Description of how the state's oversight systems (licensure and certification standards, provider manuals, person-centered plan monitoring by case managers, etc.) have been modified to embed the regulatory criteria into ongoing operations:

All HCBS providers require certification to provide waiver services even if they are a licensed provider type. Certification and Recertification tools were modified to evaluate provider compliance with the HCBS final rules. The Medicaid Waiver Management Application (MWMA) has rules in place to prevent conflicted services. Case Managers are required to enter person centered planning information including goals and objectives for each service into the MWMA system. This facilitates review by the DMS or our designee to validate person centered rules are being followed. These reviews occur during the initial plan approval, at the time of any plan modification and during quality reviews. Technical assistance is provided and if necessary, providers are required to submit a corrective action plan when noncompliance or other concerns are identified.

Provider letters and guidance have been issued until the regulatory updates and provider manual changes can be finalized. DMS has provided virtual provider trainings and forums during the pandemic. In 2023 both virtual and in person sessions will be conducted.

Case Managers attended workgroups focused on plan of care development and monitoring, person centered choices and conflict free principles. Case Managers are required to lead a person-centered team meeting for development of the initial plan and at any time the plan requires a modification or change. The participant or their authorized representative/guardian determine who they would like to participate in these meetings but at a minimum the case manager, the service providers and the participant or their designee are required. A sign in sheet is required to be uploaded into the MWMA to document participation by all attendees.

A comprehensive waiver-redesign project, including needed Kentucky Administrative Regulation (KAR) updates and provider manual updates, was temporarily paused in February 2020 after a change in state administration. The federal public health emergency subsequently led to an extended pause on redesign activities while the state dealt with the impact of COVID-19 on 1915(c) HCBS waiver programs and focused on temporary waiver updates to support providers and participants. Additionally, during that timeframe, Kentucky has experienced two separate natural disasters which required resources to be focused on the impact to participant health, safety, welfare, and support of our providers to maintain operations.

Description of how the state assesses providers for initial compliance and conducts ongoing monitoring for continued compliance:

Newly enrolled providers require an initial certification review and approval prior to being assigned a KY Medicaid provider number and serving participants. This review consists of an audit and approval of policies and procedures, employee records and requirements if applicable, manuals, and organizational charts. In addition to this review, providers who serve participants onsite i.e. residential, adult day healthcare receive an onsite inspection to ensure compliance with all state and federal regulations and code.

All enrolled providers receive recertification reviews that include the initial review requirements stated above. Additionally, service documentation, medication administration records, employee training records, participant records, incident report reviews and satisfaction surveys are administered to participants.

Description of a beneficiary's recourse to notify the state of provider non-compliance (grievance process, notification of case manager, etc.) and how the state will address beneficiary feedback.

All providers are required to inform participants and their natural supports the process for filing a grievance. This includes how to notify the case manager, staff within the service agency and the State.
The State maintains a helpdesk answered during business hours as well as a ticketing system to document complaints, grievances, and concerns. All investigations, actions taken, and resolutions are logged into the ticketing system. Depending on severity of the grievance, a critical incident report may be required. The provider is required to complete the incident report in the MWMA where at a minimum case manager review and signoff is required. The participants are also provided contact information for the Ombudsman's office and the Office of the Inspector General. HCBS state waiver staff investigate all grievances and complaints.