

**Kentucky Can Better Serve Mentally
Retarded/Developmentally Disabled Persons
MAY 2002 – PERFORMANCE AUDIT**



**EDWARD B. HATCHETT, JR.
AUDITOR OF PUBLIC ACCOUNTS**

The Auditor Of Public Accounts Ensures That Public Resources Are Protected, Accurately Valued, Properly Accounted For, And Effectively Employed To Raise The Quality Of Life Of Kentuckians.



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AUDITOR OF PUBLIC ACCOUNTS

May 21, 2002

To the People of Kentucky

The Honorable Paul E. Patton, Governor

Marcia Morgan, Secretary, Cabinet for Health Services

Michael Robinson, Commissioner, Department for Medicaid Services

Margaret Pennington, Commissioner, Department for Mental Health/Mental Retardation Services

Re: Performance Audit of Kentucky's Program for Mentally Retarded and Developmentally Disabled Persons

Ladies and Gentlemen:

We present our report on Kentucky's services to mentally retarded and developmentally disabled persons. We are distributing this report in accordance with the mandates of KRS 43.090. In addition, we are distributing copies to members of the committees of the General Assembly exercising oversight authority over health and welfare issues, as well as other interested parties.

KRS 43.090 (1) requires an agency to which a report of the Auditor of Public Accounts pertains to notify the Legislative Research Commission and the Auditor of Public Accounts, within 60 days of completion of the audit report, which of the audit recommendations have been implemented and which have not. After an appropriate period of time, we will contact the Department for Medicaid Services to determine whether the report's recommendations are implemented and will advise the Legislative Research Commission regarding the status of that implementation. Once we are advised that the recommendations have been implemented, they will be considered closed.

Our Division of Performance Audit evaluates the effectiveness and efficiency of government programs. The Division also performs risk assessments and benchmarks government operations. We will be happy to discuss with you at any time this audit or the services offered by our office. If you have any questions, please call Gerald W. Hoppmann, Director of our Division of Performance Audit, or me.

We appreciate the courtesies and cooperation offered to our staff during the audit.

Respectfully submitted,

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Executive Summary

Audit Objectives	<p>Determine whether the Commonwealth is providing optimal care for mentally retarded and developmentally disabled (MR/DD) persons through its Medicaid community-based services program, known as the Support for Community Living (SCL) Waiver.</p> <p>Determine whether better cost management will permit the Commonwealth to expand community-based services to more persons.</p>
Background	<p>In 1971, Congress enacted Medicaid provisions to help states pay for the institutional care of mentally retarded and developmentally disabled persons. In 1981, the Social Security Act authorized the federal government to waive the institutionalization requirement and reimburse states for services provided in the community as well.</p> <p>Kentucky began community-based services in 1983 with the Alternative Intermediate Services/Mental Retardation Medicaid Waiver program. That program was replaced in 1997 by the SCL Waiver, which remains Kentucky's Medicaid program for providing community-based services to mentally retarded and developmentally disabled persons.</p>
Deficiencies Revealed in Certification Reviews	<p>From a sample of 12 providers, certification reviews performed by Health Services during a four-year period revealed 361 deficiencies in critical areas. Deficiencies included problems with criminal record checks, individual rights, safety, incident reporting, and training.</p>
Abuse and Neglect in Community Based Services	<p>There were 299 incidents of alleged abuse and neglect or other serious events in community-based services settings from September 1997 through May 2001, including deaths, injuries, sexual abuse, and physical violence. Ninety-one percent of these incidents were not referred to law enforcement.</p>
Demand for Services Not Met	<p>Research suggests that there are eight to ten thousand persons in Kentucky who need MR/DD services. During FY01, Medicaid only provided services for 2,566, with 1,547 served through community-based services and 1,019 served in institutional facilities. As of September 25, 2001, there were 1,725 persons on the waiting list for community-based services. Kentucky faces a potential court-imposed mandate to serve those on its waiting list.</p>
Provider Screening/Hiring Practices Deficient	<p>Although most files reviewed contained evidence of background checks, providers hire employees with criminal records. Providers should exercise meticulous care when vetting such job candidates. There were lapses in drug screening, health screening, and the review of driving records. Finally, there were inconsistencies in records documentation.</p>
One Provider Delivers Services to One-Third of Kentucky's SCL Population	<p>The growth of ResCare, Inc. in the Kentucky SCL Waiver program has been substantial. As of October 1, 2001, ResCare, Inc. operated 10 providers serving 464 consumers, or almost 30% of the total consumers of community-based services in Kentucky. Kentucky has no emergency placement plan for loss of services if any provider should cease serving Kentucky residents. Current provider agreements only allow for a 30-day notice, which is inadequate.</p>
Kentucky Pays More Per Person for Community Based Services Than Other States	<p>Kentucky has not implemented better cost management strategies to fund expansion of community-based services to more citizens. The Commonwealth's annual average cost per person to deliver these services (\$49,598) is almost twice as much as the average cost for North Carolina, Alabama, Florida, Mississippi, Georgia, South Carolina, and Tennessee.</p>

Executive Summary

Fraud Detection Not Used to Manage Costs

During a four-year period beginning September 1997, the Commonwealth identified as improper only one-tenth of one percent of the total Medicaid payments for the community-based services program. In a 1992 report, GAO reported to Congress that estimates of fraud and abuse losses could amount to 10% of annual healthcare expenditures. Because Kentucky's diligence in this area is suspect, the potential savings have not been realized.

Payments for Community Habilitation Too Permissive

Almost any type of activity provided as community habilitation is reimbursed by Medicaid, regardless of whether that activity is meaningful and helps a person gain independence and assimilate into the community. In FY 2001, community habilitation was the second most expensive community-based service, totaling approximately \$19 million or 25% of total program costs.

Recommendations

Consumer Safety

1. Health Services should eliminate abuse and neglect in community-based settings.
2. Families and Children should, as mandated by KRS 209.030(4), notify appropriate law enforcement agencies of all incidents of alleged abuse, neglect, or exploitation.
3. Health Services should ensure that providers are in compliance with the statutory requirement of reporting all incidents of alleged abuse, neglect, or exploitation to Families and Children.
4. Families and Children should ensure that DCBS-284s are completed and sent to the Attorney General's Office as specified in the 1999 MOU and internal procedures.
5. Families and Children should send final investigation reports of alleged incidents of abuse, neglect, or exploitation to all appropriate parties, i.e. Attorney General, Kentucky State Police, local law enforcement, Health Services, etc., regardless of the outcome.
6. Medicaid should assess monetary damages or penalties against providers who fail to report incidents of abuse and neglect.
7. Health Services should ensure that investigation and complaint files regarding abuse and neglect are complete, organized, and safeguarded.
8. Medicaid should develop a hiring and screening process to be used by all providers.
9. Medicaid should require a high school diploma or GED for persons providing community habilitation services.

Program Administration and Access

10. Kentucky should ensure that comprehensive services are available to meet the needs of MR/DD persons.
11. Health Services should ensure that each MR/DD person's Individual Support Plan defines the individual's goals and interests and that strategies are tied to the achievement of those outcomes.

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12. Medicaid should periodically report to the public its evaluation of provider compliance with community-based services requirements.
13. Medicaid should develop an emergency placement plan for loss of services should a provider cease serving Kentucky residents, ideally in a seamless transition.
14. Health Services should track the different types of services provided under community habilitation.

Cost Management

15. Medicaid should consider reimbursing providers of community habilitation at a daily rate for services lasting more than four hours. This practice would have saved the state \$4.8 million in FY 2000, which could have funded services for an additional 103 consumers.
16. Medicaid should consider limiting the total per person cost for community-based services at a cap equivalent to the per person cost in an intermediate care facility. This practice could have saved the state over \$2.7 million in FY 2000 and provided services for an additional 56 consumers.
17. Medicaid should provide fraud detection training to the community-based services administrators.
18. Health Services should update the Interagency Agreement between Medicaid and the Division of Mental Retardation (DMR) and include specific duties and responsibilities related to fraud detection.
19. Health Services should diligently identify, review, and pursue potential recoupments. In addition, Medicaid should routinely review and attempt to collect accounts receivable and maintain more formal documentation related to billing reviews.
20. Health Services should eliminate any duplication of services by the federally matched community-based services program and the state funded Supported Living Program.

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Acronyms and Abbreviations

AIS/MR	Alternative Intermediate Services/Mental Retardation
CMS	Center for Medicare and Medicaid Services
Commission	Commission on Services and Supports for Individuals with Mental Retardation and Other Developmental Disabilities
DMH/MRS	Department for Mental Health/Mental Retardation Services
DMR	Division for Mental Retardation
Families and Children	Cabinet for Families and Children
HCFA	Health Care Financing Administration
Health Services	Cabinet for Health Services
ICF/MR	Intermediate Care Facilities/Mentally Retarded
Medicaid	Department for Medicaid Services
MR/DD	Mentally Retarded and Developmentally Disabled
SCL	Supports for Community Living

Chapter 1

Introduction

Medicaid Services

The Cabinet for Health Services (Health Services) estimates that there are approximately 120,000 MR/DD persons residing in Kentucky. The kinds of services required by these persons range from incidental to institutionalization. Medicaid provides services to MR/DD persons requiring the highest levels of care. Medicaid was therefore the focus of this examination.

During FY 2001, the Commonwealth provided care and services to 2,566 MR/DD persons through Medicaid. Forty percent, or 1,019, received services through a federally licensed institution, referred to as an Intermediate Care Facility for the Mentally Retarded (ICF/MR). The remaining sixty percent, or 1,547, received services through the state's Medicaid Supports for Community Living (SCL) Waiver, Kentucky's community-based services program. As of September 25, 2001, there were 1,725 persons on the waiting list for community-based services.

Institutional and Community-Based Services Compared

Services for MR/DD persons in ICF/MRs are provided almost exclusively on campus grounds, and the person may leave only with the permission of guardians. Services provided at a facility generally include a wide array of therapies, on-site medical staff, and room and board. Even with the availability of these services, institutional settings do little to increase an individual's independence or integrate persons into the community.

Community-based services contrast markedly. In a staffed residence setting, up to three MR/DD persons live together in a residence, where a provider's staff help with the cooking, cleaning, hygiene, safety, personal schedules, etc. Staff is also responsible for making sure that the residents are transported safely to other sites to receive community habilitation services. Such services allow the resident to engage in a variety of activities ranging from taking shopping trips to working in sheltered workshops.

To receive community services, persons must apply to Health Services. Upon application, they are placed on a waiting list, screened for Medicaid eligibility, and evaluated to determine the appropriate level of care necessary. If approved for community care, the person selects a provider from a list supplied by Health Services. Support Coordinators on the provider's staff are responsible for the development of an Individual Support Plan, which is updated annually, for each MR/DD person enrolled in the SCL Waiver. Such plans consist of goals and suggested activities or services that will help the individual accomplish those goals. For example, if an individual wishes to improve work performance skills such as attendance, that person's Individual Support Plan may identify the need to participate in pre-vocational activities. Individual Support Plans must be updated annually.

"Community placement," long encouraged by MR/DD advocacy groups, helps persons live more independently and interact with society at large. In 1999, the United States Supreme Court ruled in *Olmstead v. L.C.* that persons in institutions have the right to move into a community-based program should they desire to do so. On January 14, 2000 all state Medicaid officials were directed by the U.S. Department of Health and Human Services "to integrate people with disabilities into the social mainstream, promote equality of opportunity, and maximize individual choice." This mandate, along with other litigation, has spurred many states into increasing community-based services and reducing the number of persons in institutions.

Medicaid “Waived” Requirements to Allow Community-Based Services

In order for states to receive federal matching funds for community-based services, Medicaid regulations had to be “waived.” In 1981, section 1915 (c) of the Social Security Act was added, authorizing states to change how MR/DD services are delivered under the Medicaid program. Kentucky elected to use the Home and Community-Based Services Waiver to deliver services using non-federally licensed providers.

States that participate in Waiver programs must ensure that community-based programs meet certain service standards and cost less, on average, than institutional care. The persons covered under these waivers must also be eligible to be served by ICF/MRs.

Kentucky Made a Commitment to Community Services

Kentucky’s first Waiver program, the Alternative Intermediate Services/Mental Retardation program, was replaced in 1997 by the SCL Wavier program.

SCL Waiver services provide assistance with independent living through

- 24 hour Staffed Residences housing up to three MR/DD persons,
- Group Homes, which are licensed facilities, housing from 4 to 8 MR/DD persons, and
- Family Homes, which are not licensed facilities, run by certified providers and housing up to three MR/DD persons.

MR/DD persons may receive employment-related services such as Supported Employment, where a provider regularly accompanies the MR/DD person to the work site and acts in the capacity of “coach,” and Pre-Vocational Employment services, where MR/DD persons are taught workplace behaviors such as punctuality and work-place decorum. There are also various therapy services available including speech, physical, behavioral, and occupational.

Each MR/DD person participating in the Waiver must be served by a support coordinator. The support coordinator, generally an employee of the service provider, is required to develop customized Individual Support Plans for each person. These plans set general goals and list services needed to accomplish the goals. Support coordinators meet with designated Waiver consumers at least monthly in order to monitor various day-to-day activities and issues.

Kentucky has reduced the number of persons in its institutions from 1,251 in FY 98 to 1,019 in FY01. The number of persons served in the community has increased from 1,030 in FY 98 to 1,547 in FY 01. As of April 2001, Health Services identified 68 providers participating in the SCL Waiver. The costs for ICF/MRs and community-based services have increased rapidly in the last two fiscal years, although the average cost per person for community services has not increased as much as that in ICF/MRs. Table 1 shows the comparative cost increases, while Table 2 shows the types and costs of SCL services.

Table 1
Cost Data for Community Services and Institutional Facilities

Type of Service	FY2000 Number Served	Total Cost	Average Cost	FY2001 Number Served	Total Cost	Average Cost	Average Cost Percentage Increase
SCL Waiver	1,274	\$59,945,416	\$47,053	1,547	\$76,727,880	\$49,598	5%
ICF/MR	1,181	83,336,249	70,564	1,019	91,924,826	90,211	28%
Totals	2,455	\$143,281,665	\$58,363	2,566	\$168,652,706	\$65,726	13%

Source: Auditor of Public Accounts, from information provided by the Department for Medicaid Services and the Commission on Services and Supports for Individuals with Mental Retardation and Other Developmental Disabilities.

Table 2
Use and Cost of the SCL Waiver
FY2001

Services Offered	# Receiving The Service	Total Paid For Services	Average Paid Per Recipient	Average Paid Per Unit
Staffed Residence	854	\$37,545,680	\$43,964	\$146/day
Community Habilitation	1467	19,044,764	12,982	2.96/15 minutes
Support Coordination	1547	5,994,157	3,874	366/month
Family Home	342	5,437,281	15,898	54.63/day
Respite	544	2,940,222	5,404	2.25/15 minutes
Behavior Supports	501	1,049,933	2,095	32.53/15 minutes
Community Living Supports	268	2,691,480	10,042	9.86/15 minutes
Speech Therapy	317	615,922	1,942	22.81/15 minutes
Group Home	36	566,247	15,729	55.07/day
Supported Employment	83	336,749	4,057	5.66/15 minutes
Occupational Therapy	120	203,687	1,697	24.29/15 minutes
Physical Therapy	79	184,566	2,336	35.35/15 minutes
Pre-Vocational	32	81,304	2,540	4.67/15 minutes
Medical Equipment	53	32,937	621	539 each
Psychological Services	6	2,943	490	36.79/15 minutes
Total	1547	\$76,727,872	\$49,598	N/A

Source: Auditor of Public Accounts, from information from the Department for Medicaid Services.

Cabinet for Health Services' Oversight

State oversight of the SCL Waiver is the responsibility of Health Services, which must make certain that community-based services do not cost more than providing the services in an institutional setting. This "cost neutrality" must be reported to the federal government annually.

Health Services manages the program through duties which include

- performing certification reviews that qualify providers for payments from Medicaid for SCL services and ensure provider compliance,
- conducting investigations of incidents of abuse or neglect, and
- maintaining the SCL Waiver waiting list and register.

The demand for community-based services far outweighs the fiscal capacity of the Commonwealth to provide them. For this reason most people requesting services are placed on a waiting list maintained by Health Services. As of September 1999

this list included approximately 1,370 persons. According to the *State of the States in Developmental Disabilities: 2000 Study Summary*, Kentucky ranked 50th in the nation in the percentage of its MR/DD resources spent on community services.

During the 2000 session, Kentucky's General Assembly enacted House Bill 144, which allocated \$14.8 million in additional funds to move at least 500 people from the waiting list and into the community by the end of FY 2002. Coupled with the 70% federal Medicaid match, these additions result in almost \$50 million in total state and federal dollars committed to the SCL Waiver. As of October 2001, 213 people from the waiting list were receiving services and another 237 people had been contacted so they could start receiving services. Unfortunately, the waiting list has not diminished, and as of September 2001 there are more than 1,700 MR/DD persons awaiting community services.

HB144 also established the Commission on Services and Supports for Individuals with Mental Retardation and Other Developmental Disabilities (Commission). The Commission was charged with developing a 10-year plan for all of Kentucky programs for MR/DD persons. The goals and financial details of the plan were released in the Spring of 2001.

Audit Focus and Objectives

Our focus compared the costs of the SCL Waiver with that of the institutional care alternative, and analyzed the quality, efficiency, and accountability of community services. We addressed the following two objectives:

Determine whether the Commonwealth is providing optimal care for mentally retarded and developmentally disabled persons.

Determine whether better cost management will permit the Commonwealth to expand community services to more persons.

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Quality of Care Provided Through the SCL Waiver

SCL Investigation Reports Chronicle Deficiencies in Quality of Care and Oversight

Serious Cases of Neglect and Abuse

SCL Waiver investigation reports chronicle significant problems with quality of care, provider accountability, information tracking procedures and practices, and internal and external communications. Frequent and severe incidents of abuse and neglect indicate unacceptable levels of risk and imperiled care for MR/DD persons.

We reviewed 299 incidents involving investigations of 37 SCL providers for the period September 1997 through May 2001. The following table provides additional information:

Table 3
Investigation Type Summary

Type of Incidents Investigated	Number of Incidents	Number of Providers
*Deaths	12	9
Injuries	54	18
Sexual Abuse Allegations	37	12
Physical Abuse Allegations	41	17
Other	155	32
Total	299	88

Source: Auditor of Public Accounts, from the Division of Mental Retardation’s investigation report files.

*Three of the deaths occurred after the conclusion of our fieldwork in May 2001. Seven of the deaths occurred in one provider’s various SCL provider locations.

The following annotative notes are summarized from specific Health Service investigations and provide evidence of alarming and severe problems in service delivery:

Death (Investigation Period 02/24/99 through 02/26/99) – A consumer was physically restrained by five staff members after a behavior outburst. The consumer was unable to rise after restraint and “staff noticed he was turning blue.” He was pronounced dead at the hospital. The Cabinet for Families and Children (Families and Children) did not substantiate any abuse or neglect, despite the fact that the provider had failed to comply with seven SCL requirements. The noncompliance areas included medication errors, inadequate restraint training, possible unnecessary use of restraint, and other related matters.

Death (Investigation Period 11/3/97 through 11/7/97) – A consumer with a history of falling was placed in an upstairs apartment. He fell down the stairs and died. An investigation by an independent organization found evidence of insufficient staffing and that the provider had exceeded the regulatory limit on the number of consumers served in one residence.

A subsequent certification review cited the provider for 23 deficiencies regarding staffing, client dignity and records, staff background checks, individual crisis plan monitoring, and Americans with Disabilities Act noncompliance.

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Physical Abuse (Investigation Period 6/4/99 through 6/8/99) - A consumer was physically abused by a staff member alleged to have a history of committing physical abuse. Additional allegations of abuse were not properly reported to Health Services. Health Services found the provider was not in compliance with SCL requirements and that the consumer was “not free from all forms of abuse, neglect and punishment.” Thirty-two incident reports concerning the abused consumer are included in the investigation findings. Caretaker neglect by the same staff member was substantiated in the recent past.

Sexual Abuse (Investigation Period 06/16/99 – 06/29/99) – A provider substantiates that a male consumer with “a long history as a sexual predator” and “diagnosis of pedophilia” sexually abused a female consumer. The provider was found not in compliance with the SCL Waiver, including a finding that the provider did not assist the victim in “obtaining needed services”. Documentation from Health Services states that additional supervision and restrictions are necessary to ensure the safety of others.

Drug Abuse (Investigation Period 05/04/99) – A provider staff member was arrested for suspicion of drug trafficking after police found a loaded shotgun and drugs at a consumer’s staffed residence. The investigation reveals that staff member had prior arrests, which included a felony conviction. The provider was found not in compliance with the SCL Waiver due to inadequate hiring and screening procedures, improper incident reporting, and other related problems.

Lack of Communication and Interaction Between Health Services and Families and Children Places SCL Consumers at Risk

There are substantive weaknesses in communication between Health Services, which has daily contact with the providers, and Families and Children, which is responsible to protect SCL consumers from abuse, neglect, and exploitation. Based on our review, regular and open communication between Health Services and Families and Children was not sufficient enough to complete investigations in a timely and effective manner and to ensure that incidents are fully reported and investigated when warranted. According to Health Services, periodic meetings between Health Services and Families and Children are now currently being conducted in order to improve communications between representative divisions.

Of 210 major incidents that involved suspected abuse, neglect, or exploitation, Families and Children stated they investigated only forty. KRS 209.030 requires that such allegations be reported to Families and Children for review. Of the 40 allegations investigated, Families and Children substantiated only 12. According to officials, of the other major incidents, 81% were either never reported to the agency or the allegations did not meet Families and Children investigation criteria. Families and Children does not track referrals from Health Services that it deems unworthy of investigation.

For nearly 1/3 of the incidents reviewed, poor records and unclear data made it impossible to determine whether Families and Children was notified as required. As the oversight agency for SCL providers, Health Services is required to ensure that providers notify Families and Children of possible abuse or neglect. Subsequently, Health Services provided documentation that 88 of the 210 major incidents were referred to Families and Children.

Health Services is not privy to Families and Children information and reports except through an open records request or an informal verbal request. The slow

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Families and Children Does Not Refer All Incidents of Alleged Abuse, Neglect, or Exploitation to Law Enforcement as Required by Law and Policy

pace of this process contributes to delays in the amount of time that it takes Health Services to develop findings, and in determining whether a provider is in compliance with the SCL Waiver.

Families and Children does not refer all reported incidents of abuse, neglect, or exploitation to law enforcement agencies as required by statute and cabinet policy.

KRS 209.030(4)(a) provides that Families and Children, upon receipt of a report of alleged abuse, neglect, or exploitation, **shall** “notify the appropriate law enforcement agency.” In addition, the cabinet’s standard operating procedures (SOP-112) require that reporting form DCBS-115 be filed with appropriate law enforcement agencies upon notification of alleged abuse, neglect, or exploitation.

Families and Children employees said that reports of alleged abuse, neglect, or exploitation are not referred to law enforcement unless an investigation is conducted. They indicated that Families and Children unilaterally decided it would not refer every report, asserting that would lessen the importance of referrals and overburden law enforcement. This practice ignores the statutory mandate and preempts the expertise trained law enforcement officers and investigators must bring to bear upon incidents of abuse, neglect, or exploitation.

Since the focus of Families and Children is the victim, referral to law enforcement is necessary in order to assure that the deterrence of the criminal law targets the criminal wrongdoing of perpetrators. When Families and Children substantiates an allegation, it is substantiating a victim’s abuse, neglect, or exploitation. It does not necessarily identify a perpetrator nor ascertain whether a specific person intended to commit the act.

The following table documents Families and Children’s referral to law enforcement.

Table 4
Referrals of Investigated Incidents

Reports Investigated by Health Services	210
Reports Referred to Families and Children	88
Reports Investigated by Families and Children	40
Number of Reports Referred to Law Enforcement	19
Reports Not Referred to Law Enforcement	91%

Source: Auditor of Public Accounts from information provided by Health Services and Families and Children.

Families and Children admitted that it does not refer cases it does not investigate to law enforcement. However it could not provide documentation that even all investigations it conducted of SCL allegations were referred to law enforcement. Rather, Families and Children could only provide documentation that a reporting

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form was prepared for 22 of the 40 allegations investigated. Three of these reporting forms showed no evidence of referral to law enforcement.

Information gathered by Families and Children during its investigation of these incidents could prove helpful to law enforcement officials; however, officials from Families and Children stated that the findings of investigations are not typically sent to law enforcement agencies. We received no documentation from Families and Children that final investigation reports related to the 40 SCL incidents were sent to law enforcement agencies.

Families and Children Does Not Refer Substantiated Incidents of Abuse, Neglect, or Exploitation to the Attorney General's Office as Required by Law and Policy

Families and Children does not refer all substantiated cases of abuse, neglect, or exploitation identified in Medicaid facilities to the Attorney General's Office as required by 42 C.F.R. Section 1007.11(b)(1) and internal policies.

According to a 1999 Memorandum of Understanding (MOU) between the Attorney General and Families and Children, "all allegations of patient abuse, neglect, or exploitation in health care facilities that receive Medicaid funds, which exhibit a substantial potential for criminal prosecution..." will be referred to the Attorney General's Medicaid Fraud and Abuse Control Division. In addition, Families and Children's operating procedures requires the filing of reporting form DCBS-284 which "shall be forwarded to the Attorney General's Office when the investigation is substantiated or likely to result in a substantiated finding."

Of the 12 SCL allegations substantiated by Families and Children, we received documentation that showed only three were referred to the Attorney General for review. However, our audit of this documentation revealed that none of the allegations were referred to the Attorney General. According to officials from Families and Children, the cabinet is considering modifying the DCBS-284 to include fields for notification to law enforcement, the Attorney General, and the Division of Mental Retardation.

Delays in Incident Reporting and Health Services' Investigation Procedures Perpetuate Risks

Oversight agencies, support coordinators, and legal guardians were not provided the required notification of incidents investigated by Health Services. Prior to February 15, 2001, Health Services' policy required SCL providers to report "major" occurrences by fax or phone within 24 hours. The provider then had 5 days to submit completed incident reports to Health Services. Incident Reports were required to have a description of the incident, a list of all parties involved, and a notation of *how soon* the applicable parties were notified.

Examination of investigation files revealed there were many failures to notify the required parties within a 24-hour period. This compliance record is illustrated in the following table:

Table 5
Compliance with 24-Hour Notification Requirement

Party/Agency	Not on Time	Not Known
Support Coordinator	18 providers for 75 instances	25 providers for 71 instances
Health Services	21 providers for 87 instances	26 providers for 68 instances
Guardian	20 providers for 63 instances	26 providers for 104 instances

Source: Auditor of Public Accounts, from the Division of Mental Retardation's investigation report files.

Many of the incident reports submitted by the providers were blank where providers should have noted when the required parties were notified. The incomplete information makes it difficult to determine whether and when the parties were ever notified. Incomplete reporting could result in SCL consumers being subjected to danger without Health Services or the family knowing. The incomplete data reporting for 24-hour notification is particularly disturbing since the incident reports reviewed were limited to those of severe nature that required Health Services investigations.

New regulations effective on February 15, 2001, reduced deadlines for preliminary reports of incidents to 8 hours from the time of the incident. In light of the fact that many providers we tracked had consistently failed to report and document incident referrals in compliance with the previous 24-hour deadline, the new deadline would seem illusory.

Furthermore, there are no regulatory time requirements for Health Services to begin necessary investigations. Based on available records, only 14 investigations were conducted on the same day the incident was reported; most occurred days, and sometimes weeks, later. Investigation delays by Health Services can place consumers in danger if the SCL provider does not take immediate corrective action.

Once an investigation is completed, deficiency citations are issued to the provider. The provider is required to respond with a plan of correction within 30 days. However, there is no time requirement for Health Services to accept or reject the correction plans. Without time requirements for Health Services to respond to a plan of correction, a provider may not know for several months if its plan of correction was acceptable and may continue observing practices that could endanger an SCL consumer.

Regulations have been strengthened and increased training has been proposed in order to help with the challenges brought by increasing populations of consumers within the SCL Waiver. Still, in order to ensure full accountability and efficiency, it is necessary to take additional steps to improve record keeping and reporting within provider networks and within Health Services.

Providers Are Not Subject to Monetary Damages or Penalties

SCL providers chronically noncompliant in reporting incidents are not subject to monetary damages or other penalties by Health Services. Severe and recurring incidents can result in more frequent certification reviews. In severe cases an

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SCL provider may be closed. However, only one SCL Waiver provider has been closed during the existence of the SCL Waiver because of quality of care issues. Noncompliance issues require plans of correction, which Health Services evaluates to determine whether sufficient measures have been taken.

In contrast, Kentucky's ICF/MRs have been issued federal fines and citations for significant incidents. Unlike our state's institutional facilities, the vast majority of SCL Waiver providers are unlicensed and, therefore, not inspected by Health Services' Office of Inspector General. Only SCL providers operating group homes, a small minority, are inspected and licensed by the Inspector General.

Investigation Files Are Missing Key Information and Are Difficult to Track

Poor record keeping practices and tracking inconsistencies made it impossible to determine whether the investigation files contained complete documentation. It was difficult, if not impossible, to fully examine the DMR investigation files. Additionally, there were no tracking numbers assigned to the majority of incident reports reviewed, making it difficult to tie related incident reports to investigations. Investigation reports were presented in various formats and were not logged or tracked in serial order. Many files contained copies of hand written notes that were obscured by generational copy degradation or otherwise illegible. Furthermore, some incident reports and related information were discovered in Medicaid files, but were missing from DMR files.

To test Health Services' follow-up procedures for investigations, we requested documentation to confirm that an approved plan of correction was developed for 25 investigations from the population of 299 previously reviewed. Health Services could produce no accepted plans of correction for 6 of the cases in the sample. Two of these instances related to one provider that was shut down ten months after the incidents occurred. Thus, in 24% of the sampled cases, Health Services failed to provide evidence that follow-up procedures were adequate, effective, or even occurred. These cases concerned sexual abuse, physical abuse, and other multiple violations.

The Center for Medicare and Medicaid Services (CMS) completed a mandatory compliance review of Kentucky's SCL Waiver in September 2000 that was limited in scope and did not opine on the effectiveness of Kentucky's program. The CMS report found that Health Services monitors incident reports, but there was no indication that follow-up procedures were effective. The focus of the CMS review appears limited to providing assurance that Kentucky's adopted policies and procedures follow, in a very general sense, the federally approved waiver plan. CMS's short visit (5 days) and narrow scope could only provide CMS with a limited idea of how the SCL Waiver actually functions.

Recent Regulatory Changes Show Improvement

Recent Kentucky regulatory changes strengthened incident reporting requirements have sought to improve oversight and quality of care. 907 KAR 1:145E, effective October 10, 2001, divides incident reports into three categories, based on severity, to aid in tracking the required level of investigation.

- Class I: minor incidents with a twenty-four hour reporting requirement
- Class II: serious incidents which must be reported within twenty-four hours
- Class III: grave incidents, which must be reported within eight hours.

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SCL Certification Reviews Report a High Number of Deficiencies

Additionally, SCL providers are required to submit a complete, written investigation report to Health Services within ten days for Class II incidents and seven days for Class III.

Health Services cited 361 quality of care deficiencies during its certification reviews of SCL providers. The high frequency and serious nature of the cited deficiencies demonstrated the importance of objective measurement tools and consistent application of certification review procedures.

Deficiencies reported by Health Services for a sample of 12 SCL providers are listed below and present results from a total of 51 certification reviews. On average, seven deficiencies per provider review were reported in key areas of quality measurement at the conclusion of Health Services' certification reviews.

Table 6
Number of Deficiencies in Specific Review Areas*

Review Areas	Number of Deficiencies	Number of Providers
Criminal Record Checks	31	12
Individual Rights	63	10
Safety	164	11
Incident Reporting	45	11
Training	58	11
Total	361	N/A

Source: Auditor of Public Accounts, from September 1997 through May 2001 certification reviews provided by the Division of Mental Retardation.

*Information based on a review of 12 SCL providers and 51 certification reviews.

The following are noteworthy certification review deficiencies reported in DMR files for the 12 SCL providers and 51 certification reviews examined.

Criminal Record Checks:

- A provider limited police checks to only one county.
- 21 of 22 employees hired on January 3, 1999 did not have a state police record check prior to hiring.
- 34 of 36 newly hired staff did not have state police checks returned prior to employment. 6 of these 34 did not have state police record checks on file during Health Services' review.

Individual Rights Deficiencies:

- Persons did not receive information about their rights in their modes of communication.
- Legal representatives of several persons were not notified of major incidents involving emergency care.
- Persons were not afforded the opportunity to participate in community and religious activities of choice.

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Safety Deficiencies:

- A person was exposed to or possibly consumed an unlawful substance while under staff supervision as evidenced by positive laboratory testing.
- Staffs at several residences did not secure keys to the medications. One medication container was not locked.

Incident Reporting Deficiencies:

- Proof was missing that two major incidents had been reported to Health Services or the legal representative within the required time. Proof was missing on many incident reports that the Support Coordination provider had reviewed the incident and evaluated the need for corrective action. Many incident reports were not complete, including type of incident, pertinent detail, assessments, and any required follow-up.
- There was no documentation that one incident of suspected abuse and one incident of suspected neglect were reported to Families and Children and Health Services.
- An incident concerning a consumer and involving significant property damage, death threats, and suicide threats was incorrectly classified as a Class I instead of Class II incident. Another incident report was classified as Class II, but there was no documentation that Health Services had been notified of any kind of follow up. Another incident was not reported on time to the Support Coordinator and Health Services.

Training Deficiencies:

- The provider failed to provide documentation of competency-based training for employees. Eight staff members did not receive Phase I training and thirteen did not receive Phase II training within required times.
- 7 of 55 new employees did not complete Phase I training within 3 months of employment. Three of these persons were functioning independently without supervision. 10 of 55 new employees had not completed Phase II training within six months of employment.

Certifications Are Strictly Compliance-Based and Subject to Inconsistent Interpretations

While DMR certification reviews necessarily include compliance measures based on the SCL Manual and state regulations, the reviews lack assessments based on personal outcomes and decisions of consumers. Unfortunately, certification reviews focus on Individual Support Plans (ISPs) that do not include sufficient information for measurement of outcomes based on self-determination and choice, a process recommended in the Commission's Ten Year Plan. Instead, the ISPs only allow DMR to audit consumer records for time and frequency compliance without reference to quality of services delivered. The exclusion of specific goals that directly relate to consumer choices such as achieving job skills, meeting new friends, and discovering new talents does not allow for measuring development of dignity and self-image or effectiveness of billed services and assurance of quality outcomes.

During on-site reviews and surveys, providers voiced complaints that SCL Manual regulations are subject to inconsistent interpretations. According to

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several SCL providers, cited deficiencies sometimes depend on personal opinions and preferences of Health Services employees. Additionally, there were complaints that new regulations and changes to the SCL Manual were not communicated or distributed to the SCL providers prior to certification reviews.

SCL providers stated that more hands-on guidance is needed and that thorough and conclusive exit conferences by area administrators would clear up issues in the field prior to formal communication of findings through written certification review reports. SCL providers expressed desire for more objective guidelines and better training materials to assist them in complying with SCL regulations. Without providing clear and specific guidelines and increased interaction with SCL providers, consistent and objective certification reviews will not be achieved and persons will not be assured of adequate oversight.

No Regulatory or Internal Time Requirements Exist for Health Services' Certification Reviews

Neither state regulations nor internal policies require Health Services' certification review results and responses to corresponding plans of correction be reported within a specific time period. Delays in Health Services' reporting of review findings to SCL providers result in the perpetuation of deficient practices and confusion on behalf of the providers. The lack of timely reporting requirements places SCL consumers at risk.

ResCare Corporation Provides Services to One-Third of Kentucky's SCL Waiver Consumers

The growth of the ResCare, Inc. in the Kentucky SCL Waiver program has been substantial. ResCare began providing community-based waiver services in Kentucky in early 1997, and operated 10 SCL providers during 2001. Although Health Services could not provide an exact number of MR/DD persons served by ResCare, as of October 10, 2001, 464 MR/DD persons received Support Coordination from ResCare providers. This market share represented almost 30% of the total SCL consumers. Until FY 2001, ResCare's rates were significantly higher than rates paid to other SCL providers. This growth has occurred amid increasing quality of care concerns with ResCare.

In addition to ResCare's presence in community-based care, it also has a substantial presence in Kentucky's ICF/MRs. ResCare has management contracts with group homes in Inez and Shelbyville and the Outwood ICF/MR in Dawson Springs, Kentucky. The following table summarizes ResCare's ICF/MR contracts with Health Services for the period July 1, 2001 through June 30, 2002:

Table 7
ResCare ICF/MR Management Contract Amounts

Entity	Contract Amount
Shelbyville 8-bed Group Home	\$ 397,060
Inez Group Home	\$ 404,520
Outwood 80-bed five cottage facility	\$5,884,081
Total	\$6,685,661

Source: Auditor of Public Accounts, from information provided by the Cabinet for Health Services.

Unlike ICF/MRs, where providers must obtain a Certificate of Need and participate in public forums before beginning or expanding activities, SCL providers need only execute a contractual agreement to participate. Provider

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agreements do not protect consumers from loss of services and Kentucky has no emergency placement plan if a provider ceases operations. In fact, these agreements give either party the right to terminate upon thirty (30) days notice. Medicaid officials agreed that an emergency plan is needed in case a provider pulls out of Medicaid or is asked to leave.

Rescare Has Enjoyed Higher Rates Than Other Providers

Although Rescare rates were higher than other providers' rates throughout its first two years in the SCL Waiver, the rates have recently been adjusted. Currently, rates are calculated based on Medicaid's change from a cost-based system to a more equitable system where rates are tied to a median rate that fluctuates with the Consumer Price Index. The following tables provide additional information on Rescare's rates during FY 2000 and FY 2001:

Table 8
ResCare Rates for SCL Services in FY 2000

Service	Average ResCare Rate	Average Non-ResCare Rate	Difference
Staffed Residence	149.48	134.82	11%
Respite	8.59	7.88	9%
Support Coordination	454.03	360.32	26%
Behavioral Services	41.22	32.71	26%
Family Home	65.96	51.09	29%
Community Habilitation	11.52	9.81	17%
Community Living	35.38	29.11	22%

Source: Auditor of Public Accounts, from information provided by the Department for Medicaid Services

Table 9
ResCare Rates for SCL Services in FY 2001

Service	Average ResCare Rate	Average Non-ResCare Rate	Difference
Staffed Residence	146.89	150.46	(2%)
Respite *	2.25	2.05	10%
Support Coordination	411.89	405.02	2%
Behavioral Services	30.65	34.39	(11%)
Family Home	63.75	53.28	20%
Community Habilitation *	2.23	2.51	(11%)
Community Living *	8.84	8.71	1%

Source: Auditor of Public Accounts, from information provided by the Department for Medicaid Services

* Services are billed based on quarter hours in 2001. In 2000, these services were billed based on hourly units.

ResCare Has Serious Quality of Care Problems

Seven of the twelve investigated deaths since Kentucky's SCL Waiver began in September 1997 have occurred in ResCare settings. In one recent death case, ResCare admitted in an internal investigation that two of its employees failed to provide needed medical attention.

Concerns about quality of care in ResCare settings have been publicized in Indiana, Texas, Tennessee, and New Mexico. Below is a summary of noteworthy problems ResCare has faced in other states:

Indiana

Since June 1998, 14 of 116 consumers died within 18 months of their moves from ICF/MRs into ResCare group homes. These statistics and the individual cases behind them were the subject of lengthy articles in *The Indianapolis Star* and resulted in Indiana contracting for an investigation report with Health Care Excel, Incorporated. The report, entitled *Mortality and Morbidity Study: Final Report*, was completed in June 2001. Although the report did not definitively attribute any death to inappropriate care, it was critical of ResCare and Indiana's quality of care oversight. ResCare and Indiana officials failed to keep autopsy records in 13 of the 14 deaths. In some cases medical records related to the deaths were unavailable. Indiana Governor Frank O'Bannon demoted, or accepted resignations from, three top Indiana human services officials.

Texas

Texas problems were heavily reported by WFAA Television, Dallas, and *The Houston Chronicle* in 2000 and 2001. In a case of gross neglect involving chemical bleach being poured on a resident by a ResCare subsidiary's employee, the Texas Attorney General's Office settled with ResCare for \$1,000,000.

New Mexico

New Mexico issued a moratorium on ResCare's acceptance of new clients, and ordered alternative placement for 18 consumers, following discovery of abuse and neglect in ResCare group homes.

Tennessee

The Tennessean and *ResCare Watch* report that abuse and neglect issues with ResCare were highest among the 75 agencies operating in the state.

**Deficient Provider
Screening/Hiring
Practices**

The lack of comprehensive personnel policies for SCL providers has contributed to inconsistent hiring/screening practices and the absence of uniform file organization procedures. SCL providers use a variety of sources for criminal checks and have different screening requirements for drugs, health, valid driver's license, and automobile insurance. Also, the organization and location of personnel documentation varied among the providers. These inconsistencies impede a thorough review of employee files for compliance with SCL Waiver requirements.

**Providers Hire Persons With
Criminal Backgrounds**

Although 907 KAR 1:145E (2)(5)(f) states that providers shall not employ persons convicted of sexual or violent crimes, the regulation does not preclude providers from hiring people convicted of lesser crimes. Our review of 150 employee files at 8 SCL providers found that employees working for the providers during our visits had been charged with the following offenses:

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Table 10
Offenses Documented in SCL Waiver Provider Files

Offense	Occurrence of Offense
Forgery	1
DUI/ Operating a motor vehicle under the influence	5
Possession of Marijuana	3
No Insurance or Fail to Produce Insurance Card	11
Theft by Deception	5
Trafficking in a simulated controlled substance	1
Other	21
Total	47

Source: Auditor of Public Accounts, from information contained in SCL providers' personnel files.
 *Offenses do not include minor traffic violations and offenses that were documented as dismissed.

Given the nature of providing services to MR/DD clients, Medicaid should continually ensure that provider employees are suitable for this personal service environment.

Files Contained Evidence of Background Checks From a Variety of Sources

All of the 150 personnel files we reviewed at 8 providers contained a criminal record check from various sources. Providers either used the Kentucky State Police (KSP), Administrative Office of the Courts (AOC), or VeriCorp, Inc., a national employment-screening service.

In October 2001, an expanded regulation was signed by the Governor requiring additional checks throughout employment and allowing additional sources for criminal background checks. 907 KAR 1:145E, Section 2 (5)(e) and (f) requires criminal records checks for potential employees prior to and during employment.

Inconsistencies in Other Hiring Practices

Consistent and thorough employment requirements that would help to ensure consumer safety and quality of services are lacking. Examples of such requirements include:

- Employee drug screening
- Employee medical health screening such as tuberculosis
- Employee drug history checks
- Employee automobile insurance verification

Inconsistencies in Record Documentation

Provider personnel files were not kept in a uniform manner and contained outdated information. Some SCL providers kept training in separate files, while others combined all types of personnel information. SCL providers have not been required to maintain their personnel file in a standardized manner, which can cause difficulty for the area administrators conducting personnel file reviews on a regular basis. Personnel files are the only means for SCL providers to document that they are hiring qualified staff and that the required training courses are being provided.

Recommendations

1. Health Services should eliminate abuse and neglect in community-based settings.
2. Families and Children should, as mandated by KRS 209.030(4), notify appropriate law enforcement agencies of all incidents of alleged abuse, neglect, or exploitation.
3. Health Services should ensure that providers are in compliance with the statutory requirement of reporting all incidents of alleged abuse, neglect, or exploitation to Families and Children.
4. Families and Children should ensure that DCBS-284s are completed and sent to the Attorney General's Office as specified in the 1999 MOU and internal procedures.
5. Families and Children should send final investigation reports of alleged incidents of abuse, neglect, or exploitation to all appropriate parties, i.e. Attorney General, Kentucky State Police, local law enforcement, Health Services, etc., regardless of the outcome.
6. Medicaid should assess monetary damages or penalties against providers who fail to report incidents of abuse and neglect.
7. Health Services should ensure that investigation and complaint files regarding abuse and neglect are complete, organized, and safeguarded.
8. Health Services should ensure that each MR/DD person's Individual Support Plan defines the individual's goals and interests and that strategies are tied to the achievement of those outcomes.
9. Medicaid should periodically report to the public its evaluation of provider compliance with community-based services requirements.
10. Medicaid should develop an emergency placement plan for loss of services should a provider cease serving Kentucky residents, ideally in a seamless transition.
11. Medicaid should develop a hiring and screening process to be used by all providers.

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Kentucky Falls Short in Providing Services to MR/DD Persons

Kentucky is not meeting the support needs of its MR/DD residents. According to the National Association of State Directors of Developmental Disability Services, Inc., Kentucky should plan to serve eight to ten thousand MR/DD persons. However, Medicaid is providing services for only 2,566 persons, 1,547 served by the SCL Waiver and 1,019 served in institutional facilities. As of September 25, 2001, there were 1,725 persons on the waiting list/registry for services. Kentucky faces a potential court-imposed mandate to serve those on its waiting list. The Protection and Advocacy Division filed a lawsuit in February 2002 asking the court to order state officials to begin providing services to MR/DD persons within 90-days.

Fifteen other states have been named as defendants in “waiting list” lawsuits. Five of these states have settled out of court. Oregon, for example, agreed to pay \$350 million over the next six years to increase the number of persons served under its waiver by 4,600. Pennsylvania agreed to invest \$850 million over the next five years to eliminate its waiting list.

States that have not reached an agreement have been ordered to develop and implement plans that would reduce their waiting lists and provide services to eligible persons with “reasonable promptness.” West Virginia, for example, was ordered by the U.S. District Court for the Southern District of West Virginia to eliminate its waiting list and “establish reasonable time frames for placing persons into the waiver program.” With a moratorium on institutional care and budgetary constraints on community-based care there was no longer a choice of care for Medicaid eligible persons. The court found that this situation violated the due process provisions of the Medicaid Act. The Kentucky State Health Plan has also placed a moratorium on new beds in institutional facilities for MR/DD persons.

Commission Plan Addresses Providing Services for 8,000 MR/DD Persons

As a result of HB 144, the Commission developed a plan to address the projected need of 8,000 MR/DD persons over a ten-year period. This plan includes establishing a low cost waiver with a limit of \$20,000 per person per fiscal year. It also includes expanding the Supported Living of Kentucky program administered by the Division of Mental Retardation to serve persons covered by the Americans with Disabilities Act (not part of Medicaid funding).

The following table illustrates the Commission’s estimated state funding requirements to serve 8,000 persons.

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Table 11
Ten-Year Growth Plan Proposed by the Commission

Fiscal Year	Current SCL Waiver ① ②		Proposed Low Cost Waiver ② ③		Supported Living Program ② ④		Total Adds	Increase in State Funds
	Additions	Cost	Additions	Costs	Additions	Cost		
2003	250	\$4,008,600	0	\$ 0	150	\$1,836,000	400	\$5,844,600
2004	250	4,211,435	200	1,224,000	150	1,928,902	600	7,364,337
2005	250	4,424,534	200	1,285,934	150	2,026,504	600	7,736,972
2006	250	4,557,270	200	1,324,512	150	2,087,299	600	7,969,081
2007	400	7,510,381	200	1,364,248	300	4,299,836	900	13,174,465
2008	400	7,735,692	250	1,756,469	300	4,428,831	950	13,920,992
2009	400	7,967,763	250	1,809,163	300	4,561,696	950	14,338,622
2010	400	8,206,796	250	1,863,438	300	4,698,547	950	14,768,781
2011	500	10,566,249	250	1,919,341	400	6,452,671	1150	18,938,262
2012	500	10,883,237	0	0	400	6,646,252	900	17,529,488
Total	3,600	\$70,071,957	1,800	\$12,547,105	2,600	\$38,966,538	8,000	\$121,585,600

Source: Auditor of Public Accounts, from information provided by the Commission on Services and Supports for Individuals with Mental Retardation and Other Developmental Disabilities.

- ① Projections based on an estimate of the average cost per person of \$52,400 plus 3% inflation per year.
- ② Includes a proposed 2% rate adjustment for wages per year for first three years to assist in retaining staff.
- ③ Waiver would provide respite, day services, and in-home supports.
- ④ Based on use of the Supported Living self-determination model.

If the SCL Waiver continues to be the only state-funded program to provide community based support for 8,000 persons, the total increase to state general funds will cost \$22,584,145 more than the Commission’s proposal. Assuming an average cost of \$52,400 per person in FY 2003, plus a 3% inflation increase, over \$144 million in additional state funding will be needed over the next ten years if the Commission’s plan is not implemented.

Kentucky’s Average Annual Cost Per Person to Deliver Community-Based Services Is Almost Twice as Much as Other States

Kentucky’s annual per person cost to deliver community-based services to MR/DD persons is almost twice as much as the average cost for the seven other states we reviewed. Five of these states implemented cost control strategies that limit reimbursable units of service. One state also has total cost limits for all services, while two states also have a limited waiver designed to provide limited services to a different segment of the MR/DD population. These strategies may help expand community-based services to more persons. Kentucky has not chosen cost control limits on community-based services as a means of serving more of its MR/DD residents.

The following table provides cost information for eight states.

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Table 12
State Cost Reduction Strategies
FY 2001

State	*Cost Per Person	Annual Cost	Number of Persons Served	Number of Services	Daily Rates for Community Habilitation	Limit on Total Cost Per Person	**Limited Waiver
Alabama	\$23,497	\$94,857,389	4,037	15	✓		
Florida	16,021	386,554,688	24,128	32	✓		✓
Georgia	33,530	251,475,000	7,500	12	✓		✓
Kentucky	49,598	76,728,106	1,547	15			
Mississippi	10,808	9,489,424	878	12			
North Carolina	38,000	228,000,000	6,000	20	✓	✓	
South Carolina	27,270	123,914,880	4,544	21	✓		
Tennessee	42,890	202,312,130	4,717	19			

Source: Auditor of Public Accounts, from information provided by various states.

*The average cost per person for reviewed states is \$27,430.

**Designed to provide limited services.

Kentucky's cost per person is more than twice as much as Alabama's. Alabama serves 160% more persons, but its total MR/DD outlay is only 24% higher, illustrating an expansion of services through better cost controls.

One cost control practice in Florida focuses on preventing billing abuses for community habilitation. A Florida official stated that providers were requesting reimbursement for excessive hours of community habilitation for persons who would not be disadvantaged by receiving only four to six hours of service. Once habilitation had commenced, providers continued to bill Medicaid for shopping excursions or visiting the beach for the remainder of the day. Florida officials now limit a person to four hours per day if the service is billed by the hour, or 20 days a month if the service is billed by the day. This decision was made because of the belief that most meaningful activities require no more than four hours per day.

Billing Community Habilitation on a Daily Rate Could Have Saved Over \$4.8 Million in FY2000 and Provided Services For an Additional 103 Consumers

Kentucky could have saved over \$4.8 million in FY 2000 if it had established daily community habilitation rates like Florida's. This savings could have provided services to 103 more citizens. Health Services officials in Kentucky told us that there are no official limits on community habilitation reimbursements. The following table shows that 76% of consumers received weekly community habilitation services exceeding 20 hours, and the amount of the potential savings resulting from a 4-hour daily rate during FY 2000.

Table 13
Potential Savings and Consumers
Resulting From Daily Rates for Community Habilitation
FY2000

Hours Per Week*	Number of Consumers Over**	Potential Savings	Number of Additional Consumers That Could Be Served
20	923	\$4,867,785	103
25	745	2,623,630	55
30	499	1,012,806	21
35	198	446,557	9
40	1	3,625	N/A

Source: Auditor of Public Accounts, from information provided by the Department for Medicaid Services.

*Based on a five-day week.

**Total number of consumers receiving community habilitation 1,221 in FY 2000.

Limiting Per Person Community-Based Costs to the ICF/MR Average Could Have Saved the Commonwealth \$2.7 Million in FY 2000 and Provided Services for 56 More Persons

Medicaid does not limit per person costs for community-based services. For 270 of those persons Kentucky paid more than the \$70,564 average per person ICF/MR cost. A limit of the ICF/MR average for 2000 would have saved the Commonwealth over \$2.7 million, which could have funded services to an additional 56 persons. North Carolina, for example, does not permit total annual costs for one person to exceed the ICF/MR average, which is around \$86,000. It limits total monthly expenses to \$7,171.50 per person.

CMS Has No Real Cost Control Requirements

The federal cost control currently required by CMS is *cost neutrality*, which prohibits average per capital costs for SCL Waiver services exceeding those for ICF/MR care. This limitation is not, however, a true cost control, since it yokes the rising congregated care costs with community-based care. Moreover, this form of cost control may become outmoded as states move more consumers from ICF/MRs into community-based programs.

Medicaid's Failure to Adjust a Provider's Rates Cost the State Millions

Medicaid did not adequately document its rate discussions and decisions in 1996 when a provider agreed to begin serving consumers previously served by a failed provider. This situation led to an \$8 million overpayment, which was settled for \$500,000. The provider asserted that Health Services officials had agreed to allow the maximum permissible rate rather than a rate based on actual costs, partly as compensation for assuming the obligations of the failed provider.

Medicaid officials stated that a delay in the reassessment of the initial rates of the new provider resulted in the overpayments, which would later be revealed in Medicaid's desk reviews of the provider's FY 1998 and FY 1999 costs reports in FY 2000. According to Medicaid, the rates were never reassessed because of personnel turnover and the expected implementation of a new reimbursement system. As a result, Medicaid forgave \$7.5 million of the overpayment.

Health Services delayed posting the overpayments to accounts receivable until a settlement was reached. Once the \$500,000 settlement was paid, Medicaid then posted it to their accounts receivable. Under Medicaid rules, after 60 days of posting the overpaid amount to accounts receivable, the Commonwealth would have been obligated for seventy percent of the overpayment to the federal government.

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Medicaid Has Taken Steps to Equalize Provider Rates

Medicaid has made attempts to improve the reimbursement system for the SCL Waiver and reduce variances between SCL provider rates. Reimbursement rates were previously based on provider cost reports, which could be inflated and vary widely among providers. Rates for 24-hour staffed residences, for example, varied by as much as \$96 per day. The new rate-on-rate system increases rates by a percentage based on the Consumer Price Index. All new providers start at a base rate rather than their projected cost. Medicaid officials stated that cost reports are still reviewed for informational purposes. Finally, Medicaid recently gave providers with below median rates a one-time increase to the median while providing little to no increase for those providers with rates far above the median level.

Billing Review and Recoupment Is Inadequate

In a 1994 report, GAO reported to Congress that fraud and abuse losses could amount to as much as 10% of annual healthcare expenditures. From September 1997 through September 2001, however, Health Services identified and sought repayment of only \$281,144 or .1% of the total Medicaid payments to SCL Waiver providers. This suspiciously minor result suggests that (1) Health Services has not performed satisfactory billing reviews, and (2) the Commonwealth has not realized the potential savings that could be expected.

Medicaid Does Not Perform Fraud Detection

According to Health Services' officials, neither employees conducting billing reviews or their supervisors are trained to detect Medicaid fraud. Since September of 1997 when the SCL Waiver began, no instances of suspected fraud have been turned over to Health Services' Office of Inspector General or the Attorney General's Medicaid Fraud and Abuse Control Division.

KRS 205.8453 requires Health Services to control recipient and provider fraud and abuse. The statute states that the following four actions shall occur:

1. Inform recipients and providers of the proper use of medical services and methods of cost containment.
2. Establish checks and audits within the Medicaid Management Information System to detect fraud and abuse.
3. Share information and reports with other departments within Health Services, the Office of the Attorney General, and any other agencies responsible for recipient or provider use review.
4. Institute other measures for controlling fraud and abuse.

The interagency agreement between Medicaid and DMR states that Medicaid is responsible for monitoring billings and processing all proper payments to providers. However, it does not offer more specific detail.

An Effective Fraud Detection Function Could Have Recouped as Much as \$22 Million

An effective fraud detection function performed by Health Services during the past four years could have recouped amounts ranging from \$2.1 million to \$21.7 million. This range of savings, as detailed in Table 13, could have funded service to between 10 and 109 more persons through the SCL Waiver based on current average consumer costs.

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Table 14
Identification of Overpayments
Which Could Have Led to Recoupments*

Projected Percentage of Overbillings That Could Have Led to Recoupments	Amount of Potential Recoupment	Average Annual Potential Recoupment	Number of Additional Persons That Could Have Been Served Annually
1%	\$2,170,845	\$542,711	10
2%	4,341,690	1,085,422	21
3%	6,512,536	1,628,134	32
4%	8,683,381	2,170,845	43
5%	10,854,227	2,713,557	54
6%	13,025,072	3,256,268	65
7%	15,195,917	3,798,979	76
8%	17,366,762	4,341,690	87
9%	19,537,608	4,884,402	98
10%	21,708,453	5,427,113	109

Source: Auditor of Public Accounts Using Information from the Cabinet for Health Services.

*Projections are based on SCL Waiver Payments from September 1997 to June 2001 and the FY01 annual cost per person of \$49,598.

Health Services does not levy fines or interest when overbillings or improper claims are revealed. According to 907 KAR 1:671, Medicaid is authorized to levy sanctions, including interest. In addition, there is no state or federal statute that would preclude Medicaid from assessing interest on all improper claims and overbilled amounts. The Commonwealth is missing an opportunity to deter providers from improper billing practices.

Medicaid Failed to Collect \$14,496 and Was Remiss in Posting \$59,071 to Accounts Receivable

Medicaid did not collect \$14,496 of a \$281,144 accounts receivable balance identified through billing reviews. The uncollected amount consists of accounts receivable that are over 60 days old. According to Medicaid officials, the Division of Financial Management could not identify any recent collection attempts for these receivables.

We discovered billing errors of \$59,071 that were not being pursued for repayment. Although DMR submitted the billing errors to Medicaid for action, none was taken. According to Medicaid officials, the oversight occurred as a result of a lack of communication caused by internal reorganization. The amount was posted during our audit, over two years after DMR's review was completed.

There is no recoupment database within Health Services to store and track billing reviews. Instead, staff rely on inadequate hard copy data and notes. A more comprehensive and assessable system would identify billing review amounts, dates, and resolution status, and help expedite processing of overpayments. Such a system would also help to identify trends indicative of fraud.

Health Services Has Not Adequately Ensured That Duplicative Services Are Not Being Provided to SCL Recipients

We identified 39 MR/DD persons who are receiving services through both the SCL and the Supported Living Program (SL). SL is funded entirely by the state's general fund and consequently duplicative services may have been reimbursed. Since 1997 the Commonwealth has expended \$353,806 for persons participating in both programs. According to Medicaid policy, the "Medicaid Program shall be the payer of last resort." This means that other avenues for receiving services should be exhausted before participating in the Medicaid program.

After our identification of this issue, Health Services is now in the process of auditing expenses, services, and applications related to persons who received SCL and SL services. It is also in the process of developing a system of routine reviews, training, and a shared database to store information on SL and SCL services.

Recommendations

1. Kentucky should ensure that comprehensive services are available to meet the needs of MR/DD persons.
2. Medicaid should consider reimbursing providers of community habilitation at a daily rate for services lasting more than four hours. This practice would have saved the state \$4.8 million in FY 2000, which could have funded services for an additional 103 consumers.
3. Medicaid should consider limiting the total per person cost for community-based services at a cap equivalent to the per person cost in an intermediate care facility. This practice could have saved the state over \$2.7 million in FY 2000 and provided services for an additional 56 consumers.
4. Medicaid should provide fraud detection training to the community-based services administrators.
5. Health Services should update the Interagency Agreement between Medicaid and DMR and include specific duties and responsibilities related to fraud detection.
6. Health Services should diligently identify, review, and pursue potential recoupments. In addition, Medicaid should routinely review and attempt to collect accounts receivable and maintain more formal documentation related to billing reviews.
7. Health Services should eliminate any duplication of services by the federally matched community-based services program and the state funded Supported Living Program.

Chapter 4

Community Habilitation Through the SCL Waiver

Payments for Community Habilitation Too Permissive

Health Services allows almost any type of activity to be reimbursed as a community habilitation service. As long as a consumer's Individual Support Plan (ISP) documents the desire for community habilitation and the service is not provided in a residential setting, various activities can be provided and reimbursed through Medicaid. As a result, MR/DD citizens may not be receiving community habilitation services that truly help them assimilate into the community.

Community habilitation is defined broadly in the SCL Waiver to include activities that will be furnished in the community or in a nonresidential setting. There is no definition of unallowable activities. In FY 2001, community habilitation was provided to 1,467 persons and was the second most expensive service provided by the SCL Waiver at \$19 million. The following are some examples of community habilitation services that have been reimbursed by Medicaid and approved by Health Services:

- Shopping trips.
- Library trips.
- Visits to historic sites and places of interest such as the Frankfort Floral Clock.
- Trips to arboretums and parks.
- Travel and sightseeing within Kentucky.
- Sheltered workshop activities.
- Activities at fixed community habilitation sites such as paper shredding, pretend catalog shopping, reading and looking at magazines, and looking at photographs of community businesses.

Focused Monitoring of Community Habilitation Activities Does Not Occur

Kentucky's definition of "community habilitation" has been approved by the Center for Medicare and Medicaid Services (CMS), formerly the Healthcare Financing Administration (HCFA). However, there has not been adequate monitoring by Medicaid to ensure that community habilitation services will enable an SCL recipient to accomplish the following goals mandated in 907 KAR 1:145E:

- *Participate in a community project as a volunteer in a typically unpaid position.*
- *Access and utilize community resources; and*
- *Utilize a variety of assistance and training to interact with the environment through expressive services, which shall be based on goals, and be therapeutic rather than diversional.*

Chapter 4

Community Habilitation Through the SCL Waiver

However, Health Services' poorly defined guidelines make accountability and goal measurement nearly impossible. According to Health Services officials, there are no efforts to track the different types of services that are reimbursed under community habilitation. All services are simply defined as community habilitation and are tracked as such. As a result, Health Services does not know how often various types of services are being billed under community habilitation and whether those services are actually meeting the regulatory goals articulated. This lack of monitoring makes it almost impossible to determine whether certain services reimbursed as community habilitation are effectively helping MR/DD citizens.

Questionable Billings

Although some providers have developed innovative ideas to provide community assimilation, many of the activities observed during our on-site visits offered little in the way of acquiring or improving skills needed to reside in community based settings. In fact, many of the community habilitation activities observed might have been accomplished in an institutional setting, something the SCL Waiver purports to avoid. The following are questionable examples of community habilitation activities observed during on-site visits to eight SCL providers:

- A provider sent consumers on day trips where transportation time to and from events in Frankfort and Louisville constituted a majority of the community habilitation activity. This same provider had, on a prior occasion, been investigated for “van therapy” which was described as a process where “individuals are driven out into the community and never leave the van.”
- Consumers were gathered at an isolated community habilitation site and looked at photographs of retail stores and fast food restaurant signs in order to discuss places where they might like to eat or visit when they go into the community. One consumer sat at a table “shopping” through a catalog, while another looked at a recipe book.
- One provider used a residential home, which is a direct violation of SCL regulations, as a community habilitation site laundry center. Consumers were transported from their homes so that they could wash and dry clothes.
- One provider's community habilitation activities included repetitive paper shredding by hand in a small room.
- A review of daily community habilitation logs documented that community habilitation activities were repeated on a routine basis.
- Provider staff transported consumers to and from community habilitation locations in their own cars, yet Kentucky's SCL Waiver does not have guidelines for monitoring car insurance and car safety.

The absence of monitoring to ensure that the desired outcomes and goals are achieved has resulted in the use of limited and repetitive activities in the name of community habilitation. Health Services is therefore reimbursing SCL providers millions of dollars for community habilitation services without ensuring that consumers are getting the personal assistance needed to live in home and community-based settings.

Chapter 4 Community Habilitation Through the SCL Waiver

Sheltered Workshop Activities Are Billed as Community Habilitation and Are Not Tracked

Four of the eight SCL providers we visited receive community habilitation reimbursement for providing paid labor activities in what the Kentucky Labor Cabinet designates as sheltered workshops. Health Services was not able to accurately identify how many of the providers offer sheltered workshop activities. Health Services does not track consumers' wages, duration of employment, or transition to outside employment. Additionally, there is no aggregate data tracking that indicates the percentage of providers' hours billed to community habilitation. Sheltered workshop activity is repetitive contract labor work typically performed in closed industrial settings with little direct community interaction. According to information from Kentucky's Labor Cabinet, 21 of 49 SCL providers in our sample were certified to operate sheltered workshops in FY2000.

Sheltered work we observed included processing food, collating shipping materials, manufacturing cardboard boxes, and other assembly tasks. Average pay was less than \$1.00 per hour for consumers at one provider we visited. The sheltered workshop sites we visited varied widely in form and sophistication but all functioned as piecework labor shops that were devoid of direct interaction with the public. In fact, one sheltered workshop was located in a residential home, which is a direct violation of the state regulations.

Although sheltered workshop activities are paid for under Health Services' broad definition of community habilitation, they are unlikely to be effective in meeting goals of community integration. According to a CMS Director of Medicaid Benefits in Washington D.C., there is concern at the federal level that sheltered workshop activities should not be covered as habilitation services within a community-based waiver. The official also stated that such activities are typically covered as vocational rehabilitation and may be better funded under this source. Currently, CMS is studying the issue for all states.

The Department of Vocational Rehabilitation within the Workforce Development Cabinet stated it can no longer fund sheltered workshop employment. An October 2001 amendment in federal regulations will not allow persons restricted to sheltered employment to be considered successful employment outcomes. When the Department purchases services from a provider, "the vocational goal for the individual must be integrated, community based employment." Like SCL funding, the Department's funding is based on a federal and state match.

Although sheltered workshops are, in theory, transitional workplaces where persons learn job skills and eventually make their way into the competitive workplace, some studies have shown only 3 to 5 % of consumers make the transition. Those with very low productivity can remain in sheltered workshops without ever making a transition or being offered alternative community habilitation activities. Health Services expressed no concerns that consumers might not be moving from the workshops into private employment.

Although we could not identify the percentage of community habilitation that took place in sheltered workshops, we contacted one provider who stated that 60% of SCL Waiver services it bills under community habilitation are activities in a sheltered workshop environment. Without adequate tracking and monitoring, there is no way to know how many consumers receive daily community habilitation services through sheltered workshops, or whether this activity is

Chapter 4 Community Habilitation Through the SCL Waiver

Employment Transition
Services Are Available but
Not Used

effective and meets the goals of 907 KAR 1:145E.

Kentucky's SCL Waiver includes two employment related services- "prevocational" and "supported employment" intended to assist consumers with transition into private sector employment, but these services are rarely used. In FY 2001, use was dismally low with only 32 of the 1,547 persons in the SCL Waiver receiving prevocational services and only 83 receiving supported employment services.

These services are defined as follows:

Prevocational: Services prepare an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving, and safety.

Supported Employment: Services consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of disabilities, need intensive ongoing support to perform in a work setting. Supported employment includes activities needed to sustain paid work by persons receiving waiver services, including supervision and training.

Health Services and SCL
Providers Are Taking Steps
To Improve Community
Integration and Offer
Innovative Alternatives

Health Services has recently increased efforts to encourage new community habilitation activities. Some SCL providers like Arc of the Bluegrass and Latitudes, both in Fayette County, offer creative arts activities that have been well received by the community and the participating consumers. Health Services is promoting creative expression programs as alternatives for new providers. These activities are expected to provide more community interaction and be more therapeutic than many of the activities we observed.

A few providers we visited have integrated community habilitation activity sites and staffed residences into sustainable neighborhood networks with pedestrian access. The homes and apartments of Arc of the Bluegrass, as well as its community habilitation program, *Minds Wide Open*, exemplify neighborhood inclusion. The Bluegrass Regional community habilitation site is located in a small residential shopping area with nearby consumer housing, a park, and shopping access, and offered an integrated location. Still, there is no requirement that providers supply community habilitation services near consumer residences to reduce the amount of travel and provide local neighborhood interaction.

High School Diploma or
GED Not Required for
Direct Contact Staff
Providing Community
Habilitation

Under current state regulations, direct-care staff who provide community habilitation are not required to have high school diplomas or GEDs if they are at least twenty-one years old. State regulations were changed, effective February 2001, to remove the high school diploma and GED requirement as long as the staff member possesses "effective" communications skills. Community habilitation supervisory staff are also not required to have high school diplomas or GEDs if they have one year of experience and effective communications skills. According to Health Services officials, Kentucky Medicaid was concerned about employees' ability to read and write staff notes and plans so they added a requirement for "effective" communications skills. Despite the weak education requirements, some SCL providers employ community habilitation staff with college and advanced degrees.

Chapter 4
Community Habilitation Through the SCL Waiver

Recommendations

1. Health Services should track the different types of services provided under community habilitation.
2. Medicaid should require a high school diploma or GED for persons providing community habilitation services.

Scope

The Kentucky Auditor of Public Accounts conducted a performance audit to examine the cost and quality of services provided to mentally retarded/developmentally disabled (MR/DD) persons. This audit was conducted in accordance with *Government Auditing Standards*, as promulgated by the Comptroller General of the United States General Accounting Office and undertaken with authority granted under Kentucky Revised Statute 43.050. Audit fieldwork began in November 2000 and was concluded during December 2001. The audit's purpose was to address the following objectives:

Determine whether the Commonwealth is providing optimal care for mentally retarded and developmentally disabled (MR/DD) persons through its Medicaid Community-Based Services Program.

Determine whether better cost management will permit the Commonwealth to expand community-based services to more persons.

Assessments of management controls and computer-generated data were not significant to our audit objectives or findings except as noted in our report. Reliance on computer and management controls was left to the Cabinet for Health Services' assertions of reliability, external audits of the agency, and controls and audits related to its Medicaid fiscal agent.

Methodology

To accomplish these objectives, we conducted interviews with staff from the following state and federal agencies concerning MR/DD issues:

- Kentucky Cabinet for Health Services (Health Services), Department for Medicaid Services
- Health Services', Department for Mental Health and Mental Retardation Services
- Health Services', Office of General Counsel
- Health Services', Office of Certificate of Need
- Health Services', Office of the Inspector General
- Kentucky Cabinet for Families and Children (Families and Children), Department for Community Based Services
- Families and Children's, Office of Technology Services
- Kentucky Office of Attorney General, Medicaid Fraud and Abuse Control Division
- Kentucky Transportation Cabinet, Office of Transportation Delivery
- Kentucky Labor Cabinet
- Kentucky State Police
- Kentucky Administrative Office of the Courts
- Centers for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration (HCFA)), Atlanta Regional and Washington D.C. offices

Advocacy Groups Contacted

We also interviewed the following advocates and other stakeholders regarding quality service delivery to MR/DD persons:

- Kentucky Department of Public Advocacy, Protection and Advocacy Division

- Kentucky Association for Retarded Citizens
- Central State ICF/MR Bingham Center Family Group

Benchmarking With Other States

To compare Kentucky’s SCL Waiver cost, fiscal oversight practices, and services provided with the other states in our CMS region, we contacted Medicaid officials in the following states:

- Tennessee
- Alabama
- Mississippi
- South Carolina
- North Carolina
- Georgia
- Florida

Reviewed Applicable Laws and Regulations – Related Publications

We reviewed Kentucky’s applicable statutes and regulations pertaining to MR/DD persons and the SCL Waiver. For more specific information related to the SCL Waiver, we reviewed the *Supports for Community Living Manual* (various transmittals) and the Division of Mental Retardation’s Area Administrators Handbook.

In order to assess national trends related to institutional and community-based services, we examined background information consisting of federal audit reports, other states performance audit reports, professional and academic journal articles, and other media treatments.

We also reviewed federal enabling legislation related to disabilities and Section 1915(c) of the Social Security Act, which established Home and Community-Based Waivers. In addition, we reviewed the United States Supreme Court’s decision in *Olmstead v. L.C.* (1999) and analyzed its impact on Kentucky’s community-based and congregated service delivery.

We analyzed legislative budget appropriations to MR/DD programs, paying particular attention to House Bill 144 that was enacted in 2000 for the purpose of expanding community-based services through the SCL Waiver. In addition, we attended several meetings of the Commission on Services and Supports for Persons with Mental Retardation and Other Developmental Disabilities, which was created by House Bill 144. We also reviewed the Commission’s 10-year plan entitled, *From Dreams to Realities for Quality and Choice for All Individuals with Mental Retardation and Other Developmental Disabilities*, submitted to Governor Patton and the General Assembly on April 17, 2001.

Review of Cost Information Maintained by the Department for Medicaid Services

We assessed cost and expenditure data on the SCL Waiver and ICF/MRs in order to perform analyses on aggregate and average costs for fiscal years 1998, 1999, 2000, and 2001. We analyzed cost data related to specific billed services, SCL consumers, and SCL providers for fiscal years 1998, 1999, and 2000. We analyzed billing reviews, cost settlements, and accounts receivables for SCL Waiver providers from September 1997 through September 2001.

Review of SCL Providers' Certification and Investigation Files

In order to directly assess quality of services, we reviewed Health Services' certification reviews and investigations files to test for specific attributes. We reviewed a sample of 12 SCL providers' certification reviews for the period September 1997 through May 2001. All investigations on file with Health Services were reviewed for the period of September 1997 through January 2001. This amounted to 299 incidents that were investigated by Health Services. We also tested 225 of the 299 incidents to determine whether the required parties were notified of the incidents within 24 hours. Finally, of the 299 incidents, 210 were forwarded to the Department of Community Based Services within Families and Children in order to determine if proper referrals were made.

We also reviewed Office of Inspector General certification and investigation files on the 7 SCL providers offering group home placements.

SCL On-Site Reviews and Surveys

Of the 12 SCL providers for which we reviewed the Health Services' certification reviews, we performed on-site examinations of 8 SCL providers. These on-site reviews consisted of interviews with provider staff, visits of SCL consumers' homes and service delivery locations, and a review of a sample of the SCL provider's personnel files.

In addition, we surveyed all SCL providers on cost and quality issues related to the SCL Waiver. We had a response rate of 52 providers of the 65 SCL providers. The SCL providers surveyed were those that were active and had submitted claims for payment as of April 20, 2001.

Certification Review Process

Provider Complaints:

- No exit conferences are held with SCL providers at the end of the review.
- Communication delays – providers do not receive a timely written response from Health Services.
- Inconsistent interpretations – deficiencies cited depend on the area administrator.
- Some area administrators lack experience and are too rigid in interpretations of regulations – missing the big picture.
- SCL Waiver regulations conflict with Inspector General’s licensing regulations (affects providers operating group homes only).

Provider Requests:

- More standardized review criteria and guidelines so that the review process is not subjective.
- More assistance from area administrators instead of merely forwarding written findings.
- Area administrators should conduct exit conferences and submit a findings report in 30 days.
- Improve training for area administrators so that their reviews will be more consistent.
- Updates in SCL Waiver regulations should be communicated to all providers on a timely basis and prior to a certification review.
- More involvement with the development of regulations.

Training

Provider Complaints:

- It is too expensive to do internal training.
- Medicaid training provided on billing issues was useless.

Provider Requests:

- More funding to increase and improve training.
- More on-site technical assistance and meetings concerning waiver changes/issues.
- Training manuals provided to all SCL Waiver providers.
- Training presented on best practices.
- Opportunities to collaborate and share ideas with other SCL Waiver providers.

Transportation

Provider Complaints:

- Frequent delays and no pick-ups disturb consumer participation.
- Provider locations used as pick-up and drop-off hubs.

Provider Requests:

- Improved access to transportation.
- Trained vendors to provide transportation.
- Sensitivity training for providers and drivers.
- Weekend and evening transportation.

SCL Waiver Services

Provider Complaints:

- SCL Waiver regulations should be less rigid concerning where community habilitation occurs.
- Aging consumers need more flexibility.
- Waiver lacks crisis intervention service.
- Waiver lacks equality in consumer referrals.

Provider Requests:

- More focus on quality of life.
- The consumers' level of need identified prior to referral to a provider.
- Support coordination provided by an independent agency so that services are the choice of the consumers/guardians.
- More psychiatric and counseling services available.
- Recreation added as a reimbursed service.

SNAP Assessment Tool (identifies "high intensity" consumers for higher compensation rates)

Provider Complaints:

- SNAP assessors spent little time with the consumers.
- SNAP failed to capture behavior problems and other consumer issues that demand additional staffing.

Provider Requests:

- SNAP reevaluated and replaced.
- Provider input for high intensity assessment when applicable.

Employee Turnover

Provider Complaints:

- Lack of funds to attract and retain qualified personnel.
- Lack of persons interested in working with this population.
- SCL Waiver regulations create numerous roadblocks and delays for hiring staff without an increase in reimbursements to cover new requirements.

Provider Requests:

- Higher rates to pay qualified staff.

Lack of Funding

Provider Complaints:

- Persons do not have true choice because of the SCL waiting list and scarcity of ICF/MR beds.
- Community Habilitation and Respite rates are too low to cover the expense – makes it difficult to individualize the services provided.

Provider Requests:

- Prior authorization for specific consumer services so that SCL Waiver funds can be used for more people.
- Fees paid to not-for-profit as high as those paid to for-profits.
- More resources to serve more individual needs.
- Local input as to who should receive funding.
- Providers equally reimbursed.
- More flexibility in the consumer's ability to choose how to spend funds and use services – e.g. use of the self-determination model.
- Increase funding for extreme behavior problems.
- Simplify application and acceptance process.

- Funding for the SCL Waiver blended with other funding streams.
- Compensation for pre-needs assessments prior to the development of the Individual Support Plan.



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MARCIA R. MORGAN
SECRETARY

March 14, 2002

Mr. Edward B. Hatchett, Jr.
Auditor of Public Accounts
Suite 144, Capitol Annex
Frankfort, KY 40601-3448

Dear Mr. Hatchett:

Attached is our response to your audit of the Supports for Community Living (SCL) program. As I am sure you and your staff learned during the course of the audit, this is an extremely important program to the citizens of this Commonwealth who have mental retardation and developmental disabilities, as well as to those who love them. The Supreme Court's 1999 Olmstead decision made it clear that individuals with disabilities have a right to live in the community. As importantly, they have a right and need to be part of the social fabric of the community. For many people with mental retardation and their families, it is the services and supports through the SCL program that make that possible. The SCL program is a waiver program within the Department for Medicaid Services. Since July 1, 1998, the Department has contracted with the Department for Mental Health and Mental Retardation Services to manage and administer the program with Medicaid retaining responsibility of the payment to providers for SCL services.

We believe it is important to note that during the 3 1/2 years covered by the audit, significant changes have been made in the Supports for Community Living program to make it more responsive to the individuals it is designed to serve.

We take very seriously the issues addressed in your report, the most important of which are the safety and well being of the people we serve and the



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Mr. Edward B. Hatchett, Jr.
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effective stewardship of allocated dollars. The Cabinet for Health Services has created a work group consisting of representatives of the Cabinet of Families and Children, the Department for Medicaid Services, the Department for Mental Health and Mental Retardation Services, and the Office of the Inspector General. This group will review the audit report and present findings and recommendations to me within ninety (90) days.

Thank you for giving us the opportunity to respond to the audit of the Supports for Community Living Waiver.

Sincerely,



Marcia R. Morgan
Secretary

Attachment

Cabinet for Health Services Audit Response March 14, 2002

Information provided in this response is intended to either clarify information provided in the audit or to respond to specific recommendations contained in the report. Information and comments are presented in the same sequence as the audit report. Responses to specific recommendations are contained in the Executive Summary Section.

Audit Area	Cabinet Response
Executive Summary	
Certification Reviews	The certification tool utilized by survey staff is a comprehensive instrument that has the capacity to identify 430 potential citations for each review. Deficiencies range from minor to serious in nature. The number cited in the audit report represents an overall deficiency rate of 2.3% for the 12 providers over the length of the review period. All deficiencies cited required a Plan of Correction from the provider and were monitored for compliance. Our goal is to further reduce the deficiency rate through provider training and technical assistance.
Abuse and Neglect in Community Based Services	The auditor's office reviewed 299 investigation files that spanned a four- year period. An investigation file is created for a variety of incidents ranging from minor in nature to more serious incidents including allegations of abuse and neglect. <u>However, the Cabinet agrees that no incident of abuse or neglect is acceptable. The Cabinet remains committed to refining and improving prevention and reporting mechanisms.</u>
Meeting Demand for Services	As noted in Chapter 3 of the Audit Report, the HB144 Commission developed a plan to address the projected need of 8,000 individuals with MR/DD over a ten-year period. Since the signing of HB144, funding has been provided to serve an additional 500 people, and the Governor's FY2003-2004 budget provides funding for another 500 people. The Cabinet is committed to serving all eligible individuals as funding becomes available. However, both the Cabinet and the HB 144 Commission recognize that developing the community resources across Kentucky that can adequately meet the needs of this very service-intensive population is critical in insuring that needs are met in a way that maintains a safe environment for the individual and insures that funds are spent appropriately.
Provider Screening/Hiring Practices	Since September 1997, the SCL waiver has required police record checks prior to hiring. In February 2001, the requirement was strengthened to include <u>annual</u> record checks and to eliminate hiring anyone with a felony conviction. The monitoring and certification review processes identify compliance associated with provider qualifications. Any finding of failure to comply with the requirements necessitates a Plan of Correction that is monitored to ensure compliance.
Comparison of Per-Person Costs of SCL Waiver Services in Kentucky with Other States	The comparison provided by the auditor's office does not take into consideration the substantial differences in the design of waiver programs in the listed states and the funding mechanisms for various services provided. The mix of services provided through waiver programs differs significantly from state to state, making

a true cost comparison extremely difficult. Additionally, states are in various stages of court-mandated compliance that may impact the level of services offered and the associated costs. However, the Cabinet is committed to reducing the waiting list as soon as possible and intends to review all services offered through the SCL waiver program with a goal of maximizing fiscal resources.

Use of Fraud Detection to Contain Costs

The 10 year-old GAO report cited by the auditor's may have reflected systemic control weaknesses nationwide in 1992 in the health care industry as a whole. However, the Cabinet is unclear how the 1992 report, which was not specific to Kentucky or the Medicaid program, can be used as a basis for questioning Kentucky's diligence in preventing and detecting fraud. Many changes have been made to the program in the last 10 years, both at the federal and state level, to prevent and detect fraud. A June 2001, GAO report titled "Medicaid State Efforts to Control Improper Payments Vary," indicated the following: "There are no reliable estimates of the extent of improper payments throughout the Medicaid Program. An even more difficult portion of improper payments to identify are those attributable to intentional fraud." However, the Cabinet understands that this is a very important concern and that fraud control is essential to maximizing fiscal resources both for the entire Medicaid program and, more specifically, for the SCL waiver program.

Payments for Community Habilitation

Community habilitation is critical for integrating the individual into the community both in terms of socialization and possible gainful employment. The associated cost of community habilitation reflects the priorities of the Cabinet and the Medicaid program. The Cabinet will continue to support the development of individualized plans to assure they reflect appropriate activities and related costs. Additionally, as a part of the upcoming program review, the Cabinet intends to focus on costs and benefits associated with community habilitation to ensure that services and reimbursements are arrayed in a manner that promotes maximum value to both the individual and to the public.

Auditor's Recommendations

1. Health Services should eliminate abuse and neglect in community-based settings.

The vigilance of responsible state agencies, providers and the general public is even more critical for our most vulnerable citizens. Policies of the SCL program that are designed to mitigate the possibility of abuse or neglect include:

- police records check on all direct care staff for any felony convictions;
- training on the individualized needs of the person; the identification and reporting of abuse, neglect, and exploitation;
- supplemental training on abuse and abuse prevention; and
- interviewing of potential staff by the provider agency and by the individual whom they will support.

As noted above, the Cabinet agrees that no incident of abuse or neglect is acceptable and the Cabinet remains committed to refining and improving both prevention and reporting mechanisms.

2. Health Services should require that incidents of abuse and neglect be reported to Families and Children as required by law.

The Cabinet agrees with this recommendation. Our records indicate that we are in substantial compliance. Of the 211 investigation files reviewed by the auditors, 130 cases met the criteria for referral to the Department for Community Based Services, of which 122 were referred.

To further compliance in this area, extensive training and technical assistance have been provided to Supports for Community Living providers, and will be continued. Additionally, the Department for Mental Retardation and the Department for Community Based Services have been meeting regularly to address issues related to reporting of abuse and neglect. It is anticipated that these meetings will culminate in the development of a formal interagency agreement between the two entities.
3. Medicaid should assess monetary damages or penalties against providers who fail to report incidents of abuse and neglect.

The Cabinet intends to review any statutory and regulatory implications for implementing a monetary damages/penalties program.
4. Health Services should ensure that investigation and complaint files regarding abuse and neglect are complete, organized, and safeguarded.

The Cabinet agrees that investigation and complaint files regarding abuse and neglect should be complete, organized and safeguarded. The incident and investigation database established in July 1998, was revised in September 1999, March 2000, and most recently January 2002 to incorporate additional data elements for improved tracking to ensure all files are complete, thorough and properly organized and safeguarded. The most recent revisions include DCBS notifications and investigation results and Plan of Correction monitoring results. The Cabinet would appreciate specific recommendations from the auditor's office on improving current practices.
5. Medicaid should develop a hiring and screening process to be used by all providers.

The Supports for Community Living Waiver application, regulation, and manual specify requirements for participation for individual service providers. Cabinet staff conducts an initial certification review to ensure that the provider is in compliance with all requirements prior to certifying the provider SCL waiver services. One component of this initial review is to ensure that the provider is in compliance with the personnel requirements. If deficiencies are noted, a Plan of Correction is required and monitored for compliance. Thereafter, the provider receives an annual certification review. Again, if any deficiencies are noted, a Plan of Correction is required and monitored for compliance.
6. Medicaid should require a high school diploma or GED for persons providing community habilitation services.

The Cabinet agrees that this recommendation is a goal to strive for. However, at the present time, 21% of the adult population in Kentucky has less than a high school credential. Coupled with the low unemployment rate in the state, it is not practical at this time to eliminate 21% of the potential applicant pool from consideration.

Recently, Kentucky received a Real Choices: Systems Change Grant, a portion of which focuses on workforce issues. The goal is to develop a workforce that is competent in the provision of home and community supports to people with disabilities. The Cabinet will be working with the Council on Post-Secondary Education and its affiliates to develop a career ladder and curricula that leads to certificates and formal educational credits, including degrees.

-
7. Kentucky should ensure that comprehensive services are available to meet the needs of MR/DD persons.
- The Cabinet is unclear how this recommendation differs from the Cabinet's stated goals for the SCL program. The Cabinet is working diligently to address the needs of people with mental retardation and other developmental disabilities through, not only the SCL program, but also through the state funded services provided by the community mental health/mental retardation centers and their affiliates, and through the intermediate care facilities (ICFs-MR).
- In April 2001, the HB 144 Commission on Services and Supports for Individuals with Mental Retardation and Developmental Disabilities set forth a 10-year plan for building the appropriate capacity within the Commonwealth. In accordance with the Commission and enabling legislation, an additional 500 individuals were funded in the SCL program in the FY01-02 biennium. Additionally, funds are included in the Governor's budget for the FY03-04 biennium that will result in another 500 individuals being served.
8. Health Services should ensure that each MR/DD person's Individual Support Plan (ISP) defines the individual's goals and interests and that strategies are tied to the achievement of those outcomes.
- This is a fundamental expectation of the SCL program, its providers and its administrators. Policies and processes in place to address this requirement are:
- Each Individual Support Plan is reviewed at least annually to determine whether the plan is individualized and adequately meets the needs and choices of the individual;
 - Services are not authorized unless they directly relate to the ISP; and
 - Provider agencies staff receive training regarding development of individualized goals and outcomes and delivering services and supports that are tied to the achievement of those outcomes.
- Additionally, as a pilot project, we intend to provide enhanced training to individuals and their family members to assist them in being full participants and decision-makers in the design and implementation of the Individual Support Plan.
9. Medicaid should periodically report to the public its evaluation of provider compliance with community-based service requirements.
- DMS will revise the current regulation to require providers to maintain copies of their most recent certification surveys readily available at the provider site for access upon request by individuals seeking services. In addition, the Cabinet will proceed with the recommendations of the Commission on Services and Support for Persons with Mental Retardation and Other Developmental Disabilities (H.B. 144 Commission) regarding the posting of certification survey findings and satisfaction surveys for each certified provider on the DMR web site. A hard copy will be available upon request by the general public.
10. Medicaid should develop an emergency placement plan for loss of services should a provider cease serving Kentucky residents, ideally in a seamless transition.
- The Cabinet agrees with this recommendation. An informal process has been followed successfully in the past during the closure of two other providers. For the future, a written emergency plan will be developed and in place by July 1, 2002.
11. Health Services should track the different types of services provided under community
- The variety and types of services for community habilitation are as varied as there are people in the program. Learning to be as independent as possible and learning the skills that will enable the individual to be a part of the community demand activities that are meaningful to the person and include activities that take place in

- habilitation. the community. We agree, however, with the ongoing need to monitor the services to assure that they are in accordance with the person's desired objectives. This monitoring, therefore, will focus on the quality of the individual's life and the achievement of desired outcomes.
12. Medicaid should reimburse providers of community habilitation at a daily rate for services lasting more than four hours. This practice would have saved the state \$4.8 million in FY 2000, which could have funded services for an additional 103 consumers.
- The Cabinet has seen no documentation to support this recommendation. We believe this recommendation resulted from a comparison with the state of Florida who is currently in a lawsuit over its use of capitation for community habilitation services. Community habilitation is a vital service that assists individuals in community inclusion. Capitation of this service would restrict the opportunities for individuals to participate as active members of their communities and would have a negative impact upon the overall quality of individuals' lives. However, the Cabinet-level review of the SCL program will look at all expenditures, including those for community habilitation, to insure maximum benefit for limited dollars.
13. Medicaid should consider limiting the total per person cost for community-based services at a cap equivalent to the per person cost in an intermediate care facility. This practice could have saved the state over \$2.7 million in FY 2000 and provided services for an additional 56 consumers.
- This recommendation does not take into account the very differing and complex needs of individual program recipients. Further, it is not consistent with the recommendation that "Kentucky should ensure that comprehensive services are available to meet the needs of MR/DD persons." The Cabinet's upcoming internal review of the SCL waiver program will review current services provided and how services are funded.
14. Medicaid should provide fraud detection training to the community-based services administrators.
- Substantial measures are currently in place to prevent, and to recoup, improper payments. The SCL waiver requires that an individualized plan is developed and that each service be pre-authorized. Unless the service is pre-authorized and entered into Medicaid's computer system, the services cannot be paid. This process substantially reduces the possibilities for fraud and abuse.
- DMR is responsible for identifying any discrepancies during their certification surveys, billing reviews, or any monitoring activity of providers. On-site billing reviews are conducted at least annually on a minimum of 15% of the individual records for each provider. If discrepancies are found, the billing review can be expanded to cover all individuals receiving supports from the provider or to cover longer time periods. Staff members take computerized printouts of all services billed for particular individuals to the service site. The individual's record is reviewed against the billing document. Discrepancies are annotated with the following codes:
- a. No documentation of service provided found in record
 - b. No beginning and/or ending time for service

- c. Number of units of service provided rounded up
- d. Not appropriate to service definition
- e. No documentation of face-to-face contact between Support Coordinator and the individual served
- f. Two services billed at the same time
- g. Other

The annotated listing of the services is reviewed by DMR staff and then forwarded to DMS for review and processing. Any area of discrepancy that is questionable is referred by DMR to DMS for review and further action or referral. Discrepancies may also be referred to the Office of the Inspector General for special investigation or audit. Additionally, Medicaid has a contract with an outside provider to monitor Medicaid claims for fraud and abuse.

15. Health Services should update the Interagency Agreement between Medicaid and DMR and include specific duties and responsibilities related to fraud detection.

The agreement will be reviewed and revised to ensure that specific duties and responsibilities discussed above are included.

16. Health Services should diligently identify, review, and pursue potential recoupments. In addition, Medicaid should routinely review and attempt to collect accounts receivable and maintain more formal documentation related to billing reviews.

The Cabinet would appreciate specific recommendations regarding changes needed to current practices. At the present time, the Department for Mental Health and Mental Retardation Services conduct routine annual reviews of SCL providers to identify potential overpayments. Areas identified by the review as having insufficient documentation to support payment are sent to the Division of Medicaid Services for Mental Health/Mental Retardation for review. If DMS validates the findings, a "Demand Letter" is sent to the provider asking for a refund of the overpayment amount and stating that recoupment of payments to the provider will begin in 60 days if payment is not received. The letter also spells out provider appeal rights and other recoupment process issues as set forth in 907 KAR 1:671.

Medicaid does routinely review and attempt to collect receivables over 60 days old. System recoupment begins when a receivable reaches 60 days old without payment from the provider. A provider with an outstanding balance will be sent no payments until the entire amount owed has been collected. Effective January 2002, once a receivable reaches 240 days old an additional letter is sent to the provider stating that the account is past due and requesting immediate payment. The letter states that if full payment is not received within ten days, the matter will be turned over to the Cabinet's Office of General Counsel for appropriate legal action. Additional protocols for all aged and newly established accounts receivables were developed by the Division of Program Integrity and implemented beginning January 4, 2002. The backlog of aged accounts receivable and current receivables are now being processed in accordance with these protocols.

17. Health Services should eliminate any duplication of services

It appears that an assumption has been made that a duplication of services automatically exists if an individual receives support from both the Supports for Community Living Program and the Supported Living Program. The two

by the federally matched community-based services program and the state funded Supported Living Program.

programs are separate and distinct in that they serve differing populations and provide for differing supports and services. DMR has taken steps to ensure that controls are in place to detect duplication of services. DMR will cross-reference the names of the individuals who are determined eligible for the SCL program with the names of individuals served by the Supported Living Program. Individuals will be informed of the need to terminate their participation in the Supported Living Program for any services covered by the Waiver. The cross-referencing of names will be repeated on an annual basis.

Chapter One

Medicaid Services

Most prevalence studies utilizing IQ to define mental retardation use a range between .3% and 3% of total population. Using this prevalence figure there may be approximately 120,000 people with mental retardation/developmental disabilities residing in Kentucky. Not all of these are eligible for the waiver, nor choose the waiver over another support program. In addition to the individuals served through Medicaid, approximately 6,000 individuals receive MR/DD services through state general funds.

Institutional and Community-Based Services Compared

To clarify, people are not screened for eligibility or evaluated for level of care until funding or a placement becomes available. Once a person is notified of a vacancy or funding, he/she is assisted with the process of determining eligibility and level of care needed.

The Olmstead decision indicates that the individual has the right to move into a community-based program should he desire to do so and if the treatment team determines that community-based treatment is appropriate for the individual.

The Cabinet is working diligently to address the needs of people with mental retardation, not only through the SCL program, but also through the state funded services provided by the community mental health/mental retardation centers and their affiliates and through the intermediate care facilities (ICFs-MR).

In April 2001, the HB 144 Commission on Services and Supports for Individuals with Mental Retardation and Developmental Disabilities set forth a 10-year plan for building the appropriate capacity within the Commonwealth. Five hundred additional individuals were notified of funding in the SCL program in the FY01-02 biennium. Also, funds are included in the Governor's budget for the FY03-04 biennium that will result in another 500 individuals being served.

Certification of SCL providers

The Department for Mental Health/Mental Retardation certifies SCL waiver providers in accordance with the waiver provider qualifications as approved by the Center for Medicaid/Medicare Services. The certification requirements and review methodology were adopted from the licensing procedures of the Office of the Inspector General and an independent review organization, the Accreditation Council. The certification process will be reviewed by the Cabinet as a part of a more thorough review of the SCL waiver program.

Commitment to Community Services

Other residential supports provided under the waiver include in-home supports, adult foster care, respite, and periodic supports to people choosing to live in their own homes or the home of a relative or family member. Other support and

services provided under the waiver include: behavior supports, community habilitation, occupational therapy, physical therapy, pre-vocational services, psychological services, speech therapy, support coordination, supported employment, and specialized medical equipment and supplies.

SCL Related Costs

Table 1 of the audit document provides the total cost for the Categories of Service “Supports for Community Living (SCL)” and “ICF/MR” on a date of payment basis. Table 2 is a breakdown of the procedure codes included in the Category of Service “Supports for Community Living”. Neither of these tables provides the total cost of services to a recipient enrolled in the SCL waiver or the cost to the Medicaid Program for each waiver participant. Once an individual not previously eligible for the Medicaid Program gains eligibility through the waiver, he has access to all non-waiver services as well.

In developing the projected cost for a waiver participant, the average annual cost is used along with assumptions of the actual time period each placement will be used. (Example: some placements may begin 7/1 while others may not start until later in the year.) Once an individual is approved for the waiver there will be a time lag between waiver approval, services delivery, billing and actual payment. The time lag between waiver approval and service delivery is the period when the individual’s needs are identified and providers selected.

Community Services

The figures cited in the audit report were based on 1998 data and reflect the percentage comparison of all MR/DD funding between community and facilities. This report also indicates that 47% of resources were allocated for community services. Data for Fiscal Year 2000 shows an increased effort for funding community services where 53% of total MR/DD funding went to the community. Neither of these reflect the additional funding for 2001-2002.

Chapter Two

Communication and Interaction Between Health Services and Families and Children

DMR and DCBS have initiated monthly meetings for improved communication and have begun providing joint education and orientation to staff regarding each Cabinet's role and responsibility. In addition, DMR and DCBS began providing joint abuse/neglect training for all staff and providers in 2001. The Cabinet will continue to work with DCBS to develop an interagency agreement for timely flow of information needed for completion of investigations.

Incident Investigations

Not all investigations conducted by DMR involve alleged abuse or neglect. The determination as to whether an investigation is required is based upon the nature of the incident. Incidents are classified as Class I, II, or III. All Class III incidents must be reported to DCBS. Class III incidents are grave in nature and require an investigation initiated by the provider agency. These incidents may include death, suspected abuse, neglect or exploitation, life threatening illness or injury, and other unusual events. For all investigations, DMR issues the findings to providers within 30 days of completion of the investigation. The Cabinet will pursue further consultation with Families and Children to improve the investigative and reporting process.

Incident Reporting	<p>The purpose and philosophy of the changes in Incident Reporting and Management was to ensure the health, safety and welfare of individuals supported by community agencies through prevention, identification, classification, proper reporting, investigation, and implementation of effective actions in response to incidents.</p> <p>Investigations are assigned and conducted based upon specific criteria that determine severity. Typically, staff members are on-site within the day if appropriate provider action cannot be verified from the incident report or phone notification. Incidents are classified as Class I, II or III and have specific timelines for reporting to an individual's legal representative, DMR, DCBS, the Support Coordination agency and others. The new incident reporting requirements allow the provider time to conduct their own internal investigation and take appropriate action. The provider action, upon review, may be sufficient to not require a DMR on-site review. Provider action will be reviewed as part of their certification and Plan of Correction, and that incident along with any others will determine the length of certification and state oversight of the provider. Area Administrators are required to conduct a follow-up site visit to monitor the Plan of Correction implementation.</p> <p>Incident reporting is included as an agenda topic in each of the quarterly provider workshops and specific focused training is provided by the Area Administrators and DMR Quality Initiative staff as needed.</p>
Conducting Investigations	<p>Investigations are assigned and conducted based upon specific criteria that determine severity. The Cabinet will consider implementing additional standards regarding timing, nature and extent of investigations.</p>
Tracking System	<p>The Cabinet has implemented a tracking log to ensure reports are returned to providers within 30 days of the completion of the survey/investigation. A weekly report is developed and monitored for compliance.</p>
Information in and Tracking of Investigation Files	<p>As of March 2000, DMR began assigning tracking numbers to all investigations. The database includes dates and actions of all phases of the investigation and is designed to ensure completion of the investigation, including all needed correspondence and monitoring of the Plan of Correction. In addition, in January 2002, the database was enhanced to include additional elements to facilitate trend analysis.</p>

Compliance Reviews

Since it is CMS' responsibility to review the state's waiver programs, the Cabinet defers to and concurs with the CMS compliance review findings. CMS stated in a letter (a copy of which is attached hereto) to the Commissioner of Medicaid Services dated January 31, 2001, "During recent compliance reviews of Kentucky's waiver programs, our staff found Medicaid's procedures for monitoring and oversight to be exceptional. During the review of the MR/DD waiver it was noted that the behavioral support plans were a particular strength of the program. We believe it would be beneficial for our other States to learn of some of the practices utilized within your waivers." This letter also requested that Kentucky present our practices at a CMS Regional training session in Atlanta in March 2001.

Deficiencies Found in SCL Certification Reviews

Our records indicate that 12 providers had 361 deficiencies over a three-year period. The certification tool utilized by survey staff is a comprehensive instrument that has the capacity to identify 430 potential citations for each review. Deficiencies range from minor to serious in nature. This represents a deficiency rate of 2.3% for these 12 providers over the length of the review period. Through provider training and technical assistance, we continually strive to reduce the deficiency rate to an even lower percentage. All deficiencies cited required a Plan of Correction from the provider that was monitored for compliance. We agree that objective measurement tools and consistent application of certification review procedures are important.

Certification length is based on findings from the certification survey, investigations and implementation of past Plans of Correction throughout the review period. Areas related to health, safety and welfare are considered critical areas in determining length of certification for the provider. Repeat deficiencies are identified in the findings report and length of certification may be shortened. The Area Administrator for each provider works with the provider agency and provides any needed technical assistance in correcting issues and development of preventive measures. In addition, the Quality Initiative Specialist has provided statewide training related to incident reporting and investigations and specific training for agencies based on the survey or investigation findings.

In addition to the certification surveys, DMR staff conduct drop-in visits to each agency at least quarterly to monitor and provide technical assistance; conduct follow-up monitoring to monitor implementation of the submitted/approved plans of correction; and conduct investigations as assigned by the Quality Initiative Specialist.

DMR established a Training and Prevention Specialist position in August 2001 to focus on review and analysis of statewide trends from certification surveys and investigations and will be developing needed training and other prevention efforts for ensuring the health, safety and welfare of the individuals and high quality service provision.

Methodologies used in Provider Certifications

Certifications are not strictly compliance-based. A focus on individual goals and attainment of those goals is addressed through the following:

1. **Prior Authorization.** All SCL services are pre-authorized; this process includes the review of assessments, including personal goals of the individual; the plan for meeting those goals; and the training objectives to be implemented, all of which should support the services being requested.
2. **Utilization Review.** DMR conducts utilization review via sampling to determine whether the plan is individualized and adequately meets the needs and desires of the individual.
3. **Certification review.** During certification reviews, the implementation of the service plan is monitored. In addition, interviews with individuals are conducted to determine if services provided are meeting their needs.
4. **Core Indicators Project.** This nationally standardized survey tool is utilized to determine key indicators of quality of life.

The Cabinet agrees that the SCL waiver program will continue to strive for inclusion of additional quality measures in the certification process and will review current procedures as a part of the upcoming SCL waiver review.

Technical Assistance to Providers

DMR staff received training in September 2001 regarding providing more effective exit conferences and the need to provide technical assistance to providers during the survey. Since that time, this issue continues to be reinforced with DMR staff during monthly staff meetings. DMR staff now provides technical assistance to providers in areas where deficiencies are being found so they may begin addressing them during the survey. Exit conferences are provided prior to DMR staff leaving the agency following a certification survey. At the exit conference, an oral report of all deficiencies is provided and recommendations are made to aid the provider in making improvements or addressing the deficiencies. The area administrators answer any questions raised. Additionally, provider workshops are held quarterly and are designed to provide consistent training and response to provider concerns.

The certification tool is available on the Web and technical assistance is provided by Area Administrators to their respective providers through quarterly on-site visits and as needed. Provider letters are mailed out to all SCL providers for clarification as needed based on provider inquiries or regulation changes.

Regulatory or Internal Time Requirements for Health Services' Certification Reviews

The Cabinet has developed a tracking log to insure that a response is returned within 30 days of completion of the survey, investigation or receipt of Plan of Correction. A weekly report is developed and monitored for compliance.

One Corporation Provides Services to One-Third of Kentucky's SCL Waiver Consumers

All SCL providers receive the same level of oversight and monitoring as other providers. Incidents involving quality of care are thoroughly investigated by DMR. If deficiencies are noted, appropriate action is taken.

Deficient Provider
Screening/Hiring Practices

The Cabinet has a responsibility to determine the required qualifications that are in place in the waiver as approved by CMS. The monitoring and certification review process will review provider compliance with meeting these qualifications

Chapter 3

Kentucky's Waiting List and the
Provision of Services by the
SCL Waiver Program

All individuals projected to need services may not need to be served by the SCL waiver program. The plan as proposed by the Commission offered alternative programs to individuals based upon the anticipated needs of the individual, believing that the SCL Program constituted a higher intensity of services than many individuals would need. Therefore, the use by the auditors of the current per-person cost in the SCL Program constitutes a flawed comparison.

Comparison of Kentucky's Per
Person Cost of SCL Waiver
Services Compared to Other
Selected States.

The comparison provided by the auditor does not take into consideration the substantial differences in the design of waiver programs in the listed states and the funding mechanisms for various services provided. The mix of services provided through waiver programs differs significantly from state to state making a true cost comparison extremely difficult. Additionally, states are in various stages of court-mandated compliance, which may impact the level of services offered and the associated costs. However, the Cabinet is committed to reducing the waiting list as soon as possible and intends to review all services offered through the SCL waiver program.

Auditors - Billing Community
Habilitation on a Daily Rate
Could Have Saved Over \$4.8
Million in FY2000

The Cabinet has seen no documentation to support this assumption. We believe this assumption resulted from a comparison with the state of Florida. Florida's community habilitation rates vary by district within the state and cannot easily be generalized. Additionally, Florida is currently involved in a lawsuit disputing the use of capitation procedures for community-based services. Community habilitation is a vital service that assists individuals in community inclusion. Capitation of this service would restrict the opportunities for individuals to participate as active members of their communities, and would have a negative impact upon the overall quality of individuals' lives. However, the Cabinet-level review of the SCL program will look at all expenditures, including those for Community habilitation, to insure maximum benefit for limited dollars.

Auditors - Limiting Per Person
Community-Based Costs to the
ICF/MR Average Could Have
Saved the Commonwealth \$2.7
Million in FY 2000 and
Provided Services for 56 More
Persons

This broad assumption does not take into account the very differing and complex needs of individual program recipients. Further, it is not consistent with the recommendation that "Kentucky should ensure that comprehensive services are available to meet the needs of MR/DD persons." The Cabinet's upcoming internal review of the SCL waiver program will review current services provided and how those are funded

Cost Control Requirements and
Fraud Detection

Kentucky currently has a number of cost control measures. With specific reference to the Supports for Community Living Waiver program, measures are in place to prevent and recoup improper payments. The SCL waiver requires that an individualized plan be developed and that each service be pre-authorized. The service cannot be paid unless it is pre-authorized and entered into Medicaid's computer system.

In addition, on-site billing reviews are conducted annually for each provider. Staff members take computerized printouts of all services billed for particular individuals to the service site. The individual's record is reviewed against the billing document. Discrepancies are annotated with the following codes:

- a. No documentation found of service provided in record
- b. No beginning and/or ending time for service
- c. Number of units of service provided rounded up
- d. Not appropriate to service definition
- e. No documentation of face-to-face contact between the support coordinator and the individual served
- f. Two services billed at the same time
- g. Other.

The annotated listing of the services is reviewed by DMR staff and is then forwarded to DMS for review and processing.

Interagency Agreement Between Medicaid and DMR

The agreement will be reviewed and revised to ensure that specific duties and responsibilities discussed above are included.

Auditors - An Effective Fraud Detection Function Could Have Recouped as much as \$22 Million

It is inappropriate and reckless to assume:

1. That the speculated "overpayments" will actually lead to recoupment; or
2. That the speculative and arbitrary percentages and dollar amounts reflected in Table 13 would readily extrapolate to additional persons, if any, that would be served by the SCL program.

Further, the table fails to consider two seminal principles in Kentucky's SCL program: individual needs and quality of life. DMR conducts on-site billing reviews at least annually to detect any irregularities.

Collection of Accounts Receivable

New protocols have been implemented to address accounts receivable that cannot be collected through the normal payment recoupment process. The account addressed in this finding and all outstanding accounts will be reviewed in accordance with this new process.

Chapter Four

Payments for Community Habilitation

The intent/goal of Kentucky's waiver program is to take the lead to build the capacity of communities and systems to provide individually-determined supports for individuals with mental retardation and other developmental disabilities and increase their opportunities for choice and inclusion as valued citizens. Best practice principles to achieve this include: ensure dignity and respect for each individual; recognize and incorporate cultural diversity; be based on individually determined goals, choice and priorities; recognize that community is our most valued resource; and be evaluated based on individually determined outcomes.

The variety and types of services for community habilitation are as varied as there are people in the program. Learning to be as independent as possible and learning the skills that will enable the individual to be a part of the community demand activities that are meaningful to the person and include activities that take place in

the community. Self-advocates are requiring more variation in services and have stepped forward to demand the opportunity for funds to be directed according to their needs. This requires a change in services to be provided on a personal need basis. The community habilitation services were a major component of building access to services by the Commission on Mental Retardation and Developmental Disabilities (HB 144, 2000). The Commission, professionals and advocates value this program and will expect to see it expanded to include an even wider array of services.

DMR monitors, evaluates and ensures accountability for outcomes for individuals through the pre-authorization process, utilization review, certification reviews, investigations and drop-in monitoring visits.

The individual may choose activities listed above as well as self-care, daily living skills, communication, social skills and vocational training in support of his/her outcomes. The area administrators of the waiver monitor these activities during the ISP pre-authorization process, during utilization review, and again during certification reviews to insure that the activities provided result in the chosen outcomes of the individual.

Review of Community Habilitation Activities

The Cabinet reviews the intent of community habilitation activities at the time of pre-authorization, and throughout the year during any of the certification reviews. The review ensures activities of community habilitation meet the intent of community participation as identified by the person and developed and provided by a chosen provider. It is important to the Cabinet to ensure the activities are meaningful. However, the current practices will be reviewed as a part of the cabinet's SCL waiver review.

Billing for Community Habilitation

The goal of the SCL program is to be individualized and assist individuals to remain in the least restrictive environment possible. Activities are monitored through ISP prior authorization, utilization review, certification reviews, billing reviews, investigations and technical assistance visits to ensure they are chosen by the individuals and assist them in reaching their personal goals and outcomes. Activities are all aimed at assisting the individuals to attain skills needed to remain in the community.

Monitoring of Community Habilitation Activities

During the audit review period, DMR implemented additional processes to ensure that the desired outcomes and goals are achieved. During the certification review process, a sample of ISP's are reviewed and monitored for compliance and implementation of the objectives developed by the individual and his support team. The certification process monitors for compliance by reviewing assessments in which individuals or guardians indicate desired outcomes and reviewing notes and summaries documenting progress toward meeting the chosen outcomes.

The Quality Assurance focus during the certification survey includes individual choice, satisfaction, quality, health and safety, access, and personal outcomes. The SCL waiver requires pre-authorization of services annually or at the time of change in status of the individual. Utilization reviews are conducted on approximately 45% of total ISP's monthly as part of the pre-authorization process. This review process includes review of individual assessments relevant

to the service, personal desire/outcomes, training objectives to meet those outcomes, and staff notes of service provision to verify implementation and documentation of progress toward personal outcomes for the individual. The utilization review is focused on whether the plan is individualized and adequately meets the needs and choices of the individual.

DMR began participating in the multi-state Core Indicators Project in 1999 for surveying quality and satisfaction of individuals receiving services in all MR/DD settings.

Workshop Activities and Community Habilitation

On December 21st, 2001, a conference call was held with Kentucky auditors, staff of DMR, and staff of the CMS Atlanta Regional office and the CMS Baltimore office. During this conference call, discussion was held regarding activities being billed as community habilitation that the auditors considered workshop activities. It was explained by DMR and CMS that individuals in the waiver program have the freedom to choose activities to meet their personal goals and that these activities may vary from individual to individual. Additionally, community habilitation can be conducted in a workshop setting as long as it is not a defined workshop activity.

DMS and CMS further clarified that workshops are allowed to be waiver providers. However, the activities are not to be workshop activities. A workshop activity is developing a specific skill for a job placement within a year, and the worker is compensated at 50% of minimum wage or above. A community habilitation activity is not working toward a specific job, but engaging in activities that are intended to develop skills to meet an individual's expressed future goal. In addition, the activity or job is one not found in the general public or competitive work environment.

CMS stated they have reviewed the community habilitation waiver of Kentucky and found it to be in compliance. They reiterated several times to the auditors that the Kentucky program was no different from other states offering similar services. CMS did indicate that in the future they would be reviewing community habilitation programs in all states and providing feedback.

Pre-Vocational Services and Supported Employment

For both of these services, these are funding sources available in addition to the Medicaid Supports for Community Living Waiver.

Pre-vocational services are also defined as a service not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or Section 602(16) and (17) of the Individuals with Disabilities Education Act, 20 USC 1401 (16 and 17).

Supported Employment services are also defined as a service that is paid when not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 99-457.

Since Medicaid is the payor of last resort, many individuals in the SCL program receive pre-vocational and supported employment services through a different payor source, and are therefore not reflected in the numbers quoted above.

Questions over Provider Rate Adjustment

In 1996, the Cabinet initiated a lawsuit against a large SCL provider that ran eight operations across the state involving over 100 individuals. At that time, ResCare had not elected to be a participating provider in the Kentucky SCL program because of the state's rate structure.

As a result of the settlement agreement, ResCare agreed to step in and provide services to those facilities with the assurance that a new rate structure would be forthcoming. In 2000, the Department for Medicaid Services became aware that there was a dispute over the interim rate for the ResCare facilities. The Department and ResCare each questioned whether the correct rate was paid and what agreement was made relative to the rate.

There was never an adjudication of a liquidated amount that the Department either overpaid or underpaid. In order to avoid the uncertainty of litigation, a settlement was reached between the Department and ResCare whereby the Department waived its claim for an overpayment and ResCare waved its claim for an underpayment. The agreement included a \$500,000 payment from ResCare; a commitment to continue to do business through the Community Alternative's of Kentucky rather than consolidating operations which could have cost the state an additional \$1.5 million per year; and acceptance by ResCare of a new adjusted rate going forward.



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VIOLA B. MILLER, ED.D.
SECRETARY

May 15, 2002

Mr. Edward B. Hatchett, Jr.
Auditor of Public Accounts
Capitol Annex Suite 144
Frankfort, KY 40601

Re: Audit Report on Supports for Community Living Waiver Program

Dear Mr. Hatchett:

I am advised that you intend to finally release your office's performance audit of the Supports for Community Living Waiver ("SCL") Program, a program funded by the Cabinet for Health Services' Department for Medicaid Services and administered by the Department for Mental Health and Mental Retardation Services. I am further advised that you undertook this performance audit at least two to three years ago. I am disappointed that, despite the amount of time you have spent on it, your office has consistently failed to appreciate the uniqueness of the SCL program and the role that the Cabinet for Families and Children plays in investigating allegations of adult abuse, neglect or exploitation. I offer this final response to your report in the hope that you will describe our role more accurately and objectively.

My comments address the "Confidential Draft" of the section of the SCL performance audit entitled "Families and Children Does Not Refer All Incidents of Alleged Abuse Neglect, or Exploitation to Law Enforcement as Required by Law and Policy." You shared this draft section with the Cabinet, and our staff responded on May 13, 2002.

Succinctly stated, in this section of your audit you have: (1) ignored the statutory authority of this office to "adopt such rules, regulations, procedures, guidelines, or any other expressions of policy necessary to effect the purpose of this chapter" [KRS 209.030 (1)]; (2) imposed an impossibly strict and unduly burdensome reading of KRS 209.090 (4)(a); (3) misinterpreted the Cabinet's Standards of Practice ("SOP"); and (4) focused on form over substance without suggesting ways to improve the quality of life for SCL participants.

I shall detail these objections in turn.



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KRS 209.030 (1) gives me, as the Cabinet Secretary, authority to adopt necessary rules and regulations to effectuate the purpose of KRS Chapter 209 which, among other things, is to protect vulnerable adults from abuse, neglect, or exploitation. To ensure an appropriate response from the principal parties involved in adult protective services, law enforcement and social workers, it is necessary to screen referrals to ensure they meet criteria for investigation. Those criteria are set out in SOP 108 and KRS 209.030 and KRS209.060. KRS 209.020(7) defines an abused "adult" as a person who is injured or subjected to the infliction of physical pain or mental injury. KRS 209.020(15) defines a neglected adult as a person who is not able to perform or obtain for himself those services necessary to maintain his health or welfare or where one spouse deprives the other of such services. Exploitation is the improper use of an adult's resources for one's own gain. Thus, in order to effectuate the statutory definitions of adult [KRS 209.030(2)] abuse [KRS 209.020(7)], neglect [KRS 209.020(15)], and exploitation [KRS 209.020(8)], SOP 106 and 108 were necessarily promulgated.

To be accurate, your report must address the difference between the terms "incident" and "referral". An "incident", as defined in the SCL program, crosses a continuum of occurrences that range from serious to minor and even includes property damage, an issue far outside this Cabinet's jurisdiction. A "referral", for DCBS reporting requirements, is an incident that is or is suspected to have been caused by abuse, neglect or exploitation. Your performance audit report fails to appreciate the uniqueness of the two separate reporting requirements, as well as their scope.

The Cabinet screens each referral to determine whether it meets criteria for DCBS action. This is not an "internal investigation" as you call it. DCBS refers to law enforcement those referrals of adult abuse, neglect or exploitation that are consistent with the legal definition of those terms, meet criteria as defined in SOP, and contain some indication of criminal conduct. To do otherwise is not consistent with the law and is unnecessarily and unduly burdensome on law enforcement and DCBS.

My point is illustrated in the more than 200 incidents that your office gave to CFC for review. Only 40 were "reported" to DCBS because only those 40 incidents, required to be reported under SCL requirements, actually met DCBS reporting requirements. All 40 of those cases were investigated. Twelve of those 40 cases were substantiated; one case finding was "some indication"; and the remaining 27 cases were unsubstantiated. The other 160-plus "incidents" did not meet DCBS investigative criteria.

These data are approximately equivalent to the universe of referrals received and which are substantiated. Your report claims there is a gross problem of under-reporting without examining whether a referral to DCBS or law enforcement was appropriate and statutorily required. The Cabinet is committed to working more closely with law enforcement which, in limited situations, is a partner in the investigation of adult abuse, neglect or exploitation. In addition, the Cabinet has been working with law enforcement to review the criminal penalties for adult abuse, neglect and exploitation to ensure the penalty is commensurate with the crime. The Cabinet has also been cooperating fully

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with the Office of the Attorney General, Medicaid Fraud and Abuse Division to ensure that the division has all relevant information and assistance necessary for its investigations. However, staffing and other limitations have restricted the role that Division can play in prosecuting "abuse" as defined by that program's mandate.

The point of referrals to law enforcement is not to bury police and prosecutors in paperwork but rather to bring to their attention matters within their jurisdiction--i.e., those that meet the standards of probable cause to believe a crime has been committed. When there is such a case, the Cabinet's employees not only send a DSS-115, they also call and meet with law enforcement to ensure that there is a response, when appropriate, by the criminal justice system.

One recent example illustrates this point. Recently the Cabinet received referrals of abuse, neglect and exploitation of adults in an SCL provider's program in Manchester, KY. The local DCBS staff worked closely with local law enforcement, the Division of Mental Retardation, and the Kentucky State Police to terminate the provider from the Medicaid Program and place the residents in appropriate programs. This situation is by no means unique. When a provider from Sonora, KY was terminated from the SCL program, this Cabinet, CHS, the Kentucky State Police and local law enforcement worked together to ensure the safety of the individuals served by that provider.

Your performance audit report is also unnecessarily fixated on the Cabinet's identification or lack thereof of a "perpetrator". That is the focus of law enforcement, not social services. Where appropriate, DCBS does identify a perpetrator of abuse, neglect or exploitation. However, the focus of the investigation is not on the perpetrator but rather on the victim. Thus, your sentence that "(i)t does not identify a perpetrator nor ascertain whether a specific person intended to commit the act..." is misleading and even false, in many circumstances.

Furthermore, your office persists in ignoring the statutory definition of a health care facility. KRS 216B.015(12) defines a "health facility," and SCL placements do not meet the definition. Because of the uniqueness of the SCL setting, SOP 160 was promulgated to define the parameters of an investigation of abuse, neglect, or exploitation in that specific setting. It focuses the investigation on the question of caretaker neglect, though social workers are also alert to the possibility of abuse and/or exploitation.

This focus is appropriate, given that the SCL program strives to strike a balance between the need a person with a cognitive disability has for assistance with necessary services and the individual's right to live as independently as possible. Your performance audit report fails to respect that right by focusing on licensure requirements, which are not applicable to the home-like setting for which SCL providers strive. Thus, your references to "Medicaid facilities" and the 1999 MOU between the Cabinet and the Attorney General are not applicable.

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Finally, may I suggest some steps that will enhance the quality of life for individuals with mental retardation who are served in SCL settings.

1. Cabinet for Families and Children (CFC) should continue to strictly scrutinize all referrals to determine if they meet criteria for investigation.
2. If a referral meets investigation criteria, CFC should continue to coordinate efforts and freely communicate with DMR and DMS, which have been nationally recognized for their monitoring of the SCL program.
3. DMR should ensure that all incident reports that meet CFC reporting requirements are in fact reported to CFC, as well as to appropriate law enforcement agencies.
4. CFC should, where appropriate, continue to work closely with law enforcement, including the Office of the Attorney General while the investigation is being conducted. It should not wait, as your report recommends, until CFC's investigation is final, to work with law enforcement. Waiting can only result in unnecessary delay in protecting vulnerable adults and the loss of critical evidence.

We are already striving, in these and other respects, to improve our investigations of allegations of adult abuse, neglect and exploitation, including those we conduct on behalf of Supports for Community Living residents. We can, of course, always do better. However, your performance audit report contains no data that undermine my confidence that the Cabinet for Families and Children and the Cabinet for Health Services together are providing valuable, respectful and empowering services to Kentucky's vulnerable adults.

Thank you for your consideration of my comments.

Sincerely,



Viola P. Miller
Secretary

Cc: Secretary Luallen
Governor Paul E. Patton
Secretary Marcia Morgan
Representative Jimmie Lee
Representative Tom Burch

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General Questions

General questions should be directed to Harold McKinney, Intergovernmental Liaison, at (502) 564-5841 or the address above.

