errors occur;
- There is a lack of consistency in performance for support brokers, and the types of agencies who can provide support broker services varies waiver to waiver.

Ultimately – interviewees echoed similar themes about PDS. That is, they are concerned that an unequal application and interpretation of rules and regulations, as well as operational practices across waivers, have created confusion for all parties vested in PDS, including participants, their representatives, PDS workers, support brokers, FMS vendors, and all agencies contributing to waiver operation.

Staff Suggestions:

- Implement a needs-based formula for establishing a participant's service budget, across all waivers that allow participant directed services.
- Identify areas where confusion about participant directed services exists across departments including:
  - Who is considered eligible to self-direct
  - Who is considered eligible to be a participant directed service worker

- Consider ways to fund the required background checks and other start-up costs that participants currently are responsible to pay for.
- Clearly define the required activities and standards for support brokers consistently across all waivers, and improve monitoring and oversight of this service.
- Centralize the FMS contractor to a single statewide contract, or arrange training for the existing FMS providers on requirements for tax withholdings for PDS workers, to reduce the likelihood of negative repercussions that fall to participants.
- Coordinate PDS policy development across all three departments, currently DAIL manages this function across all waivers, but policy or procedure changes could be made using a multi-disciplinary approach that includes all impacted departments.

2.13 Quality

There is room for improvement in the quality of service delivery and there has been a limited focus on quality assurance or improvement in the past.

Interview Comments: Post-interviews, Navigant concluded that the Cabinet's efforts have been almost wholly oriented to compliance, which remains a struggle, due to the level of regulatory inconsistency, and lack of standardization in auditing and compliance activities. Interviewees suggested that there is more to be done to ensure that compliance activities have the appropriate "teeth" to drive improvements in compliance. Recent compliance efforts seem to be oriented largely to administrative and documentation requirements, with additional effort invested toward compliance with service delivery requirements.

Many interviewees indicated that while many providers strive to deliver excellent services, ample opportunity exists across the State to improve service delivery, particularly to ensure freedom of choice and autonomy for participants, as well as quality of life, and community access and inclusion. Interviewees agreed universally that the Cabinet does not currently emphasize quality outcomes in HCBS services and there is limited to no tracking of quality metrics across the HCBS Waivers. There was a high degree of enthusiasm for pivoting to incorporate a quality focus, with a strong desire across staff to play a greater role in supporting providers in achieving outcomes, as opposed to complying with administrative requirements and regulation.

Staff Suggestions:

- Re-orient technical assistance to focus more on service delivery and outcomes, instead of the current focus on administrative tasks and documentation requirements.
- Develop a long-term strategic plan to incorporate quality measurement, oversight and improvement, focused on improved care outcomes, community access and quality of life for waiver participants.

3 Conclusion

The Navigant team is both excited about and committed to supporting Kentucky's Cabinet of Health and Family Services in improving the administration and operation of the State's home- and community based delivery system. Throughout the interview process, we were struck by the high level of engagement and commitment demonstrated by all individuals we interviewed, and we can affirm that the Cabinet has multiple centers of excellence from which to draw as it works to improve day-to-day operations and HCBS delivery.

While there are many areas of opportunity to address, interviewees indicated excitement about the potential to use the interview process to provide input that can serve as a springboard to program optimization. Following release of this report, Navigant will work with Cabinet leadership to identify workflows appropriate for redesign, to enhance internal operations, partnership with providers, and customer service to provider and participants. Additionally, the Cabinet will complete a series of statewide focus groups this fall, to learn firsthand what goals participants and providers have for the future of Kentucky's HCBS waivers. We look forward to partnering with the Cabinet, its staff, and impacted stakeholders as we move forward with HCBS redesign.

In Exhibit 1 beginning on the following page, we summarize the key themes outlined above to provide an overview of the takeaways.

Exhibit 1: Summary of the Key Themes from Staff Interviews

	Key Theme	Summary of Interview Comments	Staff Suggestions
1	**Internal Communication** *Improve communication, both within departments and between departments.*	Communication Within Departments (DAIL, DBHDID and DMS): • Lack of communication within departments, which leads to frustration among the staff • Staff is generally unaware of the specific tasks and responsibilities of their colleagues • Staff have issues identifying the appropriate contact person to provide assistance when questions arise from stakeholders	Communication Within Departments (DAIL, DBHDID and DMS): • Resume staff meetings - hold meetings on a regular basis • Have systems and protocols in place to share updates, policy and procedural changes in a timely fashion • Develop a desk guide to identify subject matter experts and “point-people” for specific processes, for use across branches and departments • Provide more training on federal policies that drive state policy and or decision-making, so staff can have a holistic understanding of programs

Key Theme		Summary of Interview Comments	Staff Suggestions
		Communication Between Departments (DAIL, DBHDID and DMS): • Staff lack an overall understanding of what is happening in other areas, particularly activity that directly impacts their work or end-to-end processes • Policy decisions come from a variety of sources and are prone to misinterpretation, depending on the chain of individuals relaying information • There is no communication, tracking and monitoring process so when issues arise, departments do not use tracking or monitoring tools to review the progress of discussions, resulting outcomes, or confirm appropriate intervals between meetings (e.g., quarterly, monthly).	Communication Between Departments (DAIL, DBHDID and DMS): • Develop inter-department protocols around communication and formalize inter-departmental governance • Implement standard response times and track inter-departmental inquiries and resolutions • Provide guidance when issuing decisions, so staff understand the rationale, as opposed to giving blanket direction with no additional explanation

Key Theme		Summary of Interview Comments	Staff Suggestions
2	**Coordination Between Departments** *Implement changes to the coordination and collaboration processes for the operating agencies, to improve the multi-disciplinary approaches and solution development between DMS, DBHDID and DAIL.*	• Staff feel there is a lack of collaboration between DMS, DBHDID and DAIL • Operating agencies feel that DMS is over-prescriptive in giving guidance which can hinder their ability to properly execute contract obligations • There is no structured communication protocol so there is a lack of appropriate tracking and monitoring to keep staff up-to-date when a policy decision update has occurred or when a policy issue has been resolved • Operating agency staff indicated that contracts have historically not been finalized and provided until near the end of each fiscal year. This places operating agencies at a severe disadvantage to uphold their contractual responsibilities and plan for needed resources to deliver against contract terms	• Expand those included on decision-making teams to ensure that all departments contribute to decision-making • Provide additional training to inter-departmental leadership on person-centered principles with consensus building about how this framework fits into waiver regulations, including how it will be prioritized against medical-model principles • Align points of entry for external inquiries across departments to better coordinate responses • Develop cross-departmental protocols to share updates, policy and procedural changes in a timely fashion • Finalize and disseminate the annual DMS contract with operating agencies at the beginning of the state's fiscal year, to ensure that operating agencies have clarity on their deliverables

Key Theme		Summary of Interview Comments	Staff Suggestions
3	**Provider Communication** *Improve the dynamic between the Cabinet and providers, to drive service delivery and provider engagement.*	• There is a disconnect between the provider community and the three agencies administering the HCBS waivers • Staff believes there is a heavy provider focus in current decision making • Each department takes a different approach to technical assistance versus enforcement and penalizing, precision of auditing, and when to recoup payment or penalize providers • There are differing standards and expectations being communicated to providers that deliver services under more than one HCBS Waiver	• Develop auditing guidelines that provide clarity on when a soft warning or technical assistance is appropriate, versus when recoupment or penalty is appropriate • Train first- and second-line reviewers together, annually to drive shared understanding of regulatory requirements and how to interpret findings • Implement thresholds when technical assistance has been exhausted and a provider must comply with a requirement or face recoupment • Clearly communicate expectations and any changes in writing to all providers, with a specific deadline for when a change must be made • Formalize governance process when providers seek overturning of a recoupment or negative finding • Provide more authoritative actions to the Cabinet to ensure regulatory compliance, beyond a voluntary moratorium

Key Theme		Summary of Interview Comments	Staff Suggestions
4	**Policy Regulations** *Streamline policies across waivers to align with federal requirements, and make definitions and standards as consistent across waivers as possible.*	• Waiver regulations are highly specific to each waiver, across a plethora of program elements, including service definitions, qualified provider definitions, allowable services and service authorization standards, person-centered plan development and documentation, etc. • Providers who serve multiple waivers are at a disadvantage when trying to be regulatorily compliant, due to the differentiation across regulations • The high level of specificity across waiver regulations, contributes to the approaches that exist in CFHS departments • Political dynamics and stakeholder demands play a large role in regulatory design	• Standardize regulations across all six waivers to be as consistent as possible, particularly geared to reducing confusion for providers who deliver services for more than one waiver • Revise regulation to allow the Cabinet more ability to adjust operations without going through the legislative process • Ensure regulations are consistent with content of 1915(c) waiver applications before submitting waiver applications for CMS approval

	Key Theme	Summary of Interview Comments	Staff Suggestions
5	**Crisis Escalation** *There is a lack of clarity on how to respond to crisis and escalations, and staff spend a large amount of time "fire-fighting."*	• Unclear who is charged with crisis and critical incident management • Limited coordination between departments when incidents arise • All departments have the personnel and expertise to react appropriately, and could maximize their efforts using a whole team approach	• Develop a protocol for assigning the priority-level of an escalation, and establish procedures for standardized response that correspond to priority levels • Improve tracking and monitoring of escalations, on a platform that is easily reviewed so that relevant staff know when an issue is resolved, and the nature of the resolution • Develop inter-departmental protocols for assigning and transferring "lead agency" designation and coordinating across departments during critical incidents that require response from multiple parts of the Cabinet • Train across departments on the role and limitations of relevant parts of the Cabinet, including DMS, DAIL, DBHDID, Protection and Permanency, Public Guardianship, and any other necessary branch or department • Consider a standardized review or standing meeting to review escalations and critical incidents • Develop a standardized protocol for when and how status updates on escalations with be communicated to Kentucky executive and legislative leadership, Office of the Ombudsman, and other frequently referring parties

Key Theme		Summary of Interview Comments	Staff Suggestions
6	**Participant Education** *Customer Service to participants needs improvement.*	• There is no single point of entry for participant inquiries, related to issue resolution, waitlist and eligibility questions, denials, complaints, etc. • The process of answering participant calls varies from call to call • Participants are often transferred multiple times and fail to receive timely follow-up • Several staff members indicated that they answer calls but do not feel comfortable in a customer service, call center- like role	• Assign incoming call intake to targeted staff with customer service skills, with incoming call-flow directed to assigned staff so that all staff phones do not ring throughout the day • Develop clear definition and public awareness of which line an external party should call for waiver assistance, with improved options/prompts that better direct incoming calls. This would include directing calls to a central line that avoids "answer shopping" between departments. • Identify additional resources for the Supports for Community Living and Michelle P. Waivers, to assist with volume of incoming waitlist inquiries • Identify a desk resource to list the appropriate contacts for specific topic areas or subject matters that represent common inquiries • Develop consistent, defined requirements around acknowledgment of incoming contacts, and response times • Provide customer service training, particularly training for how to deal with difficult or upset callers • Develop a system that tracks when inquiries have been resolved, and the nature of the response, to avoid mixed messaging, duplicate response, or unanswered inquiries

Key Theme		Summary of Interview Comments	Staff Suggestions
7	**Technology** *Staff wish to leverage technology where possible, to achieve efficiencies and better track and monitor data.*	• There are multiple methods and databases across waivers and departments that are not coordinated or standardized • Implementation of MWMA did not involve the appropriate end-user and upper management from DMS, DAIL and DBHDID and thus has been in "fix-it" mode since its implementation. • MWMA solution development is constrained by the implementation budget, and thus issues raised appear to go unaddressed.	• Standardize data collection templates and formats across functions, and potentially across departments • Implement a formal change management process, so that changes to a tool or system are formally vetted, and cannot be made based strictly on individual preference • Conduct a holistic assessment of MWMA to identify end-user issues across all departments, prioritizing updates based on end-user impact and available budget for implementation • Consider implementing technology solutions that enhance the ability to conduct desk review and remote oversight activity, to reduce the demand of statewide travel to provider locations
8	**Operating Procedures** *The lack of standardization in operations and approaches poses significant challenges to day-to-day operations.*	• Not currently using a standardized approach to document current duties and responsibilities in policies and procedures	• Develop standard operating procedures that clearly define step-by-step processes, performance standards and assigned parties across all workflows • Create a central repository where staff can easily access standard operating procedures • Designate who will be responsible for maintaining and updating standard operating procedures, as well as what the process would be for disseminating any changes and training staff when needed

	Key Theme	Summary of Interview Comments	Staff Suggestions
9	**Internal Training** *Enhance training and development for employees, to ensure tools are available to optimize employee performance.*	• There is currently no overall, programmatic approach to training, resulting in a lack of subject matter and policy expertise.	• Identify a curriculum of required internal training and refresher training across departments • Promote external opportunities for training and development • Put more emphasis on training and development needs as a component of existing performance review processes • Establish a program for onboarding new staff, and cross-training them early in their time with the Cabinet • Promote more cross-training of staff, as well as interdepartmental trainings, so staff between departments are better coordinated and receive consistent training information

	Key Theme	Summary of Interview Comments	Staff Suggestions
10	**Staffing Resources** *Consider the staffing resources needed to adequately administer and operate HCBS Waiver programs, and work to maintain these resources.*	• Access to leadership is often limited and staff feel that leadership tend to be in meetings, off-site or generally inaccessible • DMS and DAIL staff described an inability to perform at maximum accuracy or effectiveness due to the volume of their workload, and few identified where efficiencies in task flows or operational procedures were implemented to better manage demanding work volumes	• Examine where staff may be currently spending time on less skilled tasks, and identify ways to transition this work to temporary workers (to avoid using temporary staff for work that requires a higher level of skill or training) to perform tasks proficiently • Identify solutions to overcome backlogs that don't require employees to exclusively focus on a backlog, to the detriment of other required tasks • Implement standing office hours for managers, to ensure that employees have access to managers and can move work forward that requires management approval, signature or collaboration • Examine work methods and approaches that reduce travel time incurred by staff, which has contributed to turnover • Consider staff resources when finalizing the deliverables and contract requirements expected of operating agencies

	Key Theme	Summary of Interview Comments	Staff Suggestions
11	**Prior Authorization** *Tailor the prior authorization process to HCBS as much as possible, and identify a process for the sister agencies to resolve PA related concerns with DMS/CareWise.*	• Staff have difficulty finding a healthy balance between medical model approaches to service delivery, while simultaneously maintaining social model and person-centered principles of HCBS delivery • Lack of interface or engagement between CareWise and operating agencies	• Develop a process that allows for multi-disciplinary input when a prior authorization discrepancy occurs, or there are mitigating circumstances required • Cross-train CareWise and relevant Cabinet staff on the prior authorization process, methodology, as well as person-centered principles so that all parties build consensus around parameters for approving HCBS • Improve the approval process, as well as ongoing monitoring and oversight of exceptional supports for SCL participants for whom exceptional supports are approved, to ensure enhanced payments result in enhanced service delivery

	Key Theme	Summary of Interview Comments	Staff Suggestions
12	**Participant Directed Services (PDS)** *Evaluate Participant Directed Services (PDS) across waivers to ensure participant access to services and program integrity, and to address potential fraud, waste and abuse.*	• There is disagreement about who is appropriate and inappropriate to self-direct services. • Budgets are disparate across waivers and several interviewees believe certain participants are given unnecessarily high budgets compared to others who are arduously penalized • There is confusion about who can be a PDS worker • There is disagreement about the required qualifications to be a PDS worker • Tax withholdings and payroll are applied inconsistently among fiscal management service (FMS) agencies, with the burden of correcting tax errors falling to the participant when errors occur • There is a lack of consistency in performance for support brokers, and the types of agencies who can provide support broker services varies waiver to waiver	• Implement a needs-based formula for establishing a participant's service budget, across all waivers that allow participant directed services • Identify areas where confusion about participant directed services exists across departments including: ➢ Who is considered eligible to self-direct ➢ Who is considered eligible to be a participant directed service worker • Consider ways to fund the required background checks and other start-up costs for which participants currently are responsible to pay • Clearly define the required activities and standards for support brokers consistently across all waivers, and improve monitoring and oversight of this service • Centralize the FMS contractor to a single statewide contract OR arrange training for the existing FMS providers on requirements for tax withholdings for PDS workers, to reduce the likelihood of negative repercussions that fall to participants • Coordinate PDS policy development across all three departments. Currently DAIL manages this function across all waivers, but policy or procedure changes could be made using a multi-disciplinary approach that includes all impacted departments.

	Key Theme	Summary of Interview Comments	Staff Suggestions
13	**Quality** *There is room for improvement in the quality of service delivery and there has been a limited focus on quality assurance or improvement in the past.*	• The Cabinet's efforts have been primarily focused on compliance rather than quality. • There is ample area of opportunity across the State to improve service delivery, particularly to ensure freedom of choice and autonomy for participants, quality of life, and community access and inclusion.	• Re-orient technical assistance to focus more on service delivery and outcomes, instead of the current focus on administrative tasks and documentation requirements • Develop a long-term strategic plan to incorporate quality measurement, oversight and improvement, focused on improved care outcomes, community access and quality of life for waiver participants

Appendix B Workflow Solution Summaries

Workflow Domain: ***Punitive Actions and Sanctions for Founded Critical Incidents***

In the Fall of 2017, Navigant Consulting, Inc. (Navigant) initiated an operational assessment to identify opportunities and solutions for the following workflow in the Kentucky Cabinet for Health and Family Services (the Cabinet):

Develop policy and standards for application of punitive actions and sanctions for founded critical incidents

For the assessment process, Navigant conducted interviews with key Cabinet staff members, observed work activity and demonstrations and reviewed existing tools and documents. In this document, Navigant outlines findings from the assessment, including the identified workflow challenges, Navigant's proposed solutions, and considerations for future implementation efforts.

Overview of Workflow Challenges

As mandated by the Centers for Medicare and Medicaid Services (CMS), the Cabinet is responsible for responding to and overseeing critical incidents across the Commonwealth. Critical incidents (CI) are defined as follows:

> *An alleged, suspected, or actual occurrence of: (a) abuse (including physical, sexual, verbal and psychological abuse); (b) mistreatment or neglect; (c) exploitation; (d) serious injury; (e) death other than by natural causes; (f) other events that cause harm to an individual; and, (g) events that serve as indicators of risk to participant health and welfare such as hospitalizations, medication errors, use of restraints or behavioral interventions.*[160]

The Department for Medicaid Services (DMS) and its sister agencies, the Division of Developmental and Intellectual Disabilities (DDID) and the Department for Aging and Independent Living (DAIL), share responsibility to monitor and address CIs. Depending on the waiver the incident occurred on, different staff within the Cabinet handle the processing and potential application of punitive actions against the provider, when a CI is determined to have occurred due to provider negligence.

There is lack of standardization across waivers when responding to CIs. For example, when CIs occur within the Supports for Community Living (SCL) Waiver and Michelle P. Waiver (MPW), the provider must conduct an initial internal investigation to identify the causal factors that led to the CI and establish steps to prevent a reoccurrence. In contrast, for Acquired Brain Injury (ABI) waiver CIs, DMS staff initiates either a desk review or an onsite investigation prior to getting a response from the provider. In addition, the Cabinet doesn't have a structured process when determining the repercussions for providers when a founded critical incident occurs that is attributed to provider negligence.

The following workflow solutions represent opportunities to improve consistency and standardization across the Cabinet when applying punitive actions for founded CIs. A

[160] https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/downloads/technical-guidance.pdf

standardized approach will assist the Cabinet in demonstrating to CMS its ability to monitor and oversee all activities related to CIs.

Workflow Proposed Solutions Summary

Solution 1: Standardize the processing and decision-making framework for incoming CIs across the Cabinet	
Assessment Findings	• DMS, DAIL and DDID have different protocols for addressing CIs and varying degrees of logic and standard method behind their decision-making processes. There are multiple approvals and determinations required to arrive at a decision regarding the appropriate punitive action and the process varies depending on the waiver. • With the critical incident responsibilities spread out across the Cabinet, it is difficult for DMS to monitor critical incident follow-up, resolution and punitive actions.
Recommendations	• *Establish a structured process including required approvals, based on category of critical incident, when determining appropriate punitive actions.* • *Establish standardized timeframes for approvals and decision-making process.*
Considerations for Implementation	• To successfully deploy this strategy, a committee may be necessary, requiring staff time for in-person meetings • Standardization is more likely if governance is inter-disciplinary and includes representation across operating agencies/waiver units.
Solution 2: Establish standard criteria for initiating review and investigation, and applying penalties against providers	
Assessment Findings	• Providers are asked to respond to CIs in a variety of ways depending on the waiver. Thus, how an investigation is initiated varies, complicating the ability to evenly apply standards and penalties (as a provider may have more lead time in some instances to respond or “clean up” prior to investigation). • Application of penalties and sanctions varies across departments and is left up to discretion of Cabinet staff, who have varied interpretations of what is permissible. • Similar CIs occurring on different waivers can result in different actions for providers. Since there are no defined criteria for applying punitive actions against providers for each waiver, Cabinet staff make inconsistent determinations of the appropriate punitive action.

Recommendations	• *Develop standardized procedure across all waivers for how CI investigations are initiated and conducted.* • *Develop written guidelines to help Cabinet staff determine the extent of the punitive action to be taken against the provider:* ➢ *Technical assistance (TA) via phone/e-mail* ➢ *On-site TA* ➢ *Corrective action plan (CAP)* ➢ *Voluntary moratorium* ➢ *Provider decertification* • *Develop similar templates and forms across waivers when responding to providers regarding CIs.*
Considerations for Implementation	• Successful execution of this strategy will include extensive training and provider/staff education. • It could be difficult to achieve a consensus when developing criteria to determine what the appropriate punitive action is for each category of CI. • Cabinet and State leadership need to buy-in to an established approach, as providers lobby politically when pushing back against a sanction. Training state leadership on the federal risks of not adequately responding to CI's may be necessary.
Solution 3: Explore opportunities to partner more with the Office of Inspector General (OIG), when investigating CIs and applying sanctions.	
Assessment Findings	• Cabinet staff mentioned that the current measures taken by the Cabinet are not effective in preventing provider misconduct resulting in CIs. Without meaningful repercussions for CIs, providers might fail to address issues concerning the health, safety and welfare of their participants. • Staff reported that there have been instances where providers do not change behaviors after CIs occur because meaningful sanctions are not put in place.
Recommendations	• *Reach out to OIG to determine if they could assist in the investigation of severe CIs – particularly those that jeopardize the health and safety of participants. The Cabinet could involve OIG strategically when providers fail to change behaviors that result in chronic CIs.*
Considerations for Implementation	• Currently, the only interaction between OIG and the Cabinet related to CIs occurs when there is a CI that could result in OIG revoking the provider's license. If this is the case, DMS will send the CI to OIG to conduct their own investigation to determine if decertification is appropriate. • This will require time and effort to build the relationship between the two organizations and set expectations on both sides.

Workflow Domain: ***Complaint and Escalation Response and Prioritization***

In the Fall of 2017, Navigant Consulting, Inc. (Navigant) initiated an operational assessment to identify opportunities and solutions for the two following workflows in the Kentucky Cabinet for Health and Family Services (the Cabinet):

Develop a standardized method for prioritization of incoming escalations across 1915(c) waivers including staff assignments for providing a response
Define operating procedures and standard response timeframes for communicating progress and resolution to frequent referrers of escalation

For the assessment process, Navigant conducted interviews with key Cabinet staff members, observed work activity and demonstrations and reviewed existing tools and documents. In this document, Navigant outlines findings from the assessment, including the identified workflow challenges, Navigant's proposed solutions, and considerations for future implementation efforts.

Overview of Workflow Challenges

The Department for Medicaid Services (DMS) and its sister agencies, the Division of Developmental and Intellectual Disabilities (DDID) and the Department for Aging and Independent Living (DAIL), share responsibility to respond to complaints and escalations across all six 1915(c) waivers. The Cabinet receives complaints and escalations daily from several sources, stemming from a variety of issues. Complaints and escalations enter DMS, DDID and DAIL through the Office of the Ombudsman, Legislative offices, the Governor's office, direct consumer/provider calls or emails to waiver staff.

Incoming complaints and escalations vary in nature and severity but are often related to the following topics:

- Medicaid Waiver Management Application (MWMA)
- Waiver waitlists
- Waiver eligibility and Prior Authorizations
- Provider and Case Management issues
- Provider billing

Currently, the Cabinet does not have a standardized, consistent process across the three departments to resolve complaints and address escalations. During the assessment, staff indicated that the lack of standardization led to confusion and mixed messages being delivered to providers. For example, when providers have requested clarification related to regulations that have changed, they have received differing interpretations of the regulation from Cabinet staff. Inconsistent messaging, along with a lack of established response timeframes and internal referral pathways, puts Cabinet staff in a difficult situation when they attempt to resolve complaints and escalations.

When similar complaints and escalations are not handled consistently, it becomes difficult to relay a uniform message to external entities. The following recommended workflow solutions represent opportunities to improve consistency and standardization across the Cabinet and enhance the Cabinet's ability to handle complaints and escalations.

Workflow Proposed Solutions Summary

Solution 1: Implement a process to centralize intake of complaints and escalations	
Assessment Findings	• Complaints and escalations come in through a variety of entry points; therefore, it is difficult to track and properly refer to the appropriate party within the Cabinet. • Complaints often pass through multiple departments and staff members before reaching the appropriate staff member able to address or resolve the complaint/escalation.
Recommendations	• *Establish one central hotline for complaints for use by all external parties.* • *Develop standardized training for the central hotline staff to help them manage escalated callers, and appropriately assign and triage incoming complaints and escalations.* • *Designate consistent subject matter experts or leads for categorical complaints, document this assignment and make a list available to staff handling calls.*
Considerations for Implementation	• Additional education is necessary for participants and providers to reinforce the appropriate avenue to outreach to the Cabinet, and also understand when it's appropriate to escalate issues to the Cabinet. • Consumers and providers may still contact staff directly, marketing a new number, and ensuring staff re-direct callers will be critical to change behaviors. • Work volume can vary and be unpredictable for staff assigned to manage incoming contacts – back-up strategies may be needed for periods of high volume (i.e. following an operational change).

Solution 2: Develop a centralized electronic complaint and escalations database with the ability to analyze trended data and uncover systematic issues	
Assessment Findings	• The method of documenting complaints and escalations is inconsistent across waivers. Each department or waiver branch uses its own logs and databases to track complaints and escalations. • There is a duplication of effort when outside entities "shop for answers," calling multiple contacts across the Cabinet until one receives a timely or favorable response. • There are inefficiencies in how recurrent complaints are researched and/or responded to, due to lack of documentation of historical responses. • The Cabinet is not able to trend and analyze complaints across all waivers.
Recommendations	• *Establish a centralized complaint and escalations database with the capability to monitor trends across waivers and providers.* • *Develop protocols for entering manager-approved responses and resolutions into the database.* Restrict access to enter information into the system to approved staff to ensure that appropriate information is stored in the database. However, all staff will have the ability to view and refer to historical complaint and escalation responses to be more consistent with external responses. • *Develop standard operating procedures (SOPs) for analyzing trended data in complaints/escalations database.* • *Conduct quarterly monitoring meetings using standardized reports to track trends across providers and types of complaints/escalations.* • *Develop a document of frequently asked questions (FAQs) for common complaints with standardized responses for staff to use to enhance consistency.* • *Develop criteria for triggering technical assistance for providers with consistent or systemic issues flagged in database.*
Considerations for Implementation	• Staff with data entry privileges will have additional workload related to updating the database, including tracking responses to ensure accurate information. • Development of database could be time-consuming but will save time and reduce confusion in the long-run. • Staff will require training on complaint/escalation documentation tools (ex. standard telephone intake form) and use of legacy documentation system to identify historical responses.

Solution 3: Create a standardized process for addressing complaints and escalations, including establishing methodology for prioritization and resolution timeframes.	
Assessment Findings	• Staff are unaware of the expectations for response times and actions to consistently perform job duties. • There is a lack of consistency between staff when prioritizing the resolution of complaints and escalations. • There is a lack of consist timeframes for resolving complaints and escalations across the Cabinet.
Recommendations	• *Develop guidelines for categorizing and prioritizing critical complaints and escalations.* Guidelines should be based on regulatory definitions and best practices. • *Establish resolution timeframes related to each category of escalation that are consistent across the Cabinet.* • *Develop formal communication that educates high-volume referral sources on the methodology and standard response timeframes*.
Considerations for Implementation	• Timelines may need to be vetted and will have to be shared with referring parties, particularly high-volume referrers.

Solution 4: Designate staff to subject areas, regions or providers, when appropriate, so staff have ownership over addressing complaints and escalations	
Assessment Findings	• It is not clear which person/agency should be the lead when responding to incoming complaints and escalations. • Staff are generally unaware where to access appropriate information within the Cabinet to address complaints or questions. • Issues often must be forwarded multiple times before the correct person responds. • Complaint and escalation assignment is based on availability, not the most appropriate person for the job.
Recommendations	• *Identify subject matter experts that address complaints and escalations based on subject matter*. Make subject matter expert assignments based on knowledge and relationships with providers. • *Establish criteria and a flow process to designate the lead agency, and inter-agency response for escalations that require inter-agency activities to reach resolution*. • *Develop documentation, such as contact lists and phone trees to assist staff, in identifying the most appropriate person to respond*.
Considerations for Implementation	• Ensure the work is divided up evenly and not dependent on just a few staff members. • Subject matter experts may be in the field and responses will be delayed. • Staff may be asked to become experts in a new area and will need additional support during transition. • Staff who are selected as subject matter experts will have to have strong communication skills, not just technical knowledge.

Solution 5: Develop provider training and documentation to assist providers in distinguishing between critical and non-critical incidents	
Assessment Findings	• Staff reported that providers may not report critical incidents for fear of punishment. • Providers have a misunderstanding of the definition of a "critical incident".
Recommendations	• *Develop guidelines on distinguishing between complaints and critical incidents* • *Retrain providers and provide additional resources to assist providers in reporting*
Considerations for Implementation	• Provider education could be time-consuming for Cabinet staff but is important for appropriate operation of these waivers and the safety of the participants.

Workflow Domain: ***Participant-directed Services***

In the Fall of 2017, Navigant Consulting, Inc. (Navigant) initiated an operational assessment to identify opportunities and solutions for the two following workflows in the Kentucky Cabinet for Health and Family Services (the Cabinet):

Develop policy and train staff on definition of eligibility for participant-directed services employees
Develop and implement a standardized tool for approval of participant-directed services employees

For the assessment process, Navigant conducted interviews with key Cabinet staff members, observed work activity and demonstrations and reviewed existing tools and documents. In this document, Navigant outlines findings from the assessment, including the identified workflow challenges, Navigant's proposed solutions, and considerations for future implementation efforts.

Overview of Workflow Challenges

Participant-directed Services (PDS) allow eligible Medicaid participants to choose their own provider for non-medical waiver services. The Kentucky Department for Aging and Independent Living (DAIL) provides oversight and support to agencies and support brokers who deliver services through the PDS program. Participants are responsible for recruiting and vetting their employees. The vetting process includes initiating background checks and partnering with support brokers and Financial Management Agent (FMA) for processing taxes and payroll.

Cabinet staff identified that an inconsistent application and interpretation of rules and regulations, have created confusion for all parties involved in PDS, including participants, their representatives, PDS workers, support brokers, FMA vendors, and all agencies contributing to waiver operation.

DAIL spends significant time responding to PDS questions, especially related to eligibility of PDS employees. Establishing standardized guidance for the definition and approval process of PDS employees across waivers will help reduce PDS program related confusion. The recommended workflow solutions listed below represent opportunities to improve consistency and standardization across the Cabinet and enhance the Cabinet's ability to administer a successful PDS program.

Additionally, there is a misunderstanding of who is eligible for PDS services, how to hire an employee and the responsibilities of participants as an employer which may be addressed in future workflow assessments.

Workflow Proposed Solution Summary

Solution 1: **Standardize PDS regulations and guidelines for PDS employment**	
Assessment Findings	Regarding regulations pertaining to PDS: • The majority of Supports for Community Living (SCL) and Home and Community Based (HCB) version 2 regulations are waiver-specific and do not carry over into other waivers. • There are commonalities across HCB Traditional, Michelle P and Acquired Brain Injury (ABI) regulations however each waiver has nuanced language. Some of these nuances are waiver specific but many rephrase ideas that all waiver regulations share and should be standardized. • HCB version 1, Michelle P, and ABI regulations use standardized language, but the language is often reorganized from waiver to waiver with no clear reason behind the rearranged text. • Clarity is needed regarding background check requirements and the definition of a violent crime. The regulations differ regarding backgrounds checks as seen in Table B.1.[161]
Recommendations	• *Update regulations to be consistent across all waivers using standardized language.* • *Consider moving all PDS regulations into one PDS regulation chapter. All waiver regulations can reference the PDS regulation going forward.* • *Consider moving PDS definitions and guidelines to a manual or guideline document that lives outside of regulations and applies to all waivers.*
Considerations for Implementation	• Updating regulations can be a long and resource intensive process (including drafting, vetting and public comment requirements).
Solution 2: **Create a decision-making tool to determine PDS employee eligibility**	

Assessment Findings	• DAIL receives multiple questions about PDS employee eligibility; particularly requests to clarify what is and is not allowed on a criminal background check for employment. For example:
	  o What qualifies as a violent crime?
	  o What are the restrictions and statute of limitations regarding drug crimes?

Recommendations	• *Create an excel workbook with conditional formatting, formulas and using simple questions to determine PDS employee eligibility. The excel will map questions including but not limited to:*

[161] A full comparison of waiver regulations regarding PDS employee eligibility can be found in Appendix A.

	o *What waiver is the participant enrolled in?* o *Is the applicant over 18 years old?* o *Has the applicant been convicted of a crime?* ▪ *If yes, was the crime violent?* o *Is the applicant a family member (parent, sibling, child, grandparent, aunt/uncle, niece/nephew or cousin?)* • *The tool would guide reviewers to an approval, denial or request for more information.*
Considerations for Implementation	• Tools will need updates as laws and regulations change. • Tool would ideally generate a document for record keeping purposes.
Solution 3: **Develop training for PDS employee definition, eligibility and responsibilities for participants, providers and case management agencies**	
Assessment Findings	• Based on focus group discussions, participants and caregivers are frustrated with the PDS enrollment process and time it takes the case management and financial management agencies to approve an eligible employee. Many prospective employees are unable to wait several weeks and, in some instances, a month or more.
Recommendations	• *Develop and conduct a series of annual trainings to educate participants, providers and caregivers on the PDS program and who is an allowable worker.* • *Develop and conduct annual webinars or in-person meetings for participants in rural parts of the Commonwealth. Record these trainings and archive the discussion and written materials for future use.* • *Implement time standards for appropriate steps across the end-to-end employee screening and eligibility determination process and monitor performance according to established standards.*
Considerations for Implementation	• Policy and regulatory updates pending changes. The Commonwealth should consider holding trainings after all regulatory updates have been made. • End-to-end PDS worker approval needs to be reviewed both by individual process step, but also for total execution time, to impact the existing concern that it can take several months to get a worker approved.

Table B.1 Background Check Regulations for Michelle P., ABI and HCB Waivers

Michelle P. and ABI Waivers	HCB Waiver
(11) A PDS provider shall: (i) Submit to a check of the: 1. Nurse Aide Abuse Registry maintained in accordance with 906 KAR 1:100 and not be found on the registry; 2. Caregiver Misconduct Registry maintained in accordance with 922 KAR 5:120 and not be found on the registry; and 3. Central Registry maintained in accordance with 922 KAR 1:470 and not be found on the registry; (j) Not have pled guilty or been convicted of committing a sex crime or violent crime;	(11) A PDS provider shall: (h) Submit to the background and related checks established in Section 2(3)(p) of this administrative regulation; (i) Not be a PDS provider excluded from providing services in accordance with Section 2(3)(q) of this administrative regulation;

Table B.2 Participant-directed Services Employee Regulations Comparison

SCL – 907 KAR 12:010	HCB v2 - 907 KAR 7:010	HCB v1 - 907 KAR 1:160	Michelle P. - 907 KAR 1: 835	ABI - 907 KAR 3:210
Section 10. Participant-Directed Services (PDS). (1)(b) An individual who provides a participant-directed service shall complete the: 1. Background and related requirements established in Section 3(3)(p), (q), (r), (v), (w), (x), (y), and (z) of this administrative regulation; and 2. Following training requirements in the timeframe established by paragraph (c) of this subsection: a. First aid and cardiopulmonary resuscitation certification by a nationally accredited entity; b. If providing supported employment services, the	Section 6. (1) (1) A PDS provider shall: (a) Be selected by the participant; (b) Be at least eighteen (18) years of age; (c) Be a citizen of the United States with a valid Social Security number or possess a valid work permit if not a U.S. citizen; (d) Be able to communicate effectively with the participant, representative, participant's guardian, or family of the participant; (e) Be able to understand and carry out instructions;	Section 6. (11) A PDS provider shall: (a) Be selected by the participant; (b) Submit a completed Kentucky Consumer Directed Options/Participant-directed Services Employee/Provider Contract to the support broker; (c) Be eighteen (18) years of age or older; (d) Be a citizen of the United States with a valid Social Security number or possess a valid work permit if not a U.S. citizen; (e) Be able to communicate effectively with the	Section 7. (11) A PDS provider shall: (a) Be selected by the participant; (b) Submit a completed Kentucky Consumer Directed Options/Participant-directed Services Employee/Provider Contract to the support broker; (c) Be eighteen (18) years of age or older; (d)1. Be a citizen of the United States with a valid Social Security number; or 2. Possess a valid work permit if not a U.S. citizen; (e) Be able to communicate effectively with the participant,	Section 10. (11) A PDS provider shall: (a) Be selected by the participant; (b) Submit a completed Kentucky Participant-Directed Services Employee Provider Contract to the support broker; (c) Be eighteen (18) years of age or older; (d) Be a citizen of the United States with a valid Social Security number or possess a valid work permit if not a U.S. citizen; (e) Be able to communicate effectively with the participant,

SCL – 907 KAR 12:010	HCB v2 - 907 KAR 7:010	HCB v1 - 907 KAR 1:160	Michelle P. - 907 KAR 1: 835	ABI - 907 KAR 3:210
Kentucky Supported Employment Training Project curriculum from the Human Development Institute at the University of Kentucky within eight (8) months of the date of employment as an employment specialist; c. Individualized instruction regarding the participant receiving a support; d. The following areas of the Kentucky College of Direct Support modules: (i) Maltreatment of vulnerable adults and children; (ii) Individual rights and choices; (iii) Safety at home and in the community; (iv) Supporting healthy lives; and (v) Person-centered planning; and e. Other training if required by the participant.	(f) Be able to keep records as required by the participant; (g) Comply with the requirements for background and related checks established in Section 2(3)(j) of this administrative regulation; (h) Not be a PDS provider excluded from providing services in accordance with Section 2(3)(k) of this administrative regulation; (i)1. Prior to the beginning of employment, complete training on the: a. Reporting of abuse, neglect, or exploitation in accordance with KRS 209.030 or 620.030; and b. Needs of the participant; and 2. Receive DAIL attendant care training initially and then annually thereafter; (j)1. Obtain first aid certification within six (6) months of providing PDS services; and 2. Maintain first aid certification for the duration of being a PDS provider; (k)1. Except as established in subparagraph 2 of this paragraph: a. Obtain cardiopulmonary resuscitation (CPR) certification by a nationally accredited entity within six (6) months of employment; and b. Maintain CPR certification for the duration of being a PDS provider; or	participant, participant representative, or family; (f) Be able to understand and carry out instructions; (g) Be able to keep records as required by the participant; (h) Submit to the background and related checks established in Section 2(3)(p) of this administrative regulation; (i) Not be a PDS provider excluded from providing services in accordance with Section 2(3)(q) of this administrative regulation; (j) Prior to the beginning of employment, complete training on the reporting of abuse, neglect, or exploitation in accordance with KRS 209.030 or 620.030 and on the needs of the participant; (k) Comply with the TB risk assessment and test requirements established in Section 2(3)(o)4 of this administrative regulation; (l)1. Obtain first aid certification within six (6) months of providing PDS services; and 2. Maintain first aid certification for the duration of being a PDS provider; and (m)1. Except as established in subparagraph 2 of this paragraph: a. Obtain cardiopulmonary resuscitation (CPR) certification by a nationally accredited entity	participant's representative, or family; (f) Be able to understand and carry out instructions; (g) Be able to keep records as required by the participant; (h) Submit to a criminal background check from the Kentucky Administrative Office of the Courts and equivalent out-of-state agency if the individual resided or worked outside of Kentucky during the twelve (12) months prior to being a PDS provider; (i) Submit to a check of the: 1. Nurse Aide Abuse Registry maintained in accordance with 906 KAR 1:100 and not be found on the registry; 2. Caregiver Misconduct Registry maintained in accordance with 922 KAR 5:120 and not be found on the registry; and 3. Central Registry maintained in accordance with 922 KAR 1:470 and not be found on the registry; (j) Not have pled guilty or been convicted of committing a sex crime or violent crime; (k) Complete training on the reporting of abuse, neglect, or exploitation in accordance with KRS 209.030 or 620.030 and on the needs of the participant; (l) Be approved by the department;	participant representative, or family; (f) Be able to understand and carry out instructions; (g) Be able to keep records as required by the participant; (h) Submit to a criminal background check conducted by: 1. The Administrative Office of the Courts if the individual is a Kentucky resident; or 2. An equivalent out-of-state agency if the individual resided or worked outside Kentucky during the year prior to selection as a provider of PDS; (i) Submit to a check of the Central Registry maintained in accordance with 922 KAR 1:470 and not be found on the registry. 1. A participant may employ a provider prior to a Central Registry check result being obtained for up to thirty (30) days. 2. If a participant does not obtain a Central Registry check result within thirty (30) days of employing a provider, the participant shall cease employment of the provider until a favorable result is obtained; (j) Submit to a check of the: 1. Nurse Aide Abuse Registry maintained in accordance with 906 KAR 1:100 and not be found on the registry; and

SCL – 907 KAR 12:010	HCB v2 - 907 KAR 7:010	HCB v1 - 907 KAR 1:160	Michelle P. - 907 KAR 1: 835	ABI - 907 KAR 3:210
	2. If the participant to whom a PDS provider provides services has a signed Do Not Resuscitate order, not be required to meet the requirements established in subparagraph 1 of this paragraph; (l) Comply with the TB risk assessment and test requirements established in Section 2(3)(h)5. of this administrative regulation; (m) Maintain and submit timesheets: 1. Signed by the: a. Participant or representative; and b. Provider; and 2. Documenting: a. Hours worked; b. The provision of a service including: (i) A full description of the service provided; and (ii) Any concerns or issues, if existing, regarding the general well-being of the participant; and c. The participant's choice of daily activities and services; and (n) Submit a completed Kentucky Consumer Directed Options/Participant-directed Services Employee/Provider Contract to the service advisor.	within six (6) months of employment; and b. Maintain CPR certification for the duration of being a PDS provider; or 2. If the participant to whom a PDS provider provides services has a signed Do Not Resuscitate order, not be required to meet the requirements established in subparagraph 1 of this paragraph; (n) Be approved by the department; (o) Maintain and submit timesheets documenting hours worked; and (p) Be a friend, spouse, parent, family member, other relative, employee of a provider agency, or other person hired by the participant.	(m) Maintain and submit timesheets documenting hours worked; and (n) Be a friend, spouse, parent, family member, other relative, employee of a provider agency, or other person hired by the participant.	2. Caregiver Misconduct Registry in accordance with 922 KAR 5:120 and not be found on the registry; (k) Not have pled guilty or been convicted of committing a sex crime or violent crime as defined in KRS 17.165(1) through (3); (l) Complete training on the reporting of abuse, neglect, or exploitation in accordance with KRS 209.030 or 620.030 and on the needs of the participant; (m) Be approved by the department; (n) Maintain and submit timesheets documenting hours worked; and (o) Be a friend, spouse, parent, family member, other relative, employee of a provider agency, or other person hired by the participant.

Table B.3 Participant-directed Services Employee Regulations – Additional References

SCL - 907 KAR 12:010, Section 3(3)(p), (q), (r), (v), (w), (x), (y), and (z)	HCB v1 -907 KAR 1:160, Section 2(3)(q)
Section 3(3)(p) Shall ensure that an employee or volunteer: 1. Completes a tuberculosis (TB) risk assessment performed by a licensed medical professional and, if indicated, a TB skin test with a negative result within the past twelve (12) months as documented on test results received by the provider within thirty (30) days of the date of hire or date the individual began serving as a volunteer; or 2. Who tests positive for TB or has a history of positive TB skin tests: a. Shall be assessed annually by a licensed medical professional for signs or symptoms of active disease; and b. If it is determined that signs or symptoms of active disease are present, in order for the person to be allowed to work or volunteer, is administered follow-up testing by his or her physician with the testing indicating the person does not have active TB disease; (q) Shall maintain documentation: 1. Of an annual TB risk assessment or negative TB test for each employee who performs direct support or a supervisory function; or 2. Annually for each employee with a positive TB test that ensures no active disease symptoms are present; (r) Shall provide a written job description for each staff person that describes the required qualifications, duties, and responsibilities for the person's job; (s) Shall maintain an employee record for each employee that includes: 1. The employee's experience; 2. The employee's training; 3. Documented competency of the employee; 4. Evidence of the employee's current licensure or registration if required by law; and 5. An annual evaluation of the employee's performance; (t) Shall require a background check: 1. And drug testing for each employee who is paid with funds administered by the department and who: a. Provides support to a participant who utilizes SCL services; or b. Manages funds or services on behalf of a participant who utilizes SCL services; or 2. For a volunteer recruited and placed by an agency or provider who has the potential to interact with a participant; (u) Shall ensure that a volunteer placed by an agency or provider does not have unsupervised interaction with a participant; (v) 1. Shall for a potential employee or volunteer obtain:	Section (2)(3)(p)1. Shall: a. Prior to hiring an individual, obtain: (i)The results of a criminal record check from the Kentucky Administrative Office of the Courts and equivalent out-of-state agency if the individual resided or worked outside of Kentucky during the twelve (12) months prior to employment; (ii) The results of a Nurse Aide Abuse Registry check as described in 906 KAR 1:100 and an equivalent out-of-state agency if the individual resided or worked outside of Kentucky during the twelve (12) months prior to employment; and (iii) The results of a Caregiver Misconduct Registry check as described in 922 KAR 5:120 and equivalent out-of-state agency if the individual resided or worked outside of Kentucky during the twelve (12) months prior to employment; and b. Within thirty (30) days of the date of hire, obtain the results of a Central Registry check as described in 922 KAR 1:470 and an equivalent out-of-state agency if the individual resided or worked outside of Kentucky during the twelve (12) months prior to employment; or 2. May use Kentucky's national background check program established by 906 KAR 1:190 to satisfy the background check requirements of subparagraph 1 of this paragraph; and (q) Shall not allow a staff person to provide HCB waiver services if the individual: 1. Has a prior conviction of or pled guilty to a: a. Sex crime; or b. Violent crime; 2. Is a violent offender; 3. Has a prior felony conviction; 4. Has a drug related conviction, felony plea bargain, or amended plea bargain conviction within the past five (5) years; 5. Has a positive drug test for an illicit or a prohibited drug; 6. Has a conviction of abuse, neglect, or exploitation; 7. Has a Cabinet for Health and Family Services finding of: a. Child abuse or neglect pursuant to the Central Registry as described in 922 KAR 1:470; or b. Adult abuse, neglect, or exploitation pursuant to the Caregiver Misconduct Registry as described in 922 KAR 5:120; 8. Is listed on the Nurse Aide Abuse Registry pursuant to 906 KAR 1:100; 9. Within the twelve (12) months prior to employment, is listed on or has a finding indicated on another state's equivalent of the: a. Nurse Aide Abuse Registry as described in 906 KAR 1:100 if the other state has an equivalent;

SCL - 907 KAR 12:010, Section 3(3)(p), (q), (r), (v), (w), (x), (y), and (z)	HCB v1 -907 KAR 1:160, Section 2(3)(q)
a. The results of a criminal record check from the Kentucky Administrative Office of the Courts and equivalent out-of-state agency if the individual resided or worked outside of Kentucky during the twelve (12) months prior to employment or volunteerism; b. The results of a nurse aide abuse registry check as described in 906 KAR 1:100 and an equivalent out-of-state agency if the individual resided or worked outside of Kentucky during the twelve (12) months prior to employment or volunteerism; c. The results of a caregiver misconduct registry check as described in 922 KAR 5:120 and an equivalent out-of-state agency if the individual resided or worked outside of Kentucky during the twelve (12) months prior to employment or volunteerism; and d. Within thirty (30) days of the date of hire or initial date of volunteerism, the results of a central registry check as described in 922 KAR 1:470 and an equivalent out-of-state agency if the individual resided or worked outside of Kentucky during the twelve (12) months prior to employment or volunteerism; or 2. May use Kentucky's national background check program established by 906 KAR 1:190 to satisfy the background check requirements of subparagraph 1 of this paragraph; (w) Shall for each potential employee obtain negative results of drug testing for illicit or prohibited drugs; (x) Shall on an annual basis: 1. Randomly select and perform criminal history background checks, nurse aide abuse registry checks, central registry checks, and caregiver misconduct registry checks of at least twenty-five (25) percent of employees; and 2. Conduct drug testing of at least five (5) percent of employees; (y) Shall not use an employee or volunteer to provide 1915(c) home and community-based waiver services if the employee or volunteer: 1. Has a prior conviction of an offense delineated in KRS 17.165(1) through (3); 2. Has a prior felony conviction or diversion program that has not been completed; 3. Has a drug related conviction, felony plea bargain, or amended plea bargain conviction within the past five (5) years; 4. Has a positive drug test for prohibited drugs; 5. Has a conviction of abuse, neglect, or exploitation; 6. Has a Cabinet for Health and Family Services finding of: a. Child abuse or neglect pursuant to the central registry; or b. Adult abuse, neglect, or exploitation pursuant to the Caregiver Misconduct Registry; or 7. Is listed on the nurse aide abuse registry;	b. Caregiver Misconduct Registry as described in 922 KAR 5:120 if the other state has an equivalent; or c. Central Registry as described in 922 KAR 1:470 if the other state has an equivalent; or 10. Has been convicted of Medicaid or Medicare fraud.

SCL - 907 KAR 12:010, Section 3(3)(p), (q), (r), (v), (w), (x), (y), and (z)	HCB v1 -907 KAR 1:160, Section 2(3)(q)
(z) Shall not permit an employee to transport a participant if the employee has a driving under the influence conviction, amended plea bargain, or diversion during the past year	

NAVIGANT

Kentucky 1915(c) Waiver Assessment: Summary of Stakeholder Focus Group Comments

The Commonwealth of Kentucky Department of Medicaid Services (DMS) contracted with Navigant Consulting Inc. (Navigant) to assist with the evaluation, improvement and ongoing support of Kentucky's 1915(c) waivers. Recognizing that a comprehensive assessment includes feedback from stakeholders, the Commonwealth held focus groups across Kentucky in the fall of 2017 with stakeholders and structured the groups as follows:

- Participants
- Caregivers
- Direct support professionals
- Providers

The intent of the focus groups was to engage and receive stakeholder input on the current state of home and community based service (HCBS) delivery through existing waivers, to better understand how waivers are working now, including what aspects are working well and what could be made better. A focus group was conducted with each stakeholder group mentioned above, in 10 sites across the Commonwealth, for a total of 40 focus groups. Nearly 500 participants attended across the Commonwealth. In this report, we summarize the themes stakeholders raised most frequently during the focus groups.

This report is intended to be a resource for the Kentucky Department of Medicaid Services (DMS) to respond to past concern expressed by stakeholders that their input did not adequately factor into policy and design decisions. Additionally, stakeholders reported that they were unaware of how their feedback had been handled in the past and requested transparency to ensure feedback was clear and not misinterpreted. Therefore, the purpose of this summary is to report the findings collected from the focus groups and promote transparency to stakeholders throughout the assessment process.

Top Focus Group Themes:

Overall, Navigant heard numerous comments from various stakeholders across the Commonwealth that are vitally important to the improvement of the HCBS programs. While discussing opportunities for improvement, stakeholders also voiced strengths of the waiver programs that they wish to see reflected in any re-design. Some of the strengths highlighted include:

- Many stakeholders voiced their appreciation for the waiver services and credited them for improving the quality of life of waiver recipients. Stakeholders shared appreciation to the waivers for allowing participants to stay in their homes and gain independence. Providers and caregivers expressed their enjoyment in seeing the progress of participants' conditions since being a waiver participant.
- Some participants complimented their case managers and support brokers for being very knowledgeable and readily accessible. Stakeholders satisfied with their case management often described the services as consistent, reliable and helpful in navigating HCBS delivery, and setting the tone for what universal, high-quality case management should deliver statewide.
- Stakeholders indicated that the webinars released by the Cabinet addressing new regulatory changes are helpful and stakeholders wish to see more of them released in the future.

- Stakeholders indicated that community integration is a beneficial service that allows waiver recipients to be a part of their community through various activities, such as volunteering and encouraging social interactions with fellow waiver recipients.
- Many providers indicated that despite frustrations, they believe that the tone of monitoring and communication from DMS and operating agencies has improved in the past year, and is more collaborative and less punitive in nature.
- Stakeholders expressed their appreciation for being able to employ family members through participant-directed services.

Based on the comments received from the focus groups, 10 key themes have been identified for areas of improvement, as summarized seen in Figure 1.

Figure 1. Overview of Key Themes

Communication	•*Improve communication from the Cabinet (DMS, DBHDID, DAIL, and DCBS) about waiver programs*
HCBS Payment Rates	•*Establish sound rates that reflect provider agency costs that are equitable across waivers*
Network Adequacy	•*Address the lack of service access and network adequacy across a variety of HCBS service types*
Eligibility and Recertification	•*Improve clarity and communication during the eligibility and recertification process*
Participant Directed Services (PDS)	•*Enhance the process of hiring participant directed services (PDS) employees, as well as ability to recruit high quality employees*
Transportation	•*Expand access to transportation, and revise regulations to promote access to paid providers*
MWMA and Carewise	•*Address challenges the Medicaid Waiver Management Application (MWMA), including its interface with Carewise*
Regulation Interpretations	•*Apply consistency and clarity in regulations across waivers*
Internal Training	•*Expand clinical and technical knowledge within the Cabinet and among the direct care workforce, to enhance quality of care*
Care Coordination	•*Improve collaboration and transition of care for current and prospective waiver recipients*

In the section below, a detailed description of each theme is provided with the information we collected from stakeholders.

2.1 Improve communication from the Cabinet about waiver programs, including more frequent information sharing, and more accurate, consistent delivery of information across departments:

Overall lack of communication and miscommunication were the most frequently reported issues in focus groups. Participants reported difficulty getting in touch with the proper contact for resolving specific issues, stating that reaching someone who could offer assistance was often a frustrating, multi-step process. Additionally, focus group attendees reported receiving varying answers to the same question from different contacts within the Cabinet. Providers indicated that the key factor in regulatory non-compliance, resulting in recoupment, is the difficulty in getting consistent information. Providers requested timely, recurring updates that clearly outline the needed information to promote regulatory compliance.

Many participants also reported that they would like to see better communication between all the parties involved with their care (i.e. doctors, case managers and providers).

2.2 Current HCBS payment rates limit providers' ability to improve quality, including attracting high-quality workforce to improve service delivery:

Focus group attendees believe reimbursement rates are not adequate or equitable, which they suggested affects the quality of care that can be provided. Several providers reported that they had not had an increase in rates in several years, others indicated that pay is too low considering the high volume of administrative and documentation required. In addition, providers noted difficulty competing with other industries for direct care staff, such as the fast food industry or industries that require less training and skills but offer higher pay. In turn, service delivery has been negatively impacted, with shortages of adequately trained employees since trainings are costly and turnover is high. The rate most recently cited by participants is the personal care rate for the Home and Community Based (HCB) waiver, which stakeholders universally described as inhibiting network development and the ability to recruit staff.

2.3 Dissatisfaction with lack of service access and network adequacy across a variety of HCBS service types:

Another common theme that emerged from focus groups was gaps in network adequacy. Attendees frequently cited lack of providers in rural areas and lack of specialized/expertise services as issues. Other common concerns specific to network adequacy included difficulty in receiving necessary services such as home delivered meals, specialized therapies, community supports, and having outdated or inaccurate information in the provider directory. Additionally, participants noted that they have encountered providers that are unwilling to render all of the services approved in a participant's service plan, or were hesitant or unwilling to offer certain services due to the associated monitoring risks and frequent recoupments associated with delivery of a service.

2.4 Improved clarity and communication during the eligibility and recertification process:

Attendees frequently reported challenges navigating annual eligibility, frequently citing instances when individuals experienced a lapse in coverage during this process. Many providers indicated that they continued to serve these recipients, experiencing financial losses to minimize disruption in service delivery to vulnerable participants. Several providers indicated losses of several thousand dollars in the past year.

Waiver participants and their caregivers complained that their applications were lost and struggled to receive direct answers to their issues, including what documentation was needed to complete an application. Similarly, those who were denied coverage could not receive a clear answer as to why they were denied. Overall – the volume and clarity of notices from Medicaid was cited as an issue. Those who participate in the eligibility and redetermination process, including professionals who assist participants and their families to navigate required procedures, advised that they expect confusion and disruption and chronically experience negative experiences each year. There is high demand among stakeholders for DMS to collaborate with the Department of Community Based Services (DCBS), as both agencies play a role in these processes.

2.5 Improve the process of hiring participant directed services (PDS) employees, as well as ability to recruit high quality employees:

Attendees indicated that the process of hiring a PDS employee is costly and time consuming, many waiver participants indicated they struggle to manage the costs of recruiting and obtaining required background checks. There were complaints of inefficiencies, such as requiring the same PDS employee to obtain the same background check for each participant they work with within a finite period. Other participants reported that documentation associated with the process is difficult for families and recommended having resources in place to help families accurately complete the application. Similarly, many attendees expressed concern that participants who elect the PDS model lack adequate education when choosing the PDS service delivery model, so need more assistance from their support broker to navigate the process. The stakeholders suggested additional oversight from providers and case managers to ensure adequate care of the waiver participant.

2.6 Improve access to transportation, and revise regulations to promote access to paid providers:

Focus group attendees frequently cited transportation as a primary challenge to community based living. Transportation is offered only under certain waivers, and stakeholders believe transportation services should be available across all waivers. Those with access to transportation services suggested services are unreliable, causing missed physician appointments and other disruptions. Stakeholders would like to see better linkage between HCBS waiver operations, and non-emergency transportation services offered within the Medicaid system. Participants indicated more logistical support is needed, such as guidance on what stop to use on the bus or where to go when exiting the bus. Many were frustrated that transportation services are denied when someone in their home owns a car, as this circumstance did not preclude individuals from needing day-time support. Finally, attendees voiced concerns that transportation is billed to one participant, regardless of whether other participants received transport within the trip.

2.7 Difficulty with the use of the Medicaid Waiver Management Application (MWMA), particularly with Carewise:

The operational processes of MWMA and Carewise were frequently cited as inefficient and the source of challenges with eligibility and issuance of prior authorization. Among the concerns:

- Participants reported miscoding in MWMA, leading to an interruption in their services.
- Carewise placed waiver participants in the incorrect waiver, disrupting services.
- Providers indicated difficulty in getting solutions from the MWMA support desk and/or Carewise who pin solution on the other party, resulting in ongoing churn.
- Stakeholders reported having issues contacting both MWMA and Carewise due to high call volumes and extended wait periods. Those that get through have encountered a lack of knowledge among answering parties, and often have their call transferred several times before reaching a knowledgeable staff member.
- Many providers would like more access and use within MWMA to communicate in a timely fashion with case management providers and DMS.

2.8 Improved consistency and clarity in regulations across waivers:

Providers want waivers that are concise and clear, and find the current waivers and regulations burdensome and subject to individual interpretation. This regulatory "gray area" has led to challenges with audits and unanticipated recoupments. Varying definitions for the similar elements between waivers is confusing, both for providers serving multiple waiver programs, as well as for participants and caregivers navigating transitions from program to program. Stakeholders pointed to arduous regulations they believe are not helpful and adversely impact certain groups or only select waivers, such as the standard 40-hour cap on services used on the Michelle P waiver.

2.9 Improved clinical and technical knowledge within the Cabinet and among the direct care workforce, to enhance programs and the quality of care waiver recipients receive:

Multiple stakeholders expressed the need for Cabinet and provider staff members with deeper expertise in disabilities and HCBS programs, so that these staff members would be better able to respond to increasing complexity and acuity in the participant population. Stakeholders would like to see more subject matter expertise related to dual-diagnosis, behavioral health and acquired brain injury, among other elements. Providers indicated that the challenge of maintaining well-trained staff stems from both current payment rates, and inconsistent technical assistance and training practices across waivers. Training for specialized staff members is expensive and a gamble for providers because of high staff turnover rates. While some stakeholders expressed concern about a lack of training, others complained of too much training that took them away from day-to-day responsibilities.

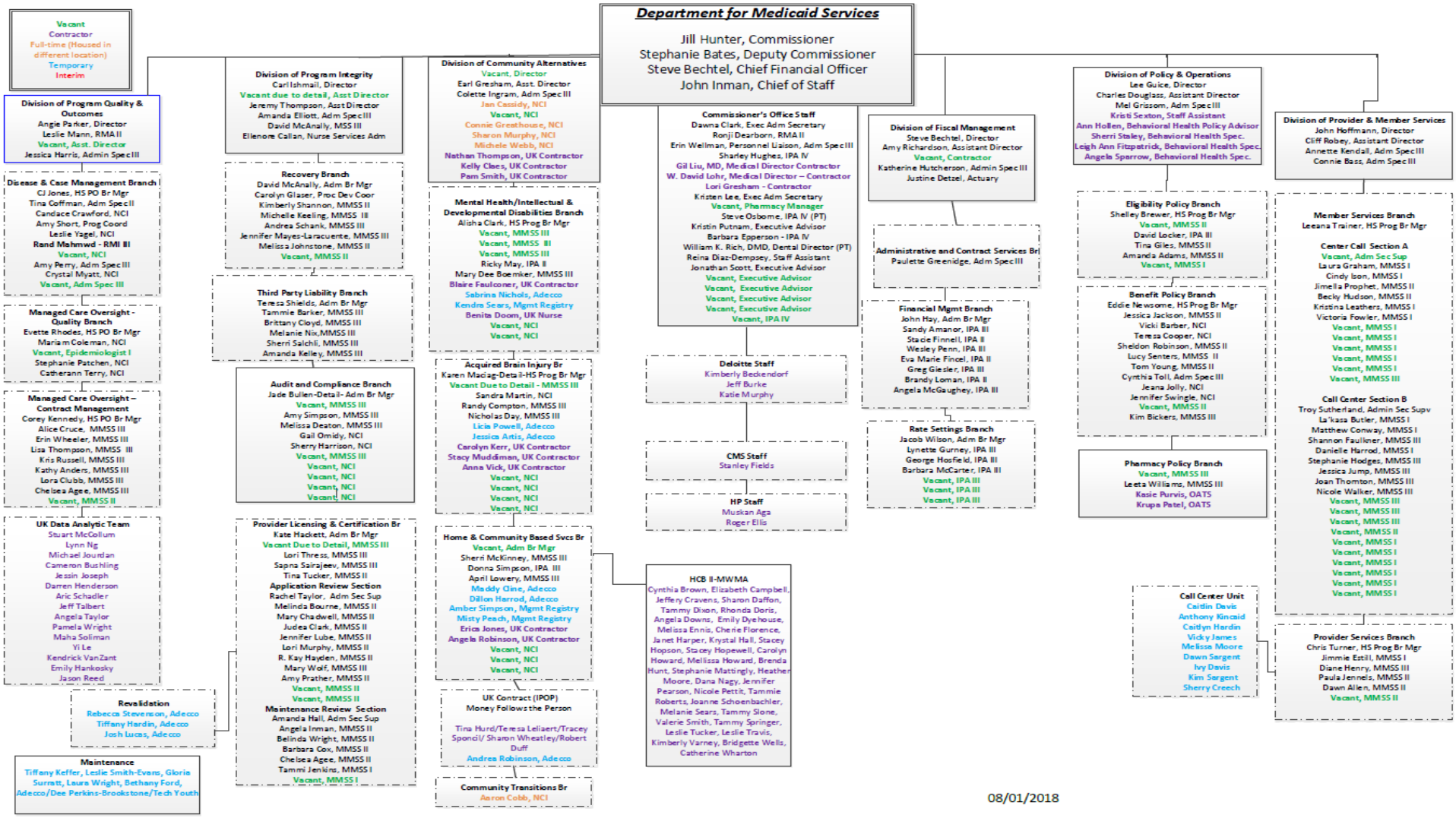
2.10 Improved collaboration and transition of care for current and prospective waiver recipients:

Coordination with non-Medicaid systems and transition of care for waiver recipients was highlighted as an unaddressed issue across all waivers. Focus group attendees specifically mentioned the difficulties encountered transitioning youth out of the public-school system into adult services. Many participants and their caregivers struggled to adjust and had not proactively planned when aging out of eligibility for school-based supports, essentially falling off a cliff with no planning or education. Other stakeholders called for better coordination across their healthcare and long-term care services and supports (LTSS) providers. Participants noted that there was a lack of coordination among Medicaid providers (including providers of non-waiver services), resulting in confusion and inefficient care delivery.

Conclusion:

At the end of the focus groups, stakeholders voiced their appreciation to the Commonwealth for including them in the waiver assessment and are hopeful for upcoming program changes. Stakeholders also seek more opportunities to address future concerns. The Commonwealth is committed to further stakeholder engagement and communication. DMS intends to carefully consider stakeholders' feedback during its ongoing assessment of HCBS waiver programs.

Appendix D DMS Organizational Chart



Appendix E Current 1915(c) Waiver Service Limitations

Figure E.1. Kentucky 1915(c) Waiver Service Limitations - SCL

SCL	
Service Name	**Service Limitations and Caps**
Case Management	1 monthly unit per month
Community Access	40 hours per week Any combination of day training, community access, personal assistance, or any hours of paid community employment or on-site supported employment shall not exceed 16 hours per day
Community Guide	144 hours per plan of care (POC) year
Community Transition	$2000 per approved transition
Consultative clinical and therapeutic (Diet/Nutrition, Functional Analysis, Positive Behavior Supports and Psychological Services)	40 hours units per POC year
Day Training	40 hours units per week alone or in combination with any hours of paid community employment (without onsite support) or onsite supported employment. Any combination of day training, community access, personal assistance, or any hours of paid community employment or on-site supported employment shall not exceed 16 hours per day
Environmental Accessibility Adaptation Services	$8000 lifetime maximum
Financial Management Service	Limited to two hours per member per calendar month. Financial management services are limited to members who opt to participant direct some or all of their non-medical services and apply only to participant-directed services.
Goods and Services	$1800 per POC year
Natural Support Training	$1000 per POC year
Person-Centered Coaching	330 hours per year
Personal Assistance	Any combination of day training, community access, personal assistance, or any hours of paid community employment or on-site supported employment shall not exceed 16 hours per day
Positive Behavior Support	Limited to amount on prior authorization
Residential Level I	There is a separate rate for residential provided to more than 3 persons in one location
Residential Level II	Limited to amount on prior authorization

SCL	
Service Name	**Service Limitations and Caps**
Residential -Technology Assisted	Limited to amount on prior authorization
Respite	830 hours per POC year
Shared Living	$600 per month
Specialized Medical Equipment	Limited to amount on prior authorization
Supported Employment (Job acquisition with support, job development and analysis, long term support and follow up, PCJS discovery)	40 hours units per week Any combination of day training, community access, personal assistance, or any hours of paid community employment or on-site supported employment shall not exceed 16 hours per day
Transportation	$265 per month
Vehicle Adaptation	$6000 per 5 years per recipient

Figure E.2. Kentucky 1915(c) Waiver Service Limitations – Michelle P Waiver

Michelle P Waiver	
Service Name	**Service Limitations and Caps**
Adult Day Health Care	Limited to 40 hours per week in combination with all services except Case Management/Support Broker, Financial Management, Respite, Environmental Home Modification and Goods and Services
Attendant Care	Limited to 40 hours per week in combination with all services except Case Management/Support Broker, Financial Management, Respite, Environmental Home Modification and Goods and Services
Case Management	1 monthly unit per month
Community Living Supports	Limited to 40 hours per week in combination with all services except Case Management/Support Broker, Financial Management, Respite, Environmental Home Mod and Goods and Services
Day Training	Limited to 40 hours per week in combination with all services except Case Management/Support Broker, Financial Management, Respite, Environmental Home Modification and Goods and Services
Environmental and Minor Home Adaptation	$500 per calendar year
Financial Management Services	Limited to two hours or $100 per month
Goods and Services	Limited to amount on prior authorization
Homemaker	Limited to 40 hours per week in combination with all services except Case Management/Support Broker, Financial Management, Respite, Environmental Home Modification and Goods and Services

Michelle P Waiver	
Service Name	**Service Limitations and Caps**
Person Centered Coaching	Limited to 40 hours per week in combination with all services except Case Management/Support Broker, Financial Management, Respite, Environmental Home Modification and Goods and Services
Personal Assistance	Limited to 40 hours per week in combination with all services except Case Management/Support Broker, Financial Management, Respite, Environmental Home Modification and Goods and Services
Positive Behavior Supports	Limited to 40 hours per week in combination with all services except Case Management/Support Broker, Financial Management, Respite, Environmental Home Modification and Goods and Services
Respite	$4000 per calendar year
Support Broker	1 monthly unit per month
Supported Employment	Limited to 40 hours per week in combination with all services except Case Management/Support Broker, Financial Management, Respite, Environmental Home Modification and Goods and Services Job development is limited to 50 hours (200 units) per job for a maximum of three episodes per year.

Figure E.3. Kentucky 1915(c) Waiver Service Limitations – ABI Long-term Care

ABI - LTC Waiver	
Service Name	**Service Limitations and Caps**
Adult Day Health Care	40 hours per member per calendar week
Adult Day Training	40 hours per member per calendar week alone or in combination with Supported Employment
Assessment and re-assessment	Limited to amount on prior authorization
Behavior Services	20 hours per member per month for first 3 months 12 hours per member per month after the first 3 months
Case Management	1 unit per month
Community Living Supports	40 hours per member per calendar week
Environmental and Minor Home Adaptations/Modification	$2000 per member per calendar year
Family Training	Two hours per member per calendar week.
Financial Management Services	Two hours per member per calendar month. Financial management services are limited to members opting to participant direct some or all of their non-medical services and only apply to participant-directed services.
Goods and Services	Limited to amount on prior authorization
Group Counseling	12 hours per member per calendar month

ABI - LTC Waiver	
Service Name	**Service Limitations and Caps**
Individual Counseling	13 hours per member per calendar month 4 hours per day
Nursing Supports	7 hours per member per calendar week
Residential Level I	1 unit per calendar day
Residential Level II	1 unit per calendar day
Residential Level III	1 unit per calendar day
Respite	1440 hours per member per calendar year
Specialized Medical Equipment	Limited to amount on prior authorization
Support Broker	1 unit per month
Supported Employment	40 hours per member per calendar week alone or in combination with Adult Day Training

Figure E.4. Kentucky 1915(c) Waiver Service Limitations – ABI

ABI Waiver	
Service Name	**Service Limitations and Caps**
Adult Day Training	40 hours alone or in combination with supported employment, per calendar week
Assessment and re-assessment	Limited to amount on prior authorization
Behavior Services	4 hours per day
Case Management	1 unit per month
Community Living Support/Companion Care	50 hours per week
Financial Management Services	Two hours or $100.00 per month
Goods and Services	Limited to amount on prior authorization
Group Counseling	12 hours per participant per calendar month
Individual Counseling	4 hours per day
Personal Care	20 hours per week
Respite	336 hours per 12 months
Specialized Medical Equipment and Supplies	Limited to amount on prior authorization
Supervised Residential Level I	1 unit per day
Supervised Residential Level II	1 unit per day
Supervised Residential Level III	1 unit per day
Support Broker	1 unit per month
Supported Employment	40 hours alone or in combination with adult day training, per calendar week

Figure E.5. Kentucky 1915(c) Waiver Service Limitations – Model II Waiver

Model II Waiver	
Service Name	**Service Limitations and Caps**
Skilled Services Provided by an LPN	Limited to 16 hours per day alone or in combination with RN or RT
Skilled Services Provided by an RN	Limited to 16 hours per day alone or in combination with LPN or RT
Skilled Services Provided by an RT	Limited to 16 hours per day alone or in combination with RN or LPN

Figure E.6. Kentucky 1915(c) Waiver Service Limitations – HCB Waiver

HCB Waiver	
Service Name	**Service Limitations and Caps**
Adult Day Health	50 hours per week
Attendant Care	$200 per day alone or in combination with Adult Day Health
Case Management	1 unit per month
Environmental or Minor Home Adaptation	$2500 per Level of Care (LOC) year
Goods and Services	$3500 per LOC year without DMS approval
Home and Community Supports	$200 per day alone or in combination with Adult Day Health Cannot exceed 45 hours per week
Home Delivered Meals	Max of 1 hot meal per day and 5 meals per week
Non-Specialized Respite	$200 per day alone or in combination with specialized respite Cannot exceed $4000 per level of care year.
Participant-directed Services Coordination	2 visits per month
Specialized Respite	$200 per day alone or in combination with non-specialized respite Cannot exceed $4000 per level of care year.

Appendix F Payment and Rate Study Provider Letter

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Matthew G. Bevin
Governor

Stephanie Bates
Director

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Scott W. Brinkman
Acting Secretary

Stephen P. Miller
Commissioner

Acquired Brain Injury (PT 17) – Provider Letter #A-32
Supports for Community Living (PT 33) – Provider Letter #A-52
Model Waiver II (PT 41) – Provider Letter #A-21
Home & Community Based Waiver (PT 42) – Provider Letter #A-91
Adult Day Care (PT 43) – Provider Letter #A-53
Home Delivered Meals (PT 48) – Provider Letter #A-1

May 1, 2018

Dear 1915(c) Waiver Provider,

The Department for Medicaid Services (DMS) is considering conducting a study of provider payment and rate-setting methodologies for home and community based services (HCBS) delivered via 1915(c) waivers. This study may include an evaluation of DMS' current methodologies against national best practices. Should DMS choose to initiate this study, it will work with Navigant Consulting, Inc. (Navigant) to begin the study this summer. This letter outlines the process Navigant would use ***IF*** DMS elects to implement Navigant's recommendation to conduct a study of HCBS payment and rate-setting methodologies.

The study of payment and rate-setting methodologies would be undertaken to identify methods to make payments and establish rates that take into consideration the costs incurred by providers furnishing 1915(c) waivers services that are consistent with efficiency, accessibility and the quality of care standards federally required by U.S.C. § 1396a (a)(30)(A). The process would also consider the needs of participants and providers and offer transparency in payments for services and the development of rates.

To better inform this study, and to potentially support the development of new rates, Navigant has advised they would collect information on provider costs, including staffing levels, direct service wages, and utilization information to inform their study so they have data points for realistic modeling of methodologies under consideration.

(continued)

DMS wants to give providers advance opportunity to prepare and compile any necessary documentation that may be requested, should DMS elect to move forward with the rate study. This is a sample of what Navigant anticipates having providers report:

- Employee wage rates by type of employee (direct service, direct service supervisors, nursing, therapy, program support, administration, etc.)
- Direct service employee time spent providing direct services to participants, etc.
- Employee benefit costs and payroll taxes
- Other administrative costs
- Other program support costs
- Others

A survey tool would be developed and released to assist providers in reporting all requested information. Navigant would take into consideration the differing abilities of providers to complete survey forms and participate in the process. DMS also expects that several training sessions would be conducted to assist providers with understanding how to complete the survey tool. It is expected that completion of the survey tool would be voluntary, but strongly encouraged.

We hope this notice assists you in understanding the information you may wish to gather in advance of a potential study, and helps to answer questions we have received on what the study process might entail. Please submit any questions or comments related to this recommendation to Medicaidpubliccomment@ky.gov, or provide testimony or written comment at the town hall of your choice.

Most sincerely,

Stephen P. Miller

Stephen P. Miller, Commissioner
Department for Medicaid Services

Appendix G Recommendation Implementation Activities

Recommendation	Key Phase I Implementation Activities *(Not All-Inclusive)*
1. Waiver Re-Write	• Develop revised 1915(c) waiver applications • Coordinate with stakeholders on proposed revisions • Conduct discussions with CMS • Propose revisions to Kentucky Administrative Regulations (KAR)
2. Implement UAT	• Conduct national scan of existing Universal Assessment Tools • Coordinate with stakeholders on design UAT elements • Develop proposed RFP and contract for UAT vendor selection • Conduct training on UAT • Identify core data elements to track from UAT • Develop methodologies for quality control and monitoring reliability
3. Individual Budgets	• Identify individualized budgeting approaches for consideration • Coordinate with stakeholders on budgeting design elements • Conduct statistical modeling options to link waiver participants assessments to payments • Select budgeting methodology • Develop and conduct participant trainings on individual budgeting methodology
4. Payment and Rate Study	• Conduct national scan of payment and rate setting methodologies • Coordinate with stakeholders on study design and approach • Develop, distribute, and collect provider cost and wage survey • Analyze claims and assessment data to inform rate impacts • Develop rate models for consideration and determine fiscal impacts • Set new reimbursement rates

Recommendation	Key Phase I Implementation Activities *(Not All-Inclusive)*
5. Implement SOPs	• Identify and categorize 1915(c) waiver administration oversight activities • Develop standard template for operating procedures • Identify steps, responsible parties, and associated timelines • Provide governance structure and process for escalation of issues
6. Strengthen Case Management	• Compile state and national quality standards • Coordinate with stakeholders on approach and key performance measures • Assess existing Case Management tools for improvement • Develop and/or modify desk-review and onsite monitoring tools • Develop requirements for modifications to MWMA • Develop Case Management handbook
7. Streamline PDS	• Develop key program design options and tool to support PDS support planning • Coordinate with stakeholders on PDS enhancements • Analyze and strengthen FMA contract language • Develop revised policies and procedures to clearly delineate responsibilities and enhance accountability • Develop and conduct Case Management training on enhanced PDS design
8. Centralize Quality Management	• Design centralized structure a quality management business unit • Map staff to new organizational structure • Utilize newly developed SOPs (see Recommendation 5) • Develop and conduct staff training and operational rollout

Recommendation	Key Phase I Implementation Activities *(Not All-Inclusive)*
9. Stakeholder Engagement	• Design provider, participant and advocacy advisory panels and sub-panels to provide insight into implementation of recommendations • Set meeting schedule and timelines for panel and sub-panel discussions • Develop content and seek advisory panel feedback throughout Phase I • Conduct public comment periods and town halls for applicable recommendations • Conduct stakeholder surveys for applicable recommendations
10. Implement QIS	• Develop proposed quality assurance measures and quality improvement strategy • Coordinate stakeholder feedback on quality improvement strategy and performance measures • Identify and select key quality improvement initiatives and outline associated timelines

Appendix H Matrix of Findings Supportive of Navigant Recommendations

Note: A checkmark indicates that a finding supports a specific Navigant recommendation.

Navigant Findings	Navigant Recommendations										
	Recommendation 1: Standardize and Revise Waiver and Waiver Related KAR	Recommendation 2: Adopt a Universal Assessment Tool	Recommendation 3: Implement an Individual Budgeting Methodology	Recommendation 4: Update the Rate Setting Methodology Across Waiver	Recommendation 5: Develop Standard Operating Procedures	Recommendation 6: Strengthen Case Management Systems	Recommendation 7: Streamline Participant-directed Service Delivery	Recommendation 8: Centralize Operation and Oversight within DMS	Recommendation 9: Improve Stakeholder Engagement	Recommendation 10: Implement a Quality Improvement Strategy	Recommendation 11: Conduct Waiver Reconfiguration Analysis
Finding 1: Kentucky's 1915(c) waiver applications vary in their content – including the level of detail across sections and application of regulatory or handbook references. Additionally, some waiver elements need to be updated to better align Commonwealth practices with updated federal requirements and/or HCBS best practices, or to more clearly state program requirements.	✓	✓	✓		✓	✓	✓	✓	✓	✓	
Finding 2: Existing waivers designate multiple departments within the Cabinet to administer and operate waivers. Using multiple departments to operate waivers, each with unique requirements, has led to inconsistency in how waiver requirements are applied and operationalized.	✓				✓			✓		✓	
Finding 3: The current waiver applications do not consistently reference applicable federal rules or Kentucky Administrative Regulation (KAR), contributing to greater inconsistency across waivers.	✓							✓			
Finding 4: Much of the description of 1915(c) waiver operations is housed in the KAR, which Cabinet staff and external stakeholder find difficult to use. Additionally, KAR contents include operational protocols that may not merit legislative input.	✓				✓			✓	✓		
Finding 5: The 1915(c) waiver application standards and requirements sometimes conflict with the corresponding KAR language for a given waiver, which	✓							✓			

Navigant Findings	Navigant Recommendations										
	Recommendation 1: Standardize and Revise Waiver and Waiver Related KAR	Recommendation 2: Adopt a Universal Assessment Tool	Recommendation 3: Implement an Individual Budgeting Methodology	Recommendation 4: Update the Rate Setting Methodology Across Waiver	Recommendation 5: Develop Standard Operating Procedures	Recommendation 6: Strengthen Case Management Systems	Recommendation 7: Streamline Participant-directed Service Delivery	Recommendation 8: Centralize Operation and Oversight within DMS	Recommendation 9: Improve Stakeholder Engagement	Recommendation 10: Implement a Quality Improvement Strategy	Recommendation 11: Conduct Waiver Reconfiguration Analysis
causes confusion among stakeholders who cannot identify which information source is correct.											
Finding 6: The Cabinet does not appear to have handbooks, manuals or other resources to provide stakeholders with guidance or interpretation of waiver program requirements.	✓							✓	✓		
Finding 7: The Cabinet uses several assessment tools across waivers, each of which focuses on different types of HCBS information. Additionally, different assessor entities conduct each assessment.	✓	✓				✓					
Finding 8: Across the waivers, HCBS assessment outcomes data is stored in varying formats and locations, and the data that is stored is not readily accessible to use for broad program analyses or management.		✓	✓			✓		✓		✓	✓
Finding 9: Assessment tools and methods currently in place are not designed to assess HCBS-related needs for participants under the age of 18.	✓	✓	✓			✓		✓		✓	✓
Finding 10: The use of an independent assessor function varies from waiver to waiver, raising questions about the potential for conflicts of interest.	✓	✓			✓	✓					
Finding 11: The Cabinet's independent assessment process presents operational challenges, particularly related to improving coordination between among the independent assessor, the participant and the participant's case manager.		✓				✓					
Finding 12: The Cabinet currently uses a chronological approach to manage the Michelle P. wait list. The Cabinet does not currently have in place a method to screen waiver applicants for waiver eligibility or risk when they apply to the Michelle P. waiting list. This approach differs from the SCL waiver which relies on a risk-based approach for wait list management.	✓	✓				✓					✓

Navigant Findings	Navigant Recommendations										
	Recommendation 1: Standardize and Revise Waiver and Waiver Related KAR	Recommendation 2: Adopt a Universal Assessment Tool	Recommendation 3: Implement an Individual Budgeting Methodology	Recommendation 4: Update the Rate Setting Methodology Across Waiver	Recommendation 5: Develop Standard Operating Procedures	Recommendation 6: Strengthen Case Management Systems	Recommendation 7: Streamline Participant-directed Service Delivery	Recommendation 8: Centralize Operation and Oversight within DMS	Recommendation 9: Improve Stakeholder Engagement	Recommendation 10: Implement a Quality Improvement Strategy	Recommendation 11: Conduct Waiver Reconfiguration Analysis
Finding 13: The Cabinet uses a series of caps and limits that vary by waiver and individual service to manage utilization and to allocate HCBS to participants. The caps and limits are applied broadly, so targeting services to participants based on level of intensity or acuity can be difficult.	✓	✓	✓			✓					
Finding 14: The Cabinet uses a medical-model approach for HCBS authorization, which presents undue administrative burden for Cabinet staff and case managers.	✓		✓			✓					
Finding 15: Participants and their informal supports seek more flexibility in how they use their budget, to allow for individualized service planning tailored to meet their needs.	✓	✓	✓			✓	✓				✓
Finding 16: The Cabinet lacks a transparent rate-setting methodology across waiver programs that reflects HCBS service delivery requirements and differences in acuity across waiver participants	✓			✓							✓
Finding 17: Providers expressed strong interest in understanding the historical basis for current rates. Many providers expressed concern that rates are not sufficient to cover incurred costs to deliver services or make improvements.				✓		✓					
Finding 18: Payment rates vary across waiver programs for services that are similar in nature, which may negatively impact provider network development for waivers offering lower payment rates.	✓			✓		✓					
Finding 19: A cost survey of providers is needed to help inform an updated HCBS payment rate methodology that considers the factors that drive provider costs.				✓					✓		
Finding 20: DMS, DAIL and DBHDID developed HCBS waiver administrative and operational	✓				✓			✓			

Navigant Findings	Navigant Recommendations										
	Recommendation 1: Standardize and Revise Waiver and Waiver Related KAR	Recommendation 2: Adopt a Universal Assessment Tool	Recommendation 3: Implement an Individual Budgeting Methodology	Recommendation 4: Update the Rate Setting Methodology Across Waiver	Recommendation 5: Develop Standard Operating Procedures	Recommendation 6: Strengthen Case Management Systems	Recommendation 7: Streamline Participant-directed Service Delivery	Recommendation 8: Centralize Operation and Oversight within DMS	Recommendation 9: Improve Stakeholder Engagement	Recommendation 10: Implement a Quality Improvement Strategy	Recommendation 11: Conduct Waiver Reconfiguration Analysis
approaches in siloes. Thus, the same task or workflow is approached differently from waiver to waiver, depending on the department executing it. The three departments have coordinated limitedly to standardize operating procedures to be similar across departments.											
Finding 21: DMS, DAIL and DBHDID each have different approaches to developing and maintaining Standard Operating Procedures (SOP) to govern task execution and guide staff on expected work approach.	✓				✓	✓	✓	✓	✓	✓	
Finding 22: DMS is not always well positioned as the single state agency for HCBS waiver oversight and lacks clear accountabilities when leveraging sister agencies as a waiver-designated operating agency. DMS has not always had final decision-making authority when departments did not agree on policies or program design.	✓				✓			✓	✓		
Finding 23: The current HCBS system lacks a centralized point of entry where external stakeholders can bring questions and concerns.					✓	✓	✓	✓	✓	✓	
Finding 24: Among DMS, DHBDID and DAIL, monitoring and annual re-certification approaches differ heavily, can be duplicative, and do not always reflect best practices in HCBS oversight.					✓			✓			
Finding 25: The level of provider support from the Cabinet varies by waiver. Thus, some providers receive far more technical assistance and training than others.					✓	✓		✓	✓		
Finding 26: The Cabinet's transitions in case management to comply with conflict-free case management (CFCM) regulations are not complete, and the Cabinet may have additional opportunities to strengthen case management and CFCM delivery						✓					

Navigant Findings	Navigant Recommendations										
	Recommendation 1: Standardize and Revise Waiver and Waiver Related KAR	Recommendation 2: Adopt a Universal Assessment Tool	Recommendation 3: Implement an Individual Budgeting Methodology	Recommendation 4: Update the Rate Setting Methodology Across Waiver	Recommendation 5: Develop Standard Operating Procedures	Recommendation 6: Strengthen Case Management Systems	Recommendation 7: Streamline Participant-directed Service Delivery	Recommendation 8: Centralize Operation and Oversight within DMS	Recommendation 9: Improve Stakeholder Engagement	Recommendation 10: Implement a Quality Improvement Strategy	Recommendation 11: Conduct Waiver Reconfiguration Analysis
Finding 27: A method or standard to deter excessive caseloads is not in place.	✓					✓					
Finding 28: Person-centered service planning (PCSP) approaches and tools vary across waivers and across case management providers.	✓					✓					
Finding 29: More coordination is needed between case management providers, DMS, and the Department of Community Based Services' (DCBS) child and adult protective services units to address suspected abuse, neglect and exploitation (A/N/E) of waiver participants.	✓				✓	✓		✓			
Finding 30: Case management providers indicated they struggle with declining payment rates while assuming expanded responsibilities, which in some cases may be excessive.	✓			✓		✓					
Finding 31: Participants and their caregivers reported that support brokers providing case management service to participants who use PDS lack training and understanding of the roles and responsibilities of a support broker.						✓	✓				
Finding 32: Participants struggle to identify available primary care and specialty providers throughout the Commonwealth, and providers struggle to recruit and retain direct care staff.							✓				✓
Finding 33: Some service provider requirements appear to pose obstacles to building a sufficient network of HCBS providers.	✓						✓				✓
Finding 34: Participant directed services are frequently used in the Commonwealth, in part because of a lacking network of traditional providers, and also to offer participant's more control and autonomy over their HCBS delivery.							✓			✓	

Navigant Findings	Navigant Recommendations										
	Recommendation 1: Standardize and Revise Waiver and Waiver Related KAR	Recommendation 2: Adopt a Universal Assessment Tool	Recommendation 3: Implement an Individual Budgeting Methodology	Recommendation 4: Update the Rate Setting Methodology Across Waiver	Recommendation 5: Develop Standard Operating Procedures	Recommendation 6: Strengthen Case Management Systems	Recommendation 7: Streamline Participant-directed Service Delivery	Recommendation 8: Centralize Operation and Oversight within DMS	Recommendation 9: Improve Stakeholder Engagement	Recommendation 10: Implement a Quality Improvement Strategy	Recommendation 11: Conduct Waiver Reconfiguration Analysis
Finding 35: Participants are often under-educated about the requirements of the PDS model. The current approach lacks strategies and supports to assist participants to self-manage employer authorities. The current approach does not clearly establish criteria to qualify a participant as "appropriate" to self-direct their care.	✓					✓	✓		✓		
Finding 36: A substantial number of parents and guardians serve as PDS employees for a waiver participant. The Cabinet has concerns about abuse of PDS, stakeholders strongly expressed widespread concerns over whether parents and guardians should be disallowed as PDS employees. Clarifying a policy stance on this issue is important to stakeholders.	✓						✓		✓		
Finding 37: Health- and first aid-related screening requirements for PDS workers are a barrier for participants to recruit employees of their choosing.							✓			✓	
Finding 38: Criminal background check requirements for PDS workers are not clear and are a barrier for participants to recruit employees of their choosing.							✓				
Finding 39: Financial Management Agencies (FMA) vary in their capabilities and performance, and the Cabinet has established few formal standards to govern their performance.	✓				✓		✓				
Finding 40: The Cabinet does not appear to have a communication strategy or plan in place, nor does it appear to have in place a rigorous process for vetting written correspondence.					✓			✓	✓	✓	
Finding 41: Historically, the Cabinet has underutilized stakeholder engagement as a tool to inform policy development. Past engagement methods are largely passive in nature and limit the ability of stakeholders to provide meaningful input. This finding also applies to									✓		

Navigant Findings	Navigant Recommendations										
	Recommendation 1: Standardize and Revise Waiver and Waiver Related KAR	Recommendation 2: Adopt a Universal Assessment Tool	Recommendation 3: Implement an Individual Budgeting Methodology	Recommendation 4: Update the Rate Setting Methodology Across Waiver	Recommendation 5: Develop Standard Operating Procedures	Recommendation 6: Strengthen Case Management Systems	Recommendation 7: Streamline Participant-directed Service Delivery	Recommendation 8: Centralize Operation and Oversight within DMS	Recommendation 9: Improve Stakeholder Engagement	Recommendation 10: Implement a Quality Improvement Strategy	Recommendation 11: Conduct Waiver Reconfiguration Analysis
the Cabinet's engagement of formal advisory bodies and state committees, which can add value when developing and operating 1915(c) programs.											
Finding 42: Historically, the Cabinet's approach to HCBS stakeholder engagement has largely relied upon ad hoc interactions with stakeholders. To the extent the Cabinet has used more structured approaches to stakeholder engagement, those have typically been focused on provider stakeholders.									✓		
Finding 43: Stakeholders lack education about the federal requirements and other rationale that govern Cabinet decision-making.	✓								✓		
Finding 44: Stakeholders have responded positively to the level of engagement and methods used during 1915(c) waiver assessment but lack confidence that the Cabinet will continue to be transparent and inclusive in the future.									✓		
Finding 45: Quality and service outcomes are under-emphasized in the Cabinet's current HCBS program management and oversight approach.								✓		✓	
Finding 46: The Cabinet has does not appear to be fully prepared to respond to CMS modifications to waiver assurance requirements issued in 2014.	✓				✓			✓		✓	
Finding 47: While the Cabinet does measure program performance in some areas, the measurement and reporting activities are not part of a disciplined continuous quality improvement cycle.	✓							✓		✓	
Finding 48: Despite the wide range of participant needs served through the Commonwealth's HCBS waivers, stakeholders expressed a need for waivers designed to serve additional subgroups and cover different services.	✓										✓

Navigant Findings	Navigant Recommendations										
	Recommendation 1: Standardize and Revise Waiver and Waiver Related KAR	Recommendation 2: Adopt a Universal Assessment Tool	Recommendation 3: Implement an Individual Budgeting Methodology	Recommendation 4: Update the Rate Setting Methodology Across Waiver	Recommendation 5: Develop Standard Operating Procedures	Recommendation 6: Strengthen Case Management Systems	Recommendation 7: Streamline Participant-directed Service Delivery	Recommendation 8: Centralize Operation and Oversight within DMS	Recommendation 9: Improve Stakeholder Engagement	Recommendation 10: Implement a Quality Improvement Strategy	Recommendation 11: Conduct Waiver Reconfiguration Analysis
Finding 49: Although there is Cabinet and stakeholder interest in reconfiguring the 1915(c) waivers, the current state of operations and information availability would make it difficult to identify the most appropriate configuration of waivers for the Commonwealth.	✓	✓	✓	✓				✓	✓	✓	✓