



U.S. Department of Health and Human Services

**Centers for Medicare & Medicaid Services
Region III**

FINAL REPORT

**Home and Community-Based Services Waiver Review
Pennsylvania's Adult Autism Waiver
CMS Control #0593.R0.02
June 25, 2015**



Executive Summary

The Commonwealth of Pennsylvania's Adult Autism Waiver for persons with Autism Spectrum Disorders (ASD) (#0593 Adult Autism Waiver) was approved under Section 1915(c) of the Social Security Act (the Act) as a statutory alternative to Medicaid-funded institutional care. The Centers for Medicare & Medicaid Services (CMS) initially approved the waiver with an effective date of July 1, 2008. The current waiver period under review is from July 1, 2011 through June 30, 2014. The state was granted a waiver of Section 1902(a)(10)(B) of the Act in order to provide home and community based services (HCBS) to individuals with intellectual and developmental disabilities who meet requirements for level of care (LOC) for an Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID), or Intermediate Care Facility for Persons with Other Related Conditions (ICF/ORC). The currently approved unduplicated number of recipients under the #0593 Adult Autism Waiver in waiver years 3, 4, and 5 is 439 with an estimated average annual cost of \$31,095.44 per beneficiary in waiver year 3, \$34,663.09 per beneficiary in waiver year 4, and \$35,255.79 in waiver year 5.

The CMS conducted a desk review of the evidence package submitted by the state on October 8, 2014, for the currently approved #0593 Adult Autism Waiver. Jennifer Lutz (Stucky), Health Insurance Specialist, conducted the review in accordance with the Interim Procedural Guidance (IPG) protocol, as revised by the interim guidance procedures of 2007. One of the main purposes of the IPG is to standardize the approach the CMS utilizes when assessing waiver programs as it transitions its quality oversight approach to one that incorporates both the assurance of statutory requirements and promotion of quality improvement. The CMS review focused on statutory requirements under Section 1915(c)(2)(A) of the Act requiring states to assure that:

- Necessary safeguards have been taken to protect clients' health and welfare;
- Waiver enrollees meet the appropriate level of care;
- Consumer freedom of choice is assured in selecting available alternatives;
- Cost neutrality is maintained relative to the cost of institutional care; and,
- Necessary safeguards have been taken to assure financial accountability.

The Department of Human Services is the single State Medicaid Agency responsible for administering HCBS in Pennsylvania. The DHS has an interagency agreement with the Office of Developmental Programs (ODP), Bureau of Autism Services (BAS). This interagency agreement establishes BAS to be the operating agency that develops policies and procedures for waiver operations and determines functional eligibility. The DHS Office of Income Maintenance (OIM) retains authority to determine financial eligibility.

The final report findings specific to each assurance are listed below.

I. State Conducts Level of Care Determinations Consistent with the Need for Institutionalization

Assurance:

- The state demonstrates that it implements the processes and instruments(s) specified in the approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with care provided in a hospital, nursing facility (NF), or ICD/ID-DD.

Finding:

- The state substantially meets the assurance.

Recommendations:

- The CMS has no recommendation for the state regarding this assurance.

II. Service Plans are Responsive to Waiver Participant Needs

Assurance:

- The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

Finding:

- The state meets the assurance with two (2) recommendations and one (1) requirement.

Recommendations:

- The state has chosen to frame some performance measures (PM)s as a negative outcome which can be misleading and confusing. The CMS recommends the state amend the PMs to accentuate that the data reflects the required level of compliance to promote consistency and clarity.
- For all future monitoring cycles for PM D/SP7a and D/SP7b, the CMS recommends 100% review sample based on the electronic file management QIP noted in the report.
- The BAS evidence shows five (5) quality improvement projects (QIP)s have been developed and are being analyzed for effectiveness. The BAS is required to provide an updated report for all five (5) QIPs identified in this report at least quarterly (no later than September 30, 2015, December 31, 2015 and at the time of submission of the renewal). Each QIP must include the details of the QIP, if the QIP is effective, interventions that have been explored, status to date, specifics on timelines, communication strategies, support and training improvements, and overall monitoring changes. The QIP must include the data for the PM including remediation completed. If the QIP is determined by the state to be ineffective, a new QIP will need to be developed.

III. Qualified Providers Serve Waiver Participants

Assurance:

- The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

Finding:

- The state substantially meets the assurance.

Recommendations:

- The CMS has no recommendation for the state regarding this assurance.

IV. Health and Welfare of Waiver Participants

Assurance:

- On an ongoing basis the state identifies, addresses, and seeks to prevent instances of abuse, neglect, and exploitation.

Finding:

- The state meets the assurance with recommendations.

Recommendations:

- The state has chosen to frame some PMs as a negative outcome which can be misleading and confusing. The CMS recommends the state amend the PMs to accentuate that the data reflects the required level of compliance to promote consistency and clarity
- The CMS recommends the state continue to develop monitoring systems that track those beneficiaries that are at high risk and have repeated problems and improvements implemented by the state (i.e. critical incidents and/or psychiatric hospitalizations).

V. State Medicaid Agency Retains Administrative Authority over the Waiver Program

Assurance:

- The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

Finding:

- The state meets the assurance with required recommendations.

Recommendations:

- The BAS did not meet the financial assurance for this evidentiary-based review (EBR) and the CMS is concerned regarding the states administrative authority oversight in this area. The BAS is required to provide a quarterly report on the state's administrative oversight for the activities regarding the financial assurance and the work plan progress that is required under Assurance VI.
- The BAS evidence shows one (1) quality improvement project implemented and being analyzed for effectiveness. The BAS is required to provide an updated

report for this QIP quarterly (no later than September 30, 2015, December 31, 2015 and at the time of submission of the renewal). The QIP must include the details of each QIP, if the QIP is effective, interventions that have been explored, status to date, specifics on timelines, communication strategies, support and training improvements, and overall monitoring changes. The QIP must include the data for the PM including remediation completed.

- At the time of renewal, the BAS will be required to develop and implement PMs that address the following areas of the administrative authority:
 - Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
 - Equitable distribution of waiver openings in all geographic areas covered by the waiver unless the state has waived the requirement of state-wideness.
 - Compliance with HCBS settings requirements and other new regulatory components

VI. State Provides Financial Accountability for the Waiver

Assurance:

- State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

Finding:

- The state does not meet this assurance because of a failure to report, remediate and incorporate system improvements for the individual claims billed and paid during this review period. The state reported on services and not total claims which does not meet the performance measure outlined in the approved waiver to meet the financial assurance. The CMS has concerns regarding the state's oversight of the processes and documentation requirements for the financial accountability required under this assurance.

Required Recommendations:

- The state is required to develop and submit a waiver specific work plan for the CMS review no later than 90 days from the date of the report. The CMS expects the waiver specific work plan will assist the state in preparations for this waiver renewal regarding this assurance. The work plan shall include:
 - a plan for designing and implementing a quality improvement system (QIS) for the waiver to assist the state in meeting and demonstrating the financial assurance for this waiver, and should include:
 - quantifiable performance measures tied to the assurance;
 - PMs demonstrating that claims are coded and paid for in accordance with the reimbursed methodology specified in the approved waiver;
 - PMs demonstrating that claims are paid for only those services rendered;

- PMs demonstrating that rates remain consistent with the approved rate methodology throughout the five year waiver cycle; and
 - The QIS for this assurance is designed and implemented to assure accountability of claims monitoring, financial reporting, and reconciliation.
 - tools to gather and analyze data for the performance measures;
 - remediation actions for noncompliant findings; and
 - processes that will assure systems improvements.
 - A timeline for designing and implementing the QIS for the financial assurance.
- The state is required to seek technical assistance (TA) for the following:
 - development of the waiver specific work plan;
 - design and implementation of the QIS, and
 - facilitation of state's awareness of CMS expectations in meeting the statutory requirements.
- The state is required to participate in monitoring calls with CMS to monitor progress on the work plan and the financial assurance. Call frequency and purpose may be adjusted based on progress in meeting mile posts for this assurance.
- The state is required to provide quarterly data for the PMs in the approved waiver showing compliance levels. The quarterly data including aggregation and analysis is due 45 days after the quarter ends.
- A report regarding the collaboration with the ODP, in consultation with the Bureau of Financial Operations, to improve oversight processes and documentation requirements specific to billing and remediation as noted in state's response to the draft report is required to the CMS by December 1, 2015 showing what changes will be commencing with the renewal of this waiver.
- The state is required to develop additional PMs for the financial accountability assurance at the time of the waiver renewal application that will assist in demonstrating compliance with the assurance. The development of the additional PMs should include oversight for claims review/analysis, lifecycle of claims, information of cost to program, and other measures that clarify the states accountability and financial oversight.

Introduction

Pursuant to section 1915(c) of the Act, the Secretary of the Department of Health and Human Services has the authority to waive certain Medicaid statutory requirements to enable a state to provide a broad array of home and community-based services as an alternative to institutionalization. The CMS has been delegated the responsibility and authority to approve state HCBS waiver programs.

The CMS must assess each HCBS program in order to determine that the state's assurances are met. This assessment also serves to inform CMS of possible issues in its review of the state's request to renew the waiver.

State Waiver Name:	#0593 Adult Autism Waiver
Number of Waiver:	0593.R01.02
State Medicaid Agency:	Department of Human Services (HHS)
Operating Agency:	Office of Developmental Programs (ODP) Bureau of Autism Services (BAS)
State Waiver Contact:	Pia Newman, Office of Developmental Programs
Target Population:	Individuals who meet clinical and financial eligibility for Intermediate Care Facility for Persons with Other Related Conditions (ICF/ORC) or ICF/ID, who have a diagnosis of Autism Spectrum Disorder, have substantial functional limitations in three or more major life activities, and who are 21 years of age or older
Level of Care:	ICF/ID or ICF/ORC
Number of Waiver Participants:	288 Unduplicated Participants reported for the waiver year ending June 30, 2012
Average Estimated Per Capita Costs:	\$34,599.97 reported for the waiver year ending June 30, 2012
Effective Dates of Waiver:	July 1, 2011 through June 30, 2016

Approved Waiver Services:

Day habilitation; residential habilitation; respite; supported employment; case management; occupational therapy; counseling; physical therapy; speech/language therapy; assistive technology; behavioral specialist services; community inclusion; community transition services; environmental modifications; family counseling; family training; job assessment and finding; nutritional consultation; temporary crisis services; and transitional work services.

CMS Contact:

Jennifer Lutz (Stucky)
215-861-4284
Jennifer.Stucky@cms.hhs.gov



Observations, Findings, and Recommendations

Assurance I. State Conducts Level of Care Determinations Consistent with the Need for Institutionalization

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/re-evaluating an applicant's/waiver participant's level of care consistent with care provided in a hospital, nursing facility (NF) or Intermediate Care Facility for the Intellectually Disabled (ICF/ID).

Authority: 42 CFR 441.301; 42 CFR 441.302; 42 CFR 441.303; State Medicaid Manual (SMM) 4442.5; 1915(c) Version 3.5 HCBS Waiver Application and corresponding Instructions, Technical Guide & Review Criteria.

CMS Finding: The state substantially meets the assurance.

Sub Assurances:

1. An evaluation for level of care (LOC) is provided to all applicants for whom there is reasonable indication that services may be needed in the future.
2. The level of care (LOC) of enrolled participants is re-evaluated at least-annually or as specified in the approved waiver.
3. The state's process and instruments documented in the approved waiver are applied appropriately and according to the approved description to determine participant LOC.

Background

An applicant who has been determined by the BAS regional office staff or contractors to meet program eligibility requirements specified in Appendix B-1 in the Waiver Management System (WMS) application are evaluated by a physician using the Medical Assistance Evaluation form (MA-51) to determine level of care (LOC).

A wavier participant's LOC evaluation is conducted by physicians licensed in Pennsylvania. If the physician indicates ICF/ID LOC, a Qualified Intellectual Disabilities Professional (QIDP) employed by Office of Developmental Programs (ODP) will evaluate whether the person meets ICF/ID level of care using the criteria specified in Appendix B-6-d in the WMS application. If the physician indicates the person meets ICF/ORC level of care criteria, an additional assessment is not necessary.

All reevaluations are completed by supports coordinators that assist physicians with this task when necessary.

B/LOC1

AAW Performance Measure: Number of applicants who receive a level of care determination within 60 days of BAS receipt of application divided by total number of applicants. (Internal AAW Code: B/LOC1)	FY 11-12	FY 12- 13	FY 13-14	
DISCOVERY DATA				
<i>Numerator (N) = Applicants who received LOC within 60 days</i>	N	17	16	137
	D	30	32	139
	<i>Denominator (D) = Applicants returning LOC determination</i>	% (N/D)	57%	50%
REMEDICATION DATA				
	<i>Noncompliant</i>	13	16	2
	<i>Remediated</i>	13	16	2
	<i>% Remediated</i>	100%	100%	100%

State Discovery and Remediation

In FY 2011-12 and FY2012-13, applicants were sent the level of care determination form (MA-51) after their age and functional eligibility determinations were made. Delays in scheduling the functional eligibility assessment, which must be done in person, delays in scheduling the physician appointment necessary for the completion of the MA-51, and the option to exercise up to two 30-day extensions during the waiver application period all contributed to the performance on this measure. Nevertheless, in FY 2011-12, the average number of days between the mailing of the MA-51 to the applicant and the receipt of the completed form by BAS was 28.6 days. In FY 2012-13, the average was 26.3 days. In FY 2013-14, BAS adjusted the application process which resulted in a significant improvement in performance to 99 percent compliance.

Some applicants who required one or two extensions exceeded the target timeline of 60 days, but did submit a completed MA-51 form before enrollment and service planning.

In order to increase the efficiency and shorten the average application time period, in FY 2013-14, the BAS adjusted the order in which the applicant is sent the LOC determination form. Rather than sending that form after other non-financial eligibility criteria are determined, the MA-51 form is now included in the initial application packet. In addition, in order to decrease the number of extensions needed to complete the application, the BAS now contacts applicants by phone as the applications are mailed, to emphasize the need to make any necessary physician appointments as soon as possible. Finally, the number of allowable 30-day extensions during the application process has been reduced to one.

FY 2011-2012 Remediation: 100% Compliance

FY 2012-2013 Remediation: 100% Compliance

FY 2013-2014 Remediation: 100% Compliance

B/LOC2

AAW Performance Measure: Number of enrolled participants who receive a level of care re-evaluation within 12 months of previous evaluation divided by number of participants who have been enrolled for at least 12 months. (Internal AAW Code: B/LOC2)	FY 11-12	FY 12-13	FY 13-14	
DISCOVERY DATA				
<i>Numerator (N) = Enrolled participants who received LOC within 365 days</i>	N	198	219	245
	D	250	269	293
	% (N/D)	79%	81%	84%
<i>Denominator (D) = Participants enrolled for at least 12 months</i>				
REMEDICATION DATA				
<i>Noncompliant</i>	52	50	48	
<i>Remediated within 2 months of due date</i>	41	40	37	
<i>Remediated within 2+ months of due date</i>	11	10	11	
<i>Total remediated</i>	52	50	48	
<i>% Remediated</i>	100%	100%	100%	

State Discovery and Remediation

Supports coordinators are expected to support participants in having their physician complete the MA-51 form within 12 months of the completion of the previous form. The BAS sends a reminder to each supports coordinator along with a blank form to share with the participant. The BAS works closely with individual supports coordinators and physicians’ offices if necessary, to facilitate the documentation of the LOC re-evaluation. Approval and authorization of the annual ISP is contingent on the completion of the annual LOC re-evaluation.

In addition to the reminder and form shared with the supports coordinator, in 2012, the BAS began to send a separate letter to the participant and his or her representative, if the participant has a representative 60 days before the due date of the MA-51, along with a copy of the form and instructions for the physician filling out the form. The letter explains the importance of timely submission of the form and the possibility of an interruption of services should the form not be submitted timely. As an improvement project, the BAS has developed an additional oversight process to monitor progress toward completion of the level of care re-certification by verifying with the supports coordinator or the participant that the form will be completed, and addressing barriers to its completion by the deadline.

FY 2011-2012 Remediation: 100% Compliance

FY 2012-2013 Remediation: 100% Compliance

FY 2013-2014 Remediation: 100% Compliance

B/LOC3

AAW Performance Measure: Number of initial level of care determinations where the instrument described in Appendix B-6 is used and BAS agrees with the decision divided by the number of initial level of care determinations reviewed by BAS. (Internal AAW Code: B/LOC3)	FY 11-12	FY 12-13	FY 13-14	
DISCOVERY DATA				
<i>Numerator (N) = Initial LOC determinations in compliance</i> <i>Denominator (D) = Initial LOC determinations</i>	N	30	32	139
	D	30	32	139
	% (N/D)	100%	100%	100%

State Discovery and Remediation

All level of care assessments are reviewed by the BAS to ensure that the correct instrument is used. In 100% of instances, the correct instrument was used and the BAS agreed with the decision. No follow-up or improvement is needed.

FY 2011-2012 Remediation: 100% Compliance

FY 2012-2013 Remediation: 100% Compliance

FY 2013-2014 Remediation: 100% Compliance

B/LOC4

AAW Performance Measure: Number of level of care re-determinations where the instrument described in Appendix B-6 is used and BAS agrees with the decision divided by total number of level of care re-determinations. (Internal AAW Code: B/LOC4)	FY 11-12	FY 12-13	FY 13-14	
DISCOVERY DATA				
<i>Numerator (N) = LOC redeterminations in compliance</i> <i>Denominator (D) = LOC redeterminations</i>	N	250	269	293
	D	250	269	293
	% (N/D)	100%	100%	100%

State Discovery and Remediation

All level of care re-determinations are reviewed by the BAS to ensure that the correct instrument is used. In 100% of instances, the correct instrument was used and the BAS agreed with the decision. No follow-up or improvement is needed.

FY 2011-2012 Remediation: 100% Compliance

FY 2012-2013 Remediation: 100% Compliance

FY 2013-2014 Remediation: 100% Compliance

State Discovery Post Draft Report

For PMs B/LOC1 and B/LOC3, the sample is 100% of applicants who returned LOC determination for each fiscal year. For FY 2011-2012 and FY 2012-2013, this number is lower than the total number of applicants because some applicants did not complete the application process and did not submit a LOC determination. The parameter used to pull data for initial LOC determinations is the fiscal year during which they are submitted by applicants. The LOC re-determination is due within 364 days of the previous year's determination and the parameter is the fiscal year during which they are submitted by applicants. The LOC re-determinations are due within 364 days of the previous year's determination and the parameter is the fiscal year during which the LOC determination is resubmitted by the participant.

Please note the number of applicants, people applying for newly available capacity, is less than the total number of waiver participants. The denominator for B/LOC1 and B/LOC3 increased significantly for year 3, state FY 2013/14, because the capacity for the AAW was funded to expand by 115 additional participants.

For B/LOC2 and B/LOC4, the sample is 100% of participants enrolled for at least 12 months for each fiscal year. The unduplicated number of people served was 288 in year 1, state FY 2011/12; 306 in year 2, state FY 2012/13; and 427 in year 3, state FY 2013/14. The denominators do not exceed the unduplicated count in any instance.

The increase in capacity by 115 people in year 3, FY 2013/14 will not affect B/LOC2 and B/LOC4 until year 4, FY 2014/15. Participants enrolled in FY2013/14 will not have a full 12 months in the waiver until FY 2014/15.

The additional oversight process under development will elaborate on the current process of the BAS sending the participant, as well as the supports coordinator, a copy of the LOC instrument (Medical Evaluation Form MA 51) and instructions to the physician on its completion. In addition, the BAS will track completion and submission of the LOC re-certification at 30, 14, and 10 calendar days prior to the anniversary of the previous LOC certification form. Participants will be advised of the risk of interruption of services if the LOC

certification is not submitted timely both at the time the Form MA 51 is sent and again at 10 days before the deadline, if that is necessary. Barriers will be addressed through the BAS collaboration with the supports coordinators and by directly contacting the participant if compliance is not evident 10 days before the deadline. The timeline for implementation of this process is May 1, 2015.

THIS CHART IS OFFERED BY BAS AS A REFERENCE FOR TABLES IN THE AAW REPORT

TABLE	PERFORMANCE MEASURES: LEVEL OF CARE	SAMPLING APPROACH	DENOMI- NATOR	DETAILS
B/LOC1	Number of applicants who receive a level of care determination within 60 days of BAS receipt of application divided by total number of applicants.	100% Review	30, 32, 139	Applicants who returned LOC certification only
B/LOC2	Number of enrolled participants who receive a level of care re-evaluation within 12 months of previous evaluation divided by number of participants who have been enrolled for at least 12 months.	100% Review	250, 269, 293	All participants enrolled for at least 12 months
B/LOC3	Number of initial level of care determinations where the instrument described in the Adult Autism Waiver/Appendix B-6 is used and BAS agrees with the decision divided by total number of initial level of care determinations reviewed by BAS.	100% Review	30, 32, 139	Applicants who returned LOC certification only
B/LOC4	Number of level of care re-determinations where the instrument described in Appendix B-6 is used and BAS agrees with the decision divided by total number of level of care re-determinations.	100% Review	250, 269, 293	LOC redeterminations only

CMS Final Response: The state substantially meets the assurance. The CMS does not have any recommendations for the state regarding this assurance.

Assurance II. Plans of Care are Responsive to Waiver Participant Needs

The state demonstrates that it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

Authority: 42 CFR 441.301-303; SMM 4442.6; SMM 4442.7; Section 1915(c) Version 3.5 HCBS Waiver Application and corresponding Instructions, Technical Guide & Review Criteria.

CMS Finding: The state meets the assurance.

Sub Assurances:

1. Service plans address all of the participants' assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means.
2. The state monitors service plan development in accordance with its policies and procedures.

3. Service plans are updated/revised at least annually or when warranted by changes in the participant's LOC.
4. Services are delivered in accordance with the service plan, including type, scope, amount, and frequency specified in the plan of care (POC).
5. Participants are afforded choice: (1) between waiver services and institutional care; and (2) among waiver services and providers.

Background

The supports coordinator is responsible for convening a team that includes the participant, his/her legal representative, and other individuals the participant selects including service providers. The goal is for the team to develop the participant's Individual Service Plan (ISP) and all required assessment documents within 20 days of the selection of a Support Coordination agency. The ISP is finalized by the supports coordinator and sent to the BAS within 45 days of the selection of the Support Coordination agency.

D/SP1

AAW Performance Measure: Number of Individual Support Plans (ISP) that address the participant's needs and goals identified in the assessments divided by total number of ISPs. (Internal AAW Code: D/SP1)		FY 11-12	FY 12-13	FY 13-14
DISCOVERY DATA				
<i>Numerator (N) = ISPs that address the participant's needs and goals</i> <i>Denominator (D) = Total ISPs</i>	N	280	301	406
	D	280	301	406
	% (N/D)	100%	100%	100%

State Discovery and Remediation

The BAS reviews every ISP, both the initial and annual reviews. The participants' assessed needs and stated goals are compared to the services included on the ISP. If an ISP is submitted that raises questions about whether needs and goals are addressed, the BAS staff works with the supports coordinator to ensure compliance before the ISP is approved and authorized. Compliance is 100 percent. No follow-up or improvement is needed.

FY 2011-2012 Remediation: 100% Compliance

FY 2012-2013 Remediation: 100% Compliance

FY 2013-2014 Remediation: 100% Compliance

D/SP2

AAW Performance Measure: Number of ISPs in which the ISP is approved without revisions, which indicates the service planning process in Appendix D was followed, divided by total number of ISPs. (Internal AAW Code: D/SP2)	FY 11-12	FY 12-13	FY 13-14	
DISCOVERY DATA				
<i>Numerator (N) = ISPs approved without revisions</i> <i>Denominator (D) = Total ISPs</i>	N	240	256	333
	D	280	301	406
	% (N/D)	86%	85%	82%
REMEDIATION DATA				
<i>Noncompliant</i>	40	45	73	
<i>Remediated</i>	40	45	73	
<i>% Remediated</i>	100%	100%	100%	

State Discovery and Remediation

The BAS staff reviews every ISP during initial plan development and during the annual review process. Supports coordinators receive guidance on expectations of ISPs and the ISP process through a Supports Coordination Manual as well as a series of web-based presentations on a variety of topics relevant to the requirements of the ISP, such as how to write goals. Periodic turnover of individual supports coordinators leads to a loss of expertise and benefit from prior technical assistance.

The BAS provides supports coordinators with specific feedback not only to instruct them on what revisions are needed but also to provide technical assistance in order to reduce the recurrence of ISP submissions that will fail to be approved. In addition, the BAS has implemented an improvement strategy in which checklists are shared with supports coordinators as tools for them to use during the drafting of plans to ensure that requirements are met and that the ISP will more likely be approved without the need for revisions. The BAS is also in the process of revising training requirements and content to address lessons learned regarding which areas of the ISP seem to be most prone to difficulties for supports coordinators.

FY 2011-2012 Remediation: 100% Compliance

FY 2012-2013 Remediation: 100% Compliance

FY 2013-2014 Remediation: 100% Compliance

D/SP3

AAW Performance Measure: Number of initial ISPs completed within 45 days of the selection of an SC agency divided by total number of initial ISPs completed during a quarter. (Internal AAW Code: D/SP3)	FY 11-12	FY 12-13	FY 13-14	
DISCOVERY DATA				
<i>Numerator (N) = Initial ISPs completed within 45 days</i> <i>Denominator (D) = Initial ISPs</i>	N	16	10	62
	D	30	32	113
	% (N/D)	53%	31%	55%
REMEDIATION DATA				
<i>Noncompliant</i>	14	22	51	
<i>Completed within 46-60 days</i>	5	6	28	
<i>Completed within 61+ days</i>	9	16	23	
<i>Total remediated</i>	14	22	51	
<i>% Remediated</i>	100%	100%	100%	

State Discovery and Remediation

Multiple factors have been identified as responsible for the results of this performance measure. As part of the ISP development process, the supports coordinator administers the Scales of Independent Behavior-Revised to every individual before the ISP is drafted. Family members or representatives often respond in addition to or on behalf of the individual. The assessment should be completed in person, particularly for the initial ISP, when the supports coordinator and the individual are just getting to know each other. The time to complete the assessment can vary widely depending on the respondent(s); some individuals and their representatives require that it be completed over more than one visit. This part of the process alone, requiring scheduling of meetings of at least an hour, can delay the submission of the plan if the individual is unavailable, cancels, or reschedules for a later time. Because of the need to meet in person, inclement weather can be a factor, particularly as many of the initial ISPs are being developed during the winter months.

In addition, there must be coordination with providers regarding their willingness to be added to a plan and regarding the start time of services. If the first choice of provider is not accepting new clients, that can also delay the completion of an individual's ISP. If a provider does not respond quickly to a Supports Coordinator's offer of a new client, that may cause a delay.

The BAS contacts the supports coordinator half-way through the 45-day period to check on the progress of the initial ISP development. If the supports coordinator reports any barriers or difficulties which the BAS can address, the BAS staff does so. The BAS has held meetings with Supports Coordination Agencies, as well as ad hoc conversations with individual support coordinators, to better understand the factors that contribute to delay from a systemic perspective. The BAS, with the support of consultants, will again analyze the initial ISP development process to identify design elements that can be changed or adjusted to shorten the

time to completion without sacrificing the integrity and person-centeredness of the process or the plan. This improvement project will include a task analysis of each step in the initial ISP development with data reflecting average completion times for each step as well as the range of completion times (i.e., mean and median completion times). The BAS will review existing documentation on the reasons for delays and will survey supports coordinators and participants, as warranted, for additional information regarding the nature of the barriers to timely completion. Improvement strategies will be identified, implemented, and evaluated. The target date for completion of this improvement project is November 14, 2014.

FY 2011-2012 Remediation: 100% Compliance

FY 2012-2013 Remediation: 100% Compliance

FY 2013-2014 Remediation: 100% Compliance

D/SP4

AAW Performance Measure: Number of ISPs for which revisions were completed within 12 months of most recent previous ISP divided by total number of ISPs for which a revision was due in a quarter. (Internal AAW Code: D/SP4)	FY 11-12	FY 12-13	FY 13-14	
DISCOVERY DATA				
<i>Numerator (N) = ISPs revised within 12 months of previous ISP</i> <i>Denominator (D) = Participants enrolled for at least 12 months</i>	N	249	266	291
	D	250	269	293
	% (N/D)	99%	99%	99%
REMEDIAION DATA				
<i>Noncompliant</i>	1	3	2	
<i>Remediated within 30 days</i>	0	0	2	
<i>Remediated within 31-60 days</i>	0	3	0	
<i>Remediated within 61+ days</i>	1	0	0	
<i>Total remediated</i>	1	3	2	
<i>% Remediated</i>	100%	100%	100%	

State Discovery and Remediation

In FY 2011-12, one participant changed Supports Coordination providers just before his annual plan review which led to missing the 12-month deadline. In FY 2012-13, three participants failed to submit documentation of level of care re-evaluation in time which delayed the approval of their ISPs. In FY 2013-14, two participants did not complete a revision within 12 months: one failed to submit documentation of level of care and the second refused services but changed his

mind when invited to withdraw from the program. The level of noncompliance was determined not significant enough for an improvement project.

FY 2011-2012 Remediation: 100% Compliance

FY 2012-2013 Remediation: 100% Compliance

FY 2013-2014 Remediation: 100% Compliance

D/SP5

AAW Performance Measure: Number of participant interview respondents who reported unmet needs divided by number of participants interviewed by BAS staff (a number above zero indicates the assurance is not met for some individuals). (Internal AAW Code: D/SP5)	FY 11-12	FY 12-13	FY 13-14	
DISCOVERY DATA				
<i>Numerator (N) = Participants who reported unmet needs Denominator (D) = Participants interviewed who answered this question</i>	N	3	1	0
	D	49	53	51
	% (N/D)	6%	2%	0%
REMEDIAION DATA				
<i>Noncompliant</i>	3	1	0	
<i>Remediated</i>	3	1	0	
<i>% Remediated</i>	100%	100%	N/A	

State Discovery and Remediation

This performance measure is written in terms of a negative outcome, i.e., the best outcome is zero percent. Participant reports of unmet needs most often concerned discontent with the degree of responsiveness of their supports coordinator or the failure of the supports coordinator to follow up on requests. The BAS contacts providers to share participants’ concerns and may cite the provider through the Plan of Correction process if the provider is found to be out of compliance with waiver or regulatory requirements.

During the reporting period, the instances of non-compliance resulted from insufficient or unsatisfactory levels of communication between the participant and the provider. Providers were offered technical assistance to address the insufficiency or the participant exercised his or her right to choice of provider and selected another agency. In FY 2011-12, in all three cases, there was follow-up by the BAS to the Supports Coordination agency, including technical assistance. In FY 2012-13, the participant changed agencies.



FY 2011-2012 Remediation: 100% Compliance

FY 2012-2013 Remediation: 100% Compliance

FY 2013-2014 Remediation: 100% Compliance

D/SP6

AAW Performance Measure: Number of participants with at least one unit of service that was authorized and not used, where unused services is not explained by participant illness; hospitalization; participant refusing services; or participant vacation with family or friends divided by number of participants interviewed by BAS (a number above zero indicates the assurance is not met for some individuals). (Internal AAW Code: D/SP6)	FY 11-12	FY 12-13	FY 13-14	
DISCOVERY DATA				
<i>Numerator (N) = Participants who reported unused service due to reasons beyond those listed in the performance measure</i> <i>Denominator (D) = Participants interviewed who answered this question</i>	N	11	9	8
	D	51	48	54
	% (N/D)	22%	19%	15%

State Discovery and Remediation

This performance measure is written in terms of a negative outcome, i.e., the best outcome is zero percent. In most of the reported cases of services not being used, provider staff was ill. In the Adult Autism Waiver, participants may elect to have a back-up or contingency plan that does not require the provider agency to send substitute staff in such cases. For some waiver services, such as Assistive Technology or Family Counseling, a contingency plan is not appropriate.

As an improvement project, the BAS has implemented a stricter review process to ensure that all direct services on each ISP have a contingency plan. The checklist used to review annual plan renewals includes the requirement of a contingency plan when appropriate. The BAS rejects ISPs that are missing contingency plans and the Supports Coordinator is instructed to resubmit once those plans are entered. The BAS will monitor progress on this measure to ensure that the systemic response is effective.

FY 2011-2012 Remediation: 78% Compliance

FY 2012-2013 Remediation: 81% Compliance

FY 2013-2014 Remediation: 85% Compliance

Table D/SP7a (Choice between Waiver and Institutional Care)

AAW Performance Measure: Number of participants who indicated they were able to choose between a) waiver and institutional care and b) among waiver services and providers are documented divided by number of participants interviewed by BAS staff. (Internal AAW Code: D/SP8)	FY 11-12	FY 12-13	FY 13-14	
DISCOVERY DATA				
<i>Numerator (N) = People for whom choice between waiver and institutional care is documented</i> <i>Denominator (D) = Participants selected for monitoring sample</i>	N	52	56	56
	D	54	56	56
	% (N/D)	98%	100%	100%

State Discovery and Remediation

The Service Preference Form, where applicants indicate their preference between institutional care and waiver services, is part of the waiver application. The form is returned to the BAS and kept on file there. A copy is shared with the supports coordinator for their participant files.

In the case of two individuals in FY 2011-12, neither the BAS files or Supports Coordinator files contained the Service Preference Form. The BAS directed the supports coordinator for each of those participants to have the form completed and sent to the BAS. In both instances the participant left the waiver before the supports coordinator could secure a completed form. As an improvement project, the BAS will evaluate changing to an electronic file management process to store a scanned version of all Service Preference Forms in a centralized location in the future. This practice would facilitate more comprehensive oversight of compliance.

FY 2011-2012 Remediation: 98% Compliance

FY 2012-2013 Remediation: 100% Compliance

FY 2013-2014 Remediation: 100% Compliance

D/SP7b (Choice among Waiver Service Providers)

AAW Performance Measure: Number of participants who indicated they were able to choose between a) waiver and institutional care and b) among waiver services and providers are documented divided by number of participants interviewed by BAS staff. (Internal AAW Code: D/SP8)	FY 11-12	FY 12-13	FY 13-14	
DISCOVERY DATA				
<i>Numerator (N) = People for whom choice among providers is</i>	N	52	56	53
	D	54	56	56

<i>documented</i> Denominator (D) = Participants selected for monitoring sample	% (N/D)	96%	100%	95%
REMEDIAION DATA				
	Noncompliant	2	0	3
	Remediated	2	0	3
	% Remediated	100%	N/A	100%

State Discovery and Remediation

During Initial ISP development, the supports coordinator asks the participant to complete a Provider Choice Form to document that the participant was offered a choice of providers. That form is kept in the Supports Coordination agency's participant files.

In two instances in FY 2011-12 and three instances in FY 2013-14, the Choice of Provider form was not in the files of the Supports Coordination agency. The BAS directed the Supports Coordination agencies to have the participants complete the forms and send a copy to the BAS as documentation of remediation. This was completed for the instances in FY 2011-12 and is in process for the instances in FY 2013-14. As an improvement project, the BAS will evaluate changing to an electronic file management process to store a scanned version of all initial Provider Choice Forms in a centralized location in the future. This would facilitate more comprehensive oversight of compliance.

FY 2011-2012 Remediation: 100% Compliance

FY 2012-2013 Remediation: 100% Compliance

FY 2013-2014 Remediation: 100% Compliance

D/SP7c (Choice among Waiver Services)

AAW Performance Measure: Number of participants who indicated they were able to choose between a) waiver and institutional care and b) among waiver services and providers are documented divided by number of participants interviewed by BAS staff. (Internal AAW Code: D/SP8)	FY 11-12	FY 12-13	FY 13-14	
DISCOVERY DATA				
<i>Numerator (N) = People for whom choice among waiver services is documented</i> Denominator (D) = Participants selected for monitoring sample	N	54	56	56
	D	54	56	56
	% (N/D)	100%	100%	100%

The BAS sends every participant a Participant Handbook once eligibility is determined and the individual is ready to begin the ISP development process. The Participant Handbook includes a description of each waiver service as well as a list of Participant Rights and Responsibilities which includes the right to choice among services. In FY 2013-14, the list of Participant Rights and Responsibilities was updated and sent to every participant. The Participant Handbook, incorporating the revised Rights and Responsibilities, was also updated and shared with all waiver participants. In addition, as part of the annual ISP review process, the supports coordinator asks the participant or representative to sign an ISP Sign-Off Form documenting that the participant or representative is aware of the right of choice among waiver services. No follow-up or improvement is needed.

FY 2011-2012 Remediation: 100% Compliance

FY 2012-2013 Remediation: 100% Compliance

FY 2013-2014 Remediation: 100% Compliance

State Discovery Post Draft Report

The sample sizes for D/SP1, D/SP3, and D/SP4 are identical to the sample sizes specified in the CMS-approved waiver. A table at the end of the response for Assurance II summarizes the measures, the sampling approach approved in the waiver, and the sample sizes for evidence presented in the AAW.

The unduplicated number of people served was 288 in year 1, state FY 2011/12; 306 in year 2, state FY 2012/13; and 427 in year 3, state FY 2013/14. The denominators for D/SP1, D/SP2 and D/SP4 do not exceed the unduplicated count.

The denominator increased significantly for FY 2013/14 in D/SP3 because the capacity for the AAW was funded to expand by 115 additional participants. Please note also that the number of initial ISPs (the denominator for D/SP3) is different from the number of total applicants reported (e.g. B/LOC1) because not all applicants returned LOC certification and/or went on to enroll and develop an initial ISP.

The sample sizes for all the measures for Assurance II, Plans of Care, are identical to the sample sizes specified in the CMS-approved waiver with the exception of PMs D/SP7 and D/SP7b. For PM D/SP7a and D/SP7b, the BAS reported results based on “Less than 100% Review Representative Sample Confidence Interval 90%+/- 10%,” which represents the participants reviewed during each monitoring cycle. For future monitoring cycles, BAS will review a 100% sample based on the electronic file management improvement project that is described on the next page.

For those performance measures based on a sample of participants (D/SP5, D/SP6, D/SP7a, D/SP7b, D/SP7c), BAS used the sample size calculator at <http://www.raosoft.com/samplesize.html> each year to determine the appropriate and statistically-

significant sample size for each of the reporting years to arrive at a 90% confidence interval with +/- 10% margin of error, as specified in the approved waiver. In addition, for D/SP5 and D/SP6, the denominator reflects the number of participants in the sample who answered the questions relative to these two performance measures. (Some interviewed participants did not answer all questions.)

The BAS will revise these performance measures to frame them as positive outcomes as part of the waiver renewal in 2016.

The BAS will monitor the progress of the contingency plan improvement project as part of its ongoing internal quarterly Quality Monitoring meetings. Beginning with the June 2015 meeting, the aggregated data on the inclusion of contingency plans for each service on every ISP, being pulled from ISP checklists for the third quarter of FY 2014-2015, will be reviewed to determine the level of compliance with this requirement. If it is discovered during the June meeting that a strategy beyond the ISP checklist is required, the BAS will develop further improvement projects to ensure that contingency plans are included for each service, as appropriate, on every ISP.

In November 2014, the BAS sent a notice to supports coordinators to remind them that the Service Provider Choice form must be scanned and sent to the regional office after each initial ISP meeting. (The Service Preference forms are already collected by BAS staff and maintained in BAS paper files.) The BAS is developing a process for staff to scan and archive both forms for each participant for all initial ISPs. This process will be disseminated to BAS staff by June 15, 2015, by the AAW quality manager. The BAS staff will then be trained to scan and upload all initial forms to a secure online platform within one month of the ISP approval.

The Department of Human Services already has an electronic file management platform (DocuShare) which will be used for archiving these forms. The file structure is developed and in place. Since BAS staff is already registered users of DocuShare, training activities will be minimal. Comprehensive oversight will be conducted periodically (at least quarterly) by the quality manager, beginning July 1, 2015, to ensure that 100% of forms are on record. BAS Regional Offices will be alerted if/when these forms are not archived for any particular participant and staff will be required to collect, scan and archive the missing forms.

For table D/SP5, the three participants in FY 2011/12 were referencing communications with their supports coordinators (SC). One participant was being supported by an SC who was removed from providing services for AAW participants during the FY 2011/12 monitoring cycle. The other two participants were being supported by SCs who were directed to complete additional training regarding the requirements for monthly contacts and quarterly monitoring. That training was completed and verified. One participant reported unmet needs in FY 2012/13 and that participant's SC was also directed to complete the same additional training which was subsequently verified. In all cases, the participants' SCs were closely monitored after

each monitoring cycle ended via Service Notes in HCSIS that document contacts made with participants.

There are five services in the most recent CMS-approved CMS 372 report for which no participants were indicated. This report was for year 2, state FY 2012-13. The services are:

- Community Transition Services
- Respite, out-of-home (15 minute unit only; a daily rate for out-of-home respite was used)
- Therapies – Occupational
- Assistive Technology
- Environmental Modifications

Community Transition Services has not been used because no waiver participant has transitioned from an institution to the waiver. The remaining four services were not used because the Individual Support Plan (ISP) planning team—the participant, his or her legal representative, and other individuals the participant selected—did not select these services to meet the participant’s goals in the ISP. All of these services except for occupational therapy have been used in previous years, when they were specified in the ISP. We have not received complaints regarding access to these services.

Communication with beneficiaries regarding available services occurs as specified in Appendix D-1-a of the waiver, subsection (c): “To ensure the participant is aware of all service options, BAS provides each participant a list of Adult Autism Waiver services with brief, easy-to-understand definitions for each service when the person is determined eligible for the Adult Autism Waiver. The service list is available at any time upon request and available on the Internet.”

Regarding the review of services from a quality management perspective, the BAS reviews each ISP for the appropriateness of services to the participant’s assessed needs and desired goals. The BAS may recommend different or additional services when appropriate based on its review. Also, the BAS interviews with a random sample of participants include questions regarding whether the person has an unmet need, as specified in performance measure D/SP5.

The performance measure related to Table D/SP3 and the improvement project initiated in Fall 2014 to “review existing documentation on the reasons for delays.” That project involved identifying, implementing, and evaluating improvement strategies.

The BAS’s analysis revealed that during FY 2013-2014, 10 individual supports coordinators associated with eight Supports Coordination Agencies (out of a total of 18 agencies that accepted new participants in that year) showed a history of submitting ISPs beyond the 45-day timeline.

As a result of the BAS’s information gathering and analysis, improvement strategies were identified and implemented. For individual supports coordinator remediation, a letter was sent to each of the eight agencies identified and included the supports coordinators’ names, the participants’ names for ISPs that were not compliant with the 45-day timeline, and the number of

days it took for those ISPs to be completed. BAS also created a tip sheet for the Supports Coordination Agencies and that tip sheet was included with the letter. The tip sheet offered strategies for staying on track during the initial ISP process and a script to use for participants who were not responsive to previous outreach.

Finally, in response to findings that families may delay or postpone meetings required to complete the ISP, an “Applicant Responsibilities” flyer was added to the packet that is sent to applicants advising that it is time to select a supports coordinator. This flyer stresses the importance of timely ISP completion and, in particular, that the cooperation of the participant in scheduling will result in services beginning sooner. In January of 2016, the BAS will evaluate the strategies implemented during FY 2014-2015 to determine whether the improvement project has been effective.

THIS CHART IS OFFERED BY BAS AS A REFERENCE FOR TABLES IN THE AAW REPORT

TABLE	PERFORMANCE MEASURES: SERVICE PLANS	SAMPLING APPROACH	DENOMI- NATOR	DETAILS
D/SP1 (Table 4.1)	Number of Individual Support Plans (ISP) that address the participant’s needs and goals identified in the assessments divided by total number of ISPs.	100% Review	280, 301, 406	All approved ISPs, initial and annual
D/SP2	Number of ISPs in which the ISP is approved without revisions, which indicates the service planning process in AAW/Appendix D was followed, divided by total number of ISPs.	100% Review	280, 301, 406	All approved ISPs, initial and annual
D/SP3	Number of initial ISPs completed within 45 days of the selection of a Supports Coordination agency divided by total number of initial ISPs completed during a quarter.	100% Review	30, 32, 113	Applicants with completed ISPs at the end of the fiscal year
D/SP4	Number of ISPs for which revisions were completed within 12 months of most recent previous ISP divided by total number of ISPs for which a revision was due in a quarter.	100% Review	250, 269, 293	All participants enrolled for at least 12 months
D/SP5	Number of participant interview respondents who reported unmet needs divided by number of participants interviewed by BAS staff (a number above zero indicates the assurance is not met for some individuals).	Less than 100% Review Representative Sample Confidence Interval 90%+/- 10%	49, 53, 51	All monitored participants who answered this question on interview (some chose not to answer)
D/SP6	Number of participants with at least one unit of service that was authorized and not used, where unused services is not explained by participant illness; hospitalization; participant refusing services; or participant vacation with family or friends divided by number of participants interviewed by BAS (a number above zero indicates the assurance is not met for some individuals).	100% Review Representative Sample Confidence Interval 90%+/- 10%	51, 48, 54	All monitored participants who answered this question on interview (some chose not to answer)

D/SP7a & D/SP7b	Number of people for whom choices between a) waiver and institutional care and b) among waiver services and providers are documented divided by total number of people with ISP.	100% Review*	54, 56, 56	All monitored participants; we split this PM into three PMs, D/SP7a, D/SP7b, and D/SP7c
D/SP7c	Number of participants who indicated they were able to choose between a) waiver and institutional care and b) among waiver services and providers are documented divided by number of participants interviewed by BAS staff.	Less than 100% Review Representative Sample Confidence Interval 90%+/- 10%	54, 56, 56	All monitored participants

CMS Final Response: The state meets the assurance with two (2) recommendations and one (1) requirement.

- The state has chosen to frame some performance measures (PM)s as a negative outcome which can be misleading and confusing. The CMS recommends the state amend the PMs to accentuate that the data reflects the required level of compliance to promote consistency and clarity.
- For all future monitoring cycles for PM D/SP7a and D/SP7b, the CMS recommends 100% review sample based on the electronic file management QIP noted in the report.
- The BAS evidence shows five (5) quality improvement projects (QIP)s have been developed and are being analyzed for effectiveness. The BAS is required to provide an updated report for all five (5) QIPs identified in this report at least quarterly (no later than September 30, 2015, December 31, 2015 and at the time of submission of the renewal). Each QIP must include the details of the QIP, if the QIP is effective, interventions that have been explored, status to date, specifics on timelines, communication strategies, support and training improvements, and overall monitoring changes. The QIP must include the data for the PM including remediation completed. If the QIP is determined by the state to be ineffective, a new QIP will need to be developed.

Assurance III. Qualified Providers Serve Waiver Participants

The state must demonstrate that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers. *Authority: 42 CFR 441.302; SMM 4442.4; 1915(c) HCBS Waiver Version 3.5 Application and corresponding Instructions, Technical Guide & Review Criteria.*

CMS Findings: The state substantially meets the assurance.

Sub Assurances:

1. The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other state standards prior to their furnishing services.
2. The state monitors non-licensed/non-certified providers to assure to waiver requirements.
3. The state implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

Background

The BAS has staff that specifically focuses on provider recruitment and there has been an increase in provider enrollment by contacting providers and provider associations proactively, focusing on areas of greatest need. During the provider application process, the BAS staff determines whether the provider meets the provider qualification criteria outlined in this waiver. If the provider meets the criteria, the BAS notifies the Office of Medical Assistance Programs, which executes a Medical Assistance Provider Agreement with the provider.

The BAS reviews provider qualifications annually. If findings from discovery activities indicate a provider does not meet provider standards, the BAS will contact the provider for more information to assess whether the provider meets standards. If a provider does not meet provider standards, the BAS will give the provider 30 days to remediate the reason for ineligibility. The BAS will provide technical assistance and training to the provider during this time to prevent disenrollment and will advise the supports coordinator that the provider may be dis-enrolled. If the provider does not meet provider standards after 30 days, the BAS will dis-enroll the provider and notify the supports coordinator that participants will need to identify a new provider. The supports coordinator will notify the participant that a new provider is necessary. The BAS will send a notice of action to the provider to let the provider know that it can appeal the disenrollment decision to the DHS Bureau of Hearings and Appeals.

C/QP1

AAW Performance Measure: Number of providers with a current license divided by total number of providers enrolled for services that require a license (i.e., day habilitation, residential habilitation, occupational therapy, speech/language therapy, family counseling, and nutritional consultation). (Internal AAW Code: C/QP1)		FY 11-12	FY 12-13	FY 13-14
DISCOVERY DATA				
<i>Numerator (N) = Enrolled and licensed providers in compliance</i> <i>Denominator (D) = Enrolled providers requiring a license</i>	N	92	112	147
	D	92	112	147
	% (N/D)	100%	100%	100%

State Discovery and Remediation

All providers required to have a license must send the BAS a copy of that license in order to enroll as an Adult Autism Waiver provider. During biennial re-validation of provider qualifications, the BAS confirms that the provider's license is current. The DHS Bureau of Human Services Licensing (BHSL) notifies the BAS when any provider of a covered service is at risk of losing or has already lost a license which is administered by the BHSL. Additionally, licensed providers serving participants in the annual monitoring sample have their licenses verified during the administrative review of provider qualifications. No follow-up or improvement is needed.

FY 2011-2012 Remediation: 100% Compliance

FY 2012-2013 Remediation: 100% Compliance

FY 2013-2014 Remediation: 100% Compliance

C/QP2

AAW Performance Measure: Number of providers with a Medical Assistance Provider Agreement and an AAW Supplemental Agreement divided by number of providers enrolled in the AAW. (Internal AAW Code: C/QP2)	FY 11-12	FY 12-13	FY 13-14	
DISCOVERY DATA				
<i>Numerator (N) = Enrolled providers in compliance</i> <i>Denominator (D) = Enrolled providers</i>	N	458	573	741
	D	458	573	741
	% (N/D)	100%	100%	100%

State Discovery and Remediation

As part of the provider enrollment process, providers must be confirmed to hold a Medical Assistance Provider Agreement and may not be enrolled without executing an Adult Autism Waiver Supplemental Agreement. The BAS staff manages the provider eligibility determination process and coordinates with the Office of Medical Assistance Programs to complete the enrollment of qualified providers. All enrolled waiver providers were verified to have a Medical Assistance Provider Agreement and an Adult Autism Waiver Supplemental Agreement. No follow-up or improvement is needed.

FY 2011-2012 Remediation: 100% Compliance

FY 2012-2013 Remediation: 100% Compliance

FY 2013-2014 Remediation: 100% Compliance

C/QP3

AAW Performance Measure: Number of direct support staff who meet age, education, and experience requirements in the AAW/Appendix C-3 divided by number of direct support staff serving AAW participants in a given month. (Internal AAW Code: C/QP3)	FY 11-12	FY 12-13	FY 13-14	
DISCOVERY DATA				
<i>Numerator (N) = Direct support staff in compliance</i> <i>Denominator (D) = Direct support staff personnel files reviewed</i>	N	150	126	178
	D	151	126	178
	% (N/D)	99%	100%	100%
REMEDIATION DATA				
<i>Noncompliant</i>	1	0	0	
<i>Remediated</i>	1	0	0	
<i>% Remediated</i>	100%	N/A	N/A	

State Discovery and Remediation

In FY 2011-12, one staff person monitored through the annual quality monitoring process was found to not meet the necessary waiver qualifications. All provider staff monitored in FY 2012-13 and FY 2013-14 met waiver requirements.

A plan of correction was issued to and completed by the provider whose staff member did not meet qualification requirements in FY 2011-12. The provider was instructed to replace the staff person with another who met qualifications. The level of noncompliance was determined not significant enough for an improvement project.

FY 2011-2012 Remediation: 100% Compliance

FY 2012-2013 Remediation: 100% Compliance

FY 2013-2014 Remediation: 100% Compliance

C/QP4

AAW Performance Measure: Number of direct support staff for whom criminal background checks have been completed divided by number of direct support staff serving AAW participants in a given month. (Internal AAW Code: C/QP4)	FY 11-12	FY 12-13	FY 13-14
DISCOVERY DATA			

<i>Numerator (N) = Direct support staff in compliance</i> <i>Denominator (D) = Direct support staff personnel files reviewed</i>	N	151	125	177
	D	151	126	178
	% (N/D)	100%	99%	99%
REMEDATION DATA				
	<i>Noncompliant</i>	0	1	1
	<i>Remediated</i>	0	1	1
	<i>% Remediated</i>	N/A	100%	100%

State Discovery and Remediation

In FY 2011-12, all monitored provider staff had criminal background checks on file at their agencies. In FY 2012-13 and FY 2013-14, one staff did not have a criminal background check on file in each year.

Plans of correction were issued to the appropriate providers to conduct and file the necessary criminal background checks. In both FY 2012-13 and FY 2013-14, the provider in each case secured the missing criminal background check, shared a copy with the BAS and instituted practices to avoid a recurrence. The level of noncompliance was determined not significant enough for an improvement project.

FY 2011-2012 Remediation: 100% Compliance

FY 2012-2013 Remediation: 100% Compliance

FY 2013-2014 Remediation: 100% Compliance

C/QP5

AAW Performance Measure: Number of direct support staff for whom required training has been completed divided by number of direct support staff serving AAW participants in a given month. (Internal AAW Code: C/QP5)	FY 11-12	FY 12-13	FY 13-14	
DISCOVERY DATA				
<i>Numerator (N) = Direct support staff in compliance</i> <i>Denominator (D) = Direct support staff personnel files reviewed</i>	N	142	125	175
	D	151	126	178
	% (N/D)	94%	99%	98%
REMEDATION DATA				
	<i>Noncompliant</i>	9	1	3

	<i>Remediated</i>	9	1	3
	<i>% Remediated</i>	100%	100%	100%

State Discovery and Remediation

In FY 2011-12, 94% of provider staff monitored during annual quality monitoring was found to have completed the required trainings. That percentage increased to 99% and 98% in the two subsequent years.

Plans of Correction were issued to the appropriate providers to have staff complete required trainings. Completion of those trainings was documented as part of the plans of correction. Given the improvement in compliance with this performance measure in years 2 and 3, the level of noncompliance was determined not significant enough for an improvement project.

FY 2011-2012 Remediation: 100% Compliance

FY 2012-2013 Remediation: 100% Compliance

FY 2013-2014 Remediation: 100% Compliance

State Discovery Post Draft Report

The PM C/QP1 represents licensed providers only. Services with licensed providers are identified in the PM in the table. The PM C/QP2 represents all enrolled providers. The waiver does not require licensed providers for several services, so the number of licensed providers is less than the number of all enrolled providers.

For each PM including C/QP1 and C/QP2, the waiver asks for a representative sample but BAS reported on 100% of each category of providers. In the waiver renewal application, the BAS intends to request to change the representative sample for C/QP1 and C/QP2 to 100% review. A 100% sample is statistically valid and significant.

For the remainder of the performance measures related to this assurance, the sample size specified in the approved waiver is “less than 100% review” and consists of the providers who served the random sample of participants. The BAS used the sample size calculator at <http://www.raosoft.com/samplesize.html> each year to determine the appropriate and statistically-significant sample size for the sample of participants for each of the reporting years to arrive at a 90% confidence interval with +/- 10% margin of error, as specified in the approved waiver. The BAS then reviewed all staff that served the sample of participants, as specified in the approved waiver.

THIS CHART IS OFFERED BY BAS AS A REFERENCE FOR TABLES IN THE AAW REPORT

TABLE	PERFORMANCE MEASURES: QUALIFIED PROVIDERS	SAMPLING APPROACH	DENOMI- NATOR	DETAILS
C/QP1	Number of providers with a current license divided by total number of providers enrolled for services that require a license (i.e., day habilitation, residential habilitation, occupational therapy, speech/language therapy, family counseling, and nutritional consultation).	Less than 100% Review Representative Sample Confidence Interval 90% +/-10%	92, 112, 147	Licensed providers only. BAS used 100% even though waiver only required a sample.
C/QP2	Number of providers with a Medical Assistance Provider Agreement and an AAW Supplemental Agreement divided by number of providers enrolled in the AAW.	Less than 100% Review Representative Sample Confidence Interval 90% +/-10%	458, 573, 741	All providers BAS used 100% even though waiver only required a sample.
C/QP3	Number of direct support staff who meet age, education, and experience requirements in the AAW/Appendix C-3 divided by number of direct support staff serving AAW participants In a given month.	Less than 100% Review A random sample of participants. Confidence interval 90% Review provider staff that served the sample of participants for meeting standards.	151, 126, 178	All direct support staff reviewed during monitoring
C/QP4	Number of direct support staff for whom criminal background checks have been completed divided by number of direct support staff serving AAW participants in a given month.	Less than 100% Review A random sample of participants. Confidence interval 90% Review provider staff that served the sample of participants for meeting standards.	151, 126, 178	All direct support staff reviewed during monitoring
C/QP5	Number of direct support staff for whom required training has been completed divided by number of direct support staff serving AAW participants in a given month.	Less than 100% Review A random sample of participants. Confidence interval 90% Review provider staff that served the sample of participants for meeting standards.	151, 126, 178	All direct support staff reviewed during monitoring

CMS Final Response: The state substantially meets the assurance. The CMS does not have any recommendations for the state regarding this assurance.

Assurance IV. Health and Welfare of Waiver Participants

The state must demonstrate that, on an on-going basis, it identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.

Authority: 42 CFR 441.302-303; SMM 4442.4; SMM 4442.9; 1915(c) Version 3.5 HCBS Waiver Application and corresponding Instructions, Technical Guide & Review Criteria.

CMS Finding: The state meets the assurance with recommendations.

Background

Providers are required to enter critical incidents into the online reporting system, Enterprise Incident Management (EIM). The BAS staff checks EIM no less than once every 24 hours for alerts of the submission of a new incident involving a participant. The BAS reviews the initial incident report and follows up with the provider, if warranted. The BAS then reviews the final report on the incident, documents timeliness and sufficiency and provides direct technical assistance to the provider as needed.

In addition to monitoring and responding to critical incidents, the BAS holds quarterly Risk Management meetings comprised of Adult Autism Waiver managers from regional and central offices as well as the BAS clinical team members. Monthly incident report data is reviewed by participant, by provider, by region and by type of incident to highlight whether there is a pattern that suggests enhanced scrutiny may be necessary. Specific participants deemed by the BAS staff to be at risk of crisis or threat to their health and welfare are discussed. This discussion allows involved staff to benefit from perspectives of others and provides an opportunity to expand expertise within the group that may be helpful in supporting another participant in a similar situation in the future.

G/HW2

AAW Performance Measure: Number of reported critical incidents where a certified investigator found abuse and/or neglect divided by number of reported critical incidents where an investigation was required and finalized. (Internal AAW Code: G/HW2)	FY 11-12	FY 12-13	FY 13-14	
DISCOVERY DATA				
<i>Numerator (N) = Critical incidents where abuse and/or neglect was found</i>	N	2	3	5
	D	2	3	8
	% (N/D)	100 %	100 %	63%
REMEDIATION DATA				
<i>Remediated</i>	2	3	5	
<i>% Remediated</i>	100 %	100 %	100%	

State Discovery and Remediation

Adult Autism Waiver providers are required to investigate critical incidents that require investigation, including abuse and neglect, when they occur at the provider's site or when a participant was receiving services from that provider at time of occurrence. Incidents of abuse or neglect that take place at other times are subject to investigation by the participant's Supports

Coordination provider. Investigators must have been trained and received a certificate in investigation from ODP as communicated via Mental Retardation Bulletin 00-01-06, issued September 6, 2001. Investigators' reports are entered into EIM and must be submitted within 30 days of the incident's recognition or discovery.

In FY 2011-12, both critical incident reports of abuse or neglect were confirmed by a certified investigator. Appropriate corrective action was taken by the provider in both instances. In FY 2012-13, all three reported incidents of abuse or neglect were confirmed by a certified investigator. In the case of abuse, the participant was removed from the home to live with another family member. In the two cases of neglect, the participant changed to another provider. In FY 2013-14, five reported incidents of abuse or neglect were confirmed by a certified investigator and three were unconfirmed. In three of the five confirmed incidents, the staff members involved were terminated from their positions. The other two incidents involved family members where the teams supporting the participants have provided the needed corrective action to assure health and welfare.

FY 2011-2012 Remediation: 100% Compliance

FY 2012-2013 Remediation: 100% Compliance

FY 2013-2014 Remediation: 100% Compliance

G/HW3

AAW Performance Measure: Number of participants interviewed by BAS who reported that someone hit or hurt them physically divided by number of participants BAS interviewed. (Internal AAW Code: G/HW3)	FY	FY	FY
	11-12	12-13	13-14
DISCOVERY DATA			
<i>Numerator (N) = Participants who reported someone hit or hurt them physically</i> <i>Denominator (D) = Participants interviewed</i>	N	1	0
	D	54	56
	% (N/D)	2%	0%

State Discovery and Remediation

This performance measure is written in terms of a negative outcome, i.e., the best outcome is zero percent. In FY 2011-12, one participant who was interviewed reported being hit or hurt by someone not associated with waiver services. The incident involved strangers in the community. The BAS interviewer spoke to the participant at length about the need for stranger awareness and safety in the community. She also contacted the supports coordinator to brief the supports coordinator on the interview. The BAS confirmed that the participant's ISP included "Stranger Awareness" as an area of need and included a goal related to community safety and stranger awareness. No interviewed participants reported being hit or hurt in FY 2012-13 or FY 2013-14.

The BAS will continue to interview participants during annual monitoring activities to discover unreported instances of incidents and to ensure their health and welfare and follow-up as appropriate to ensure participant health and welfare.

FY 2011-2012 Remediation: 98% Compliance

FY 2012-2013 Remediation: 100% Compliance

FY 2013-2014 Remediation: 100% Compliance

G/HW4

AAW Performance Measure: Number of participants interviewed by BAS who reported they do not feel safe where they live divided by number of participants BAS interviewed. (Internal AAW Code: G/HW4)	FY 11-12	FY 12-13	FY 13-14
DISCOVERY DATA			
<i>Numerator (N) = Participants who do not feel safe where they live</i> <i>Denominator (D) = Participants interviewed</i>	N	0	0
	D	54	56
	% (N/D)	0%	0%

State Discovery and Remediation

This performance measure is written in terms of a negative outcome, i.e., the best outcome is zero percent. None of the participants interviewed as part of the monitoring sample reported not feeling safe where they lived. No follow-up or improvement needed.

FY 2011-2012 Remediation: 100% Compliance

FY 2012-2013 Remediation: 100% Compliance

FY 2013-2014 Remediation: 100% Compliance

G/HW5

AAW Performance Measure: Number of participants interviewed by BAS who reported staff yells or screams at them divided by number of participants BAS interviewed. (Internal AAW Code: G/HW5)	FY 11-12	FY 12-13	FY 13-14
DISCOVERY DATA			
<i>Numerator (N) = Participants who reported staff yell or scream at them</i> <i>Denominator (D) = Participants interviewed</i>	N	2	0
	D	54	56
	% (N/D)	4%	0%

REMEDIATION DATA				
	<i>Noncompliant</i>	2	0	2
	<i>Remediated</i>	2	0	2
	<i>% Remediated</i>	100 %	NA	100 %

State Discovery and Remediation

This performance measure is written in terms of a negative outcome, i.e., the best outcome is zero percent. In FY 2011-12, two instances involved the same provider. One staff person was removed from working with the participant; the other staff was reprimanded. In FY 2013-14, two instances involved a different single provider who removed both staff.

The BAS will continue to interview participants during annual monitoring activities to discover unreported instances of incidents and to ensure their health and welfare and follow-up as appropriate to ensure participant health and welfare. The BAS will continue to convey expectations of best practices to waiver providers, including their responsibility to ensure that staff treats participants with respect.

FY 2011-2012 Remediation: 100% Compliance

FY 2012-2013 Remediation: 100% Compliance

FY 2013-2014 Remediation: 100% Compliance

Table G/HW7

AAW Performance Measure: Number of critical incident reports indicating psychiatric hospitalizations divided by total number of waiver participants. (Internal AAW Code: G/HW7)	FY 11-12	FY 12-13	FY 13-14	
DISCOVERY DATA				
	N	13	17	19
<i>Numerator (N) = Critical incidents indicating psychiatric hospitalization</i>	D	280	301	406
<i>Denominator (D) = Enrolled participants</i>	% (N/D)	5%	6%	5%

State Discovery and Remediation

This performance measure is written in terms of a negative outcome, i.e., the best outcome is zero percent. The number of psychiatric hospitalizations reflects multiple hospitalizations by a small number of participants. The performance measure therefore does not reflect the percent of participants who experienced psychiatric hospitalization. In FY 2011-12, 5 participants (or 1.8%) accounted for 13 hospitalizations; in FY 2012-13, 7 participants (or 2.3%) accounted for 17 hospitalizations; and in FY 2013-14, 10 participants (or 2.5%) accounted for 19 hospitalizations.

Participants who experience psychiatric hospitalizations are considered to be at high risk. Their progress is followed closely by the BAS staff and each participant’s support team meets to address behavioral and psychiatric needs in order to reduce future psychiatric hospitalizations. When additional expertise is warranted, the BAS accesses external resources to provide technical assistance. While waiver services are not available to the participant during hospitalization, the BAS staff stays informed about discharge planning to ensure that necessary services are in place when the participant returns to the community.

FY 2011-2012 Remediation: 95% Compliance

FY 2012-2013 Remediation: 94% Compliance

FY 2013-2014 Remediation: 95% Compliance

G/HW8

AAW Performance Measure: Number of critical incidents involving police intervention because a participant is charged with a crime or is the subject of a police investigation that may lead to criminal charges; a participant causes an event, such as pulling a fire alarm, that requires involvement of police; or a crisis intervention involving police/law enforcement personnel divided by total number of waiver participants. (Internal AAW Code: G/HW8)	FY 11-12	FY 12-13	FY 13-14	
DISCOVERY DATA				
<i>Numerator (N) = Critical incidents involving police intervention</i>	N	3	5	8
<i>Denominator (D) = Enrolled participants</i>	D	280	301	406
	% (N/D)	1%	2%	2%

State Discovery and Remediation

This performance measure is written in terms of a negative outcome, i.e., the best outcome is zero percent. Incidents involving law enforcement are tracked as a distinct category and reviewed during quarterly Risk Management meetings.

In every case, the participant's team met to address the reasons for the police involvement and revise the participant's services, goals and objectives as the team deemed appropriate in order to prevent future occurrences. The BAS will continue to provide technical assistance and support to the teams involved with participants at risk of law enforcement involvement, as needed in each case.

FY 2011-2012 Remediation: 99% Compliance

FY 2012-2013 Remediation: 98% Compliance

FY 2013-2014 Remediation: 98% Compliance

G/HW6

AAW Performance Measure: Number of critical incident reports indicating the use of restraint, including improper or unauthorized use of restraint, divided by total number of waiver participants. (Internal AAW Code: G/HW6)	FY 11-12	FY 12-13	FY 13-14	
DISCOVERY DATA				
<i>Numerator (N) = Critical incidents indicating the use of restraint</i> <i>Denominator (D) = Critical incidents reported</i>	N	0	0	1
	D	280	301	406
	% (N/D)	0%	0%	.24%

State Discovery and Remediation

This performance measure is written in terms of a negative outcome, i.e., the best outcome is zero percent. In the three years being reported, one participant was subject to unauthorized restraint, in FY 2013-14. A restraint report was filed for that individual. The participant experienced a psychiatric hospitalization in conjunction with the restraint incident. Before the participant was discharged from the hospital, the provider withdrew from the ISP and no longer served the participant. The participant changed providers shortly thereafter.

The BAS continues to closely monitor instances of restraint to ensure the health and welfare of participants, identify patterns of use of restraint by participant or by provider, and provide appropriate training or technical assistance.

FY 2011-2012 Remediation: 100% Compliance

FY 2012-2013 Remediation: 100% Compliance

FY 2013-2014 Remediation: 99.99% Compliance

G/HW1

AAW Performance Measure: Number of reported critical incidents where BAS approved the provider’s initial submission of the final report divided by total number of reported critical incidents. (Internal AAW Code: G/HW1)	FY 11-12	FY 12-13	FY 13-14	
DISCOVERY DATA				
<i>Numerator (N) = Critical incidents where BAS approved the provider’s initial submission</i> <i>Denominator (D) = Critical incidents reported</i>	N	47	67	71
	D	67	119	128
	% (N/D)	70%	56%	55%
REMEDIATION DATA				
<i>Critical incidents revised/updated with technical assistance and approved</i>	20	52	57	
<i>Remediated</i>	20	52	57	
<i>% Remediated</i>	100%	100%	100%	

State Discovery and Remediation

Submission of an incident report is done in two parts: the First Section, and within 30 days, submission of a Final Section. The BAS reviews all initial reports to ensure that participant health and welfare is protected and all necessary immediate actions have been taken. The BAS also reviews incident reports to verify that the provider filing the report is properly following waiver incident management requirements and addressing any necessary follow-up actions. If the provider is not, the BAS contacts the provider and the supports coordinator to ensure that follow-up action is taken. The BAS also reviews the Final Section to approve or reject it. The BAS has required some providers to expand or improve the level of detail in their final reports before they may be approved. In other cases, where the category of the incident is incorrect (for example, the First Section category is ER Visit, but the participant is later admitted to the hospital and the category must be changed to Hospitalization), the BAS will reject the Final Section if the correction has not been made.

Some incident reports were rejected for insufficient description of corrective actions or insufficient description of remediation activities to prevent recurrence. When a final report is deemed to be insufficiently detailed, or fails to include proper follow-up actions, the BAS works directly with the provider to remediate those insufficiencies as well as provide technical assistance in understanding the reasons for the report not being approved as submitted. This

technical assistance is designed to improve the quality of incident response and reporting in the future. The BAS conducted and recorded a web-based training in February 2014 for all Adult Autism Waiver providers on incident management requirements, including what information is needed in incident reports so that they will be approved by the BAS upon initial submission. The BAS is considering additional strategies such as requiring additional training or developing an incident reporting checklist to improve compliance and reduce the need for individual technical assistance.

FY 2011-2012 Remediation: 100% Compliance

FY 2012-2013 Remediation: 100% Compliance

FY 2013-2014 Remediation: 100% Compliance

State Discovery Post Draft Report

The sample sizes are identical to the sample sizes specified in the CMS-approved waiver. A table at the end of the recommendations and response for Assurance IV summarizes the measures, the sampling approach approved in the waiver, and the sample sizes for evidence presented in the AAW.

The cases reviewed for the PMs G/HW3, G/HW4 and G/HW5 are based on a random sample and are the same cases for each PM. The PMs are based on interviews of participants from a statistically representative sample drawn separately each year as the basis for annual monitoring reviews. This sample meets the 90% confidence level, +/- 10% margin of error consistent with the approved waiver.

The denominator for FY 2011/12 is 285; for FY 2012/13 it is 303; for FY 2013/14 it is 406. The unduplicated number of people served was 288 in year 1, state FY 2011/12; 306 in year 2, state FY 2012/13; and 427 in year 3, state FY 2013/14. The denominators do not exceed the unduplicated count in any instance.

The BAS mislabeled the denominator in the table in HW6 in the Quality Review and Assessment Report. In the CMS-approved waiver, the denominator for both HW6 and HW8 is 'the total number of waiver participants'. The data for the PMs are correct and the sampling was performed according to the CMS-approved waiver. Only the term in the report for HW6 was in error.

For those PMs based on a sample of participants (HW3, HW4 and HW5), the BAS used the sample size calculator at <http://www.raosoft.com/samplesize.html> each year to determine the appropriate and statistically-significant sample size for each of the reporting years to arrive at a 90% confidence interval with +/- 10% margin of error, as specified in the approved waiver.

For PMs HW1, HW2, HW6, HW7 and HW8, the sample size is 100% of applicants or participants who meet the criteria of the performance measure, which is statistically significant.

The BAS will revise these PMs to frame them as positive outcomes as part of the waiver renewal in 2016.

During quarterly Risk Management meetings, the BAS reviews data and analysis of critical incidents by participant, by provider and by type of incident. This analysis highlights whether particular participants are experiencing repeated incidents. Specific participants who are deemed to be at elevated risk, either as demonstrated by their frequency of incidents or for other reasons that may not include any incidents, are discussed and the BAS response to date is reviewed at the quarterly Risk Management meetings. Two BAS staff members, one on the Clinical Team and one in the BAS Regional Office, provide oversight of every participant. Those participants demonstrated or suspected of being at elevated risk (identified through analysis of incident data, review of service notes or communication with the Supports Coordinator or other providers) are followed more closely and targeted technical assistance is provided to the participant's support team, including more frequent consultation with specific providers (particularly the Behavioral Specialist, if the participant receives that service) or review at the quarterly Risk Management meetings, or a combination of those activities.

During quarterly Risk Management meetings, BAS reviews data and analysis of critical incidents by participant, by provider and by type of incident. This analysis highlights whether particular participants are experiencing repeated incidents. Specific participants who are deemed to be at elevated risk, either as demonstrated by their frequency of incidents or for other reasons that may not include any incidents, are discussed and the BAS response to date is reviewed at the quarterly Risk Management meetings. Two BAS staff members, one on the Clinical Team and one in the BAS Regional Office, provide oversight of every participant. Those participants demonstrated or suspected of being at elevated risk (identified through analysis of incident data, review of service notes or communication with the Supports Coordinator or other providers) are followed more closely and targeted technical assistance is provided to the participant's support team, including more frequent consultation with specific providers (particularly the Behavioral Specialist, if the participant receives that service) or review at the quarterly Risk Management meetings, or a combination of those activities.

On a systemic level, the BAS, through its ASERT (Autism Services, Education, Resources and Training) collaborative, has sponsored the development of several training studies and protocols for first responders, emergency room personnel and justice system staff to promote understanding and familiarity with the characteristics of autism spectrum disorder (ASD) and how better to interact with individuals on the spectrum with whom they may come into contact. Articles describing the training protocol for pre-hospital and emergency room personnel, ACT (Assess, Communicate, Treat) have been published in the Journal of Autism and Developmental Disorders, Child and Adolescent Psychiatry Clinics of North America and the Pennsylvania Patient Safety Advisory. Trainings have already been conducted and future trainings are scheduled for adult and juvenile probation and parole officers, detention and corrections staff, residential treatment facility staff and children and youth workers. ASERT is

developing a training manual for justice system personnel including probation officers, judges, magistrates, district attorneys and police who may come into contact with individuals with ASD. Training will include videos and face-to-face forums. A Justice Training webinar is expected to be completed and be available on the ASERT website (PAautism.org) in the Fall of 2015.

ASERT has also developed a training that has been added to the Crisis Intervention Training curriculum for police officers in Philadelphia, including an introduction to ASD and strategies/tools for communicating with individuals with ASD. It is also partnering to develop an ASD-specific supplement to add to the Mental Health First Aid curriculum which is widely used in training law enforcement professionals and other first responders.

THIS CHART IS OFFERED BY BAS AS A REFERENCE FOR TABLES IN THE AAW REPORT

TABLE	PERFORMANCE MEASURES: HEALTH & WELFARE	SAMPLING APPROACH	DENOMI- NATOR	DETAILS
G/HW1	Number of reported critical incidents where BAS approved the provider's initial submission of the final report divided by total number of reported critical incidents.	100% Review	67, 119, 128	All critical incidents
G/HW2	Number of reported critical incidents where a certified investigator found abuse and/or neglect divided by number of reported critical incidents where an investigation was required and finalized.	100% Review	2, 3, 8	Reports of abuse and neglect only
G/HW3	Number of participants interviewed by BAS who reported that someone hit or hurt them physically divided by number of participants BAS interviewed.	Less than 100% Review Representative Sample Confidence Interval 90% +/-10%	54, 56, 56	All monitored participants
G/HW4	Number of participants interviewed by BAS who reported they do not feel safe where they live divided by number of participants BAS interviewed.	Less than 100% Review Representative Sample Confidence Interval 90% +/-10%	54, 56, 56	All monitored participants
G/HW5	Number of participants interviewed by BAS who reported staff yells or screams at them divided by number of participants BAS interviewed.	Less than 100% Review Representative Sample Confidence Interval 90% +/-10%	54, 56, 56	All monitored participants
G/HW6	Number of critical incident reports indicating the use of restraint, including improper or unauthorized use of restraint, divided by total number of waiver participants.	100% Review	280, 301, 406	All enrolled participants; not just those enrolled for 12 months

G/HW7	Number of critical incident reports indicating psychiatric hospitalizations divided by total number of waiver participants.	100% Review	280, 301, 406	All enrolled participants; not just those enrolled for 12 months
G/HW8	Number of critical incidents involving police intervention because a participant is charged with a crime or is the subject of a police investigation that may lead to criminal charges; a participant causes an event, such as pulling a fire alarm, that requires involvement of police; or a crisis intervention involving police/law enforcement personnel divided by total number of waiver participants.	100% Review	280, 301, 406	All enrolled participants; not just those enrolled for 12 months

CMS Final Response: The state meets the assurance with recommendations.

- The state has chosen to frame some PMs as a negative outcome which can be misleading and confusing. The CMS recommends the state amend the PMs to accentuate that the data reflects the required level of compliance to promote consistency and clarity
- The CMS recommends the state continue to develop monitoring systems that track those beneficiaries that are at high risk and have repeated problems and improvements implemented by the state (i.e. critical incidents and/or psychiatric hospitalizations).

Assurance V. State Medicaid Agency Retains Administrative Authority over the Waiver Program

The state demonstrates that it retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies and contracted entities.

Authority: 42 CFR 441.301-303; 42 CFR 431 et seq.; SMM 4442.6; SMM 4442.7; 1915(c) Version 3.5 HCBS Waiver Application and corresponding Instructions, Technical Guide & Review Criteria.

CMS Finding: The state meets the assurance.

Background

The Department of Human Services (DHS) is the single State Medicaid Agency responsible for administering HCBS in Pennsylvania. The DHS has an interagency agreement with the Office of Developmental Programs (ODP), Bureau of Autism Services (BAS), establishing the BAS to be the operating agency that develops policies and procedures for waiver operations and determines functional eligibility.



The BAS contracts with assessors in the eastern part of Pennsylvania to conduct the functional eligibility application (FEA) which is part of the eligibility determination process. The BAS staff conducts all other FEA's throughout the state. The date of the assessment must be scheduled within 10 days of the assignment. The assessment must be submitted to BAS within five (5) days of the date of the assessment.

A/AA1

AAW Performance Measure: Number of applicants who receive a functional eligibility determination within 30 days of BAS receipt of an application divided by total number of applications received by BAS. (Internal AAW Code: A/AA1)	FY 11-12	FY 12- 13	FY 13- 14	
DISCOVERY DATA				
<i>Numerator (N) = Functional eligibility determinations in compliance</i>	N	24	24	105
	D	34	39	133
	<i>Denominator (D) = Functional eligibility determinations conducted</i>	% (N/D)	71%	62%
REMEDICATION DATA				
<i>Noncompliant</i>	10	15	28	
<i>Remediated within 31-40 days</i>	3	6	15	
<i>Remediated within 41-50 days</i>	5	2	6	
<i>Remediated within 51+ days</i>	2	7	7	
<i>Total remediated</i>	10	15	28	
<i>% Remediated</i>	100%	100%	100%	

State Discovery and Remediation

In FY 2011-12, three contracted assessors completed 38% of the FEAs; in FY 2012-13, two contracted assessors completed 44% of FEAs; and in FY 2013-14, two contracted assessors completed 38% of all FEAs. All other FEAs were conducted by the BAS staff. The BAS works closely with contracted assessors to address situations that may lead to a delay. If the contracted assessor will not be available when the applicant wishes to schedule the assessment, the BAS staff will conduct the assessment. If the applicant is delaying the scheduling of the meeting or is proposing a time several weeks in the future, the BAS staff will contact the applicant or their representative to emphasize the urgency of completion of the FEA. When extraordinary circumstances arise on the part of the applicant or their family member such as major illness, the BAS allows extra time for the assessment to be completed.

The BAS is currently further analyzing the data related to this performance measure in order to inform the design of improvement activities and evaluation of their effectiveness to meet the standard. Among the improvement strategies being considered: additional training of assessors

on timelines for scheduling and submitting assessments; enhanced communication with applicants on the timeframe for completion of this part of the application process; additional support from the BAS to the assessor when there are impediments to completing the assessment within the required timeline. This improvement project is expected to be completed by December 31, 2014.

FY 2011-2012 Remediation: 100% Compliance

FY 2012-2013 Remediation: 100% Compliance

FY 2013-2014 Remediation: 100% Compliance

A/AA2

AAW Performance Measure: Number of initial functional eligibility determinations where BAS agrees with the decision after a review of documentation is complete divided by the number of initial functional eligibility determinations reviewed by BAS. (Internal AAW Code: A/AA2)		FY 11-12	FY 12-13	FY 13-14
DISCOVERY DATA				
<i>Numerator (N) = Initial FEAs reviewed where BAS agrees with the determination</i>	N	8	10	36
	D	9	10	38
	% (N/D)	89%	100%	95%
<i>Denominator (D) = Initial FEAs determinations reviewed</i>				
REMEDATION DATA				
<i>Noncompliant</i>		1	0	2
<i>Remediated</i>		1	0	2
<i>% Remediated</i>		100%	NA	100%

State Discovery and Remediation

The BAS reviews every fifth FEA conducted by each assessor, both contracted assessors and the BAS staff. In addition, the BAS reviews every FEA where the applicant is found to not meet functional eligibility or where the applicant is found to have substantial functional limitations in only three of the six major life activities listed in Appendix B-1-b of the Waiver Management System (WMS) application tool.

When the BAS review of an FEA finds disagreement with the assessor, the reviewer contacts the assessor (both contracted as well as BAS staff assessors) to discuss the evaluation and gather more information to inform the review. Of the three (3) instances where there was disagreement, the reviewer overturned the assessor's determination of ineligibility. This action was accompanied by discussion of the reasons for overturning the decision and technical assistance to the assessor.

FY 2011-2012 Remediation: 100% Compliance

FY 2012-2013 Remediation: 100% Compliance

FY 2013-2014 Remediation: 100% Compliance

State Discovery Post Draft Report

The sample sizes are identical to the sample sizes specified in the CMS-approved waiver. A table summarizes the measure for Assurance V, the sampling approach approved in the waiver, and the sample size for evidence presented in the AAW report.

For performance measure A/AA1, the sample is 100% of applicants for each fiscal year. The denominator increased significantly for year 3, state FY 2013/14, because the capacity for the AAW was funded to expand by 115 additional participants. Please note the number of applicants, people applying for newly available capacity, is less than the total number of waiver participants. The total number of waiver participants includes people who applied in previous years and remain enrolled in the waiver.

For performance measure A/AA2, the waiver asks for a stratified sample. That is, all the Functional Eligibility Assessments (FEAs) where the applicant met criteria in three or fewer areas and 20% of all FEAs where the applicant met criteria in four or more areas, consistent with the approved waiver.

After analyzing data related to the timeframes for completion of the FEAs, the BAS has implemented a process for scheduling FEAs if an assessor is not able to schedule a visit with an applicant within the prescribed 10-day timeframe. In that situation, the assessor now notifies the enrollment coordinator in the regional office and the enrollment coordinator reassigns the assessment to another assessor and will assist in scheduling the assessment, as needed. Additional BAS staff are now trained to perform the FEA and enrollment coordinators have enhanced communication with applicants to convey the importance of timely completion of this step in the application process. Regardless of the assessor (contracted or staff), the enrollment coordinator verifies that the assessment is completed and intervenes if necessary to ensure that the assessment is completed. This improvement project was completed by December 31, 2014. Beginning March 2015, BAS monitors the effectiveness of this initiative on a quarterly basis by evaluating aggregate data to identify opportunities for systemic improvement if needed.

THIS CHART IS OFFERED BY BAS AS A REFERENCE FOR TABLES IN THE AAW REPORT

TABLE	PERFORMANCE MEASURES: ADMINISTRATIVE AUTHORITY	SAMPLING APPROACH	DENOMI- NATOR	DETAILS
A/AA1	Number of applicants who receive a functional eligibility determination within 30 days of BAS receipt of an application divided by total number of applications received by BAS.	100% Review	34, 39, 133	All applicants
A/AA2	Number of initial functional eligibility determinations where BAS agrees with the decision after a review of documentation is complete divided by the number of initial functional eligibility determinations reviewed by BAS.	Less than 100% Review Stratified Sample 100% of denials 100% of approvals with substantial functional limitations in only 3 of the 6 major life activities listed in Apdx B-1-b. 20% of all remaining approvals.	9, 10, 38	FEAs reviewed

CMS Final Response: The state meets the assurance with required recommendations.

- The BAS did not meet the financial assurance for this evidentiary-based review (EBR) and the CMS is concerned regarding the states administrative authority oversight in this area. The BAS is required to provide a quarterly report on the state’s administrative oversight for the activities regarding the financial assurance and the work plan progress that is required under Assurance VI.
- The BAS evidence shows one (1) quality improvement project implemented and being analyzed for effectiveness. The BAS is required to provide an updated report for this QIP quarterly (no later than September 30, 2015, December 31, 2015 and at the time of submission of the renewal). The QIP must include the details of each QIP, if the QIP is effective, interventions that have been explored, status to date, specifics on timelines, communication strategies, support and training improvements, and overall monitoring changes. The QIP must include the data for the PM including remediation completed.
- At the time of renewal, the BAS will be required to develop and implement PMs that address the following areas of the administrative authority:
 - Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
 - Equitable distribution of waiver openings in all geographic areas covered by the waiver unless the state has waived the requirement of state-wideness.
 - Compliance with HCBS settings requirements and other new regulatory components



Assurance VI. State Provides Financial Accountability for the Waiver

The state demonstrates financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

Authority: 42 CFR 441.302-303; 42 CFR 441.308; 42 CFR 447.10; 42 CFR 447.200-205; 45 CFR 74; 42 CFR 443; SMM 2500; SMM 2700.6; SMM 4442.8-10; 1915(c) Version 3.5 HCBS Waiver Application and corresponding Instructions, Technical Guide & Review Criteria.

CMS Finding: The state does not meet the assurance.

Background

Providers are reimbursed on a statewide fee for service basis for Behavioral Specialist Services, Community Inclusion, Day Habilitation, Family Counseling, Family Training, Job Finding, Nutritional Consultation, Residential Habilitation, Respite, Supported Employment, Supports Coordination, Temporary Crisis, Therapies, and Transitional Work Services. The rates for this program are published for all providers, the fee schedule has no regional variation, and there is no cost settlement.

For Assistive Technology, Community Transition Services and Environmental Modifications, providers are reimbursed at the invoice cost for the service or equipment provided. Total costs may not exceed limits for each service in Appendix C-3 of the WMS application tool.

The BAS contracted with Mercer Government Human Services Consulting (Mercer) to develop the rates for those services that are paid based on a statewide fee schedule. In developing payment rates for these services, Mercer's methodology contained an analysis of four key components: direct care salary expenses, employee related expenses, program indirect expenses and administrative expenses. Mercer conducted a compensation study to determine the appropriate wage or salary expense for the direct care workers providing each service. Mercer reviewed wage data provided by the Bureau of Labor Statistic (BLS) and other national sources to develop service-specific base wage rates based on the staffing requirements and roles and responsibilities of the worker. This component is the most significant portion of the total payment rate.

In developing the other three rate components, Mercer and the BAS first discussed the allowable costs to be funded through each service and included only allowable indirect and administrative expenses. Mercer used this information to develop rates that comply with the requirements of Section 1902(a)30(A) of the Social Security Act and the related federal regulations at 42 CFR 447.200 – 205. The BAS reviews provider enrollment and retention for each service annually to ensure that access to care and adequacy of payments are maintained.

The OMAP reimburses qualified providers through the Medicaid Management Information System (MMIS), called the Provider Reimbursement and Operations Management Information System (PROMISE). Payments are made directly to the provider of record.

AAW Performance Measure: Number of claims for which provider documentation indicates services were provided as billed divided by total number of claims paid for a sample of participants. (Internal AAW Code: I/FA1)	FY 11-12	FY 12-13	FY 13-14	
DISCOVERY DATA				
<i>Numerator (N) = Claims supported by documentation</i> <i>Denominator (D) = Services reviewed</i>	N	150	125	140
	D	156	135	149
	% (N/D)	96%	93%	94%
REMEDICATION DATA				
<i>Noncompliant</i>	6	10	9	
<i>Remediated via funds returned</i>	3	1	0	
<i>Remediated via documentation submitted</i>	2	7	1	
<i>Remediated via training/technical assistance</i>	0	1	8	
<i>Disenrolled</i>	1	1	0	
<i>Total remediated</i>	6	10	9	
<i>% Remediated</i>	100%	100%	100%	

State Discovery and Remediation

During annual monitoring activities, the BAS reviews documentation for paid claims over the two quarters prior to the monitoring visit. This includes examination of time sheets, monthly progress notes and encounter forms. For Supports Coordination agencies, review includes service notes entered into HCSIS on an ongoing basis. The BAS reviews for consistency of day and time between the documentation and the claim as well as documentation supporting the number of units being billed.

Providers who submitted claims that were insufficiently documented were issued Plans of Correction to either correct the documentation or adjust the claim to return funds paid. The BAS continues to monitor providers, cite them for non-compliance and require remediation. The BAS also provides technical assistance and guidance to providers, including a suggested encounter form that meets the documentation requirement for billing. This form was developed in consultation with the DHS Bureau of Financial Operations, and its adoption by Adult Autism Waiver providers has expanded since it was issued in September 2012. In addition, the BAS is collaborating with other staff from the ODP to improve oversight processes and documentation requirements specific to billing and remediation for financial accountability.

FY 2011-2012 Remediation: 100% Compliance

FY 2012-2013 Remediation: 100% Compliance

FY 2013-2014 Remediation: 100% Compliance

State Discovery Post Draft Report

For performance measure I/FA1, the sample size specified in the approved waiver is “less than 100% review.” BAS used the sample size calculator at <http://www.raosoft.com/samplesize.html> each year to determine the appropriate and statistically-significant sample size for the sample of participants for each of the reporting years to arrive at a 90% confidence interval with +/- 10% margin of error, as specified in the approved waiver.

The denominator the BAS used for this measure is “Services reviewed” and the numerator is “Claims supported by documentation.” The BAS reviewed claims submitted by providers and paid by DHS during each monitoring cycle for the sample of participants. The review period was specified to be at least two fiscal year quarters prior to the monitoring date. The reviewers monitored that documentation existed to substantiate that each service was provided as billed and only for services rendered. When reviewers found discrepancies for any particular provider, that provider was required to submit and complete a plan of correction which was then approved by the reviewer upon completion. Remediation included completing necessary documentation or recoupment of funds paid.

The CMS asked questions regarding variance between estimated and actual costs in response to the 372 Report for year 2, state FY 2012/13. Pennsylvania answered these questions and the report was approved March 3, 2015. The explanation from Pennsylvania is below:

“Billing rates among providers increased during this year. In previous years, providers were not billing all services within the required six-month time frame. BAS worked with providers during SFY 2011-12 to improve billing timeliness, including providers for these services.

In addition, the 372 for FY 2012/2013 looks back at the second year of the waiver renewal. Because of lags in enrollment, authorization of services, and provider billing, the waiver contains utilization estimates based on data available when the first amendment of the renewal was initially submitted (March 2013). A subsequent amendment submitted in December 2013 added capacity in year 3. In this amendment, utilization estimates for years 3-5 were revised to reflect more complete data available at that time.”

Each year since the 2011 renewal, Pennsylvania has amended AAW to add capacity. These amendments include updated cost estimates based on the most recent claims data available at that time. The average cost per person has increased over time as provider billing has increased. Before year 1 of the waiver, state FY 2011-12, providers were not billing all services within the required six-month time frame. The BAS worked with providers during that year to improve billing timeliness.

Each year since the 2011 renewal, Pennsylvania has amended AAW to add capacity. These amendments include updated cost estimates based on the most recent claims data available at that time. For most services, the average cost per person has increased over time as provider billing has increased. This increase more than off-sets the cost savings from services no participants have used.

Community Transition Services has not been used because no waiver participant has transitioned from an institution to the waiver. All other services except for occupational therapy have been used in previous years. For services that no or very few beneficiaries are using, the Individual Support Plan (ISP) planning teams—the participant, his or her legal representative, and other individuals the participant selected—have not selected these services to meet the participant’s goals in the ISP.

The trends for each service are documented in the CMS 372 reports. Also, each year since the 2011 renewal, Pennsylvania has amended AAW to add capacity. These amendments include updated cost estimates based on the most recent claims data available at that time.

Communication with beneficiaries regarding available services occurs as specified in Appendix D-1-a of the waiver, subsection (c): “To ensure the participant is aware of all service options, BAS provides each participant a list of Adult Autism Waiver services with brief, easy-to-understand definitions for each service when the person is determined eligible for the Adult Autism Waiver. The service list is available at any time upon request and available on the Internet.”

Regarding the review of services from a quality management perspective, the BAS reviews each ISP for the appropriateness of services to the participant’s assessed needs and desired goals. The BAS may recommend different or additional services when appropriate based on its review. Also, the BAS interviews with a random sample of participants include questions regarding whether the person has an unmet need, as specified in PM D/SP5.

The average cost per person has increased over time as provider billing has increased. Before year 1 of the waiver, state FY 2011-12, providers were not billing all services within the required six-month time frame. The BAS worked with providers during that year to improve billing timeliness. While the increase in the size of the waiver between years 1 and 2 was 6%, the increase between years 2 and 3 was 40 percent.

The average cost per person has increased over time as provider billing has increased. Before year 1 of the waiver, state FY 2011-12, providers were not billing all services within the required six-month time frame. The BAS worked with providers during that year to improve billing timeliness. While the increase in the size of the waiver between years 1 and 2 was 6%, the increase between years 2 and 3 was 40 percent.

As found in Section B-3-f of the approved waiver, “BAS prioritizes entry into the waiver based on four criteria: use of long-term support services; geographic distribution of capacity; a lottery that was held to help determine the

order of application for requests for service during the first six weeks of the waiver; and the date and time of requests for service received after the first six weeks of the waiver.

“- Use of Long-Term Support Services

“Since the intent of the Adult Autism Waiver is to serve new individuals, BAS prioritizes entry as follows:

“Priority 1. People not receiving ongoing state funded or state and Federally funded long-term support services (e.g., Medicaid HCBS Waiver supports; ICF/ID; nursing facility; services in an Institution for Mental Disease; Community Residential Rehabilitation Services; services in a Long-Term Structured Residence; Residential Treatment Facility; and extended acute care for people with serious mental illness).

“- Priority 2. If waiver capacity remains, the waiver will serve people who do not meet Priority 1 criteria. Priority 2 individuals will only receive applications if waiver capacity remains available after all Priority 1 individuals across the Commonwealth have had their applications processed.

“- Geographic Distribution

“Within each priority group, BAS allocates waiver capacity on a regional basis to ensure access across the Commonwealth. Four regions are defined as follows:

“West: Allegheny, Armstrong, Beaver, Butler, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Fayette, Forest, Greene, Indiana, Jefferson, Lawrence, McKean, Mercer, Potter, Venango, Warren, Washington, and Westmoreland Counties

“Central: Adams, Bedford, Blair, Cambria, Centre, Clinton, Columbia, Cumberland, Dauphin, Franklin, Fulton, Huntington, Juniata, Lancaster, Lebanon, Lycoming, Mifflin, Montour, Northumberland, Perry, Snyder, Somerset, Union, and York Counties

“Southeast: Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties

“Northeast: Berks, Bradford, Carbon, Lackawanna, Lehigh, Luzerne, Monroe, Northampton, Pike, Schuylkill, Sullivan, Susquehanna, Tioga, Wayne, and Wyoming Counties

“BAS initially allocated capacity to each region based on the percentage of Pennsylvania’s population age 20 or older, according to the U.S. Census Bureau’s 2006 Current Population Estimates. The population of 20 and older was used because these data were easily available on the Census Bureau’s Web site. Once enrolled, participants may move anywhere in the Commonwealth and continue to be enrolled in the waiver.

“When BAS adds new capacity, it will add capacity to each region so that the total waiver capacity is allocated in proportion to Pennsylvania’s population age 21 or older in each region, according to the most recent version of the U.S. Census Bureau’s Current Population

Estimates. The population of age 21 and older will be used in the future because data for this age group by county is now readily available from the U.S. Census Bureau.

“- Lottery for Requests for Service during the First Six Weeks

“When the waiver began on July 1, 2008, the Commonwealth collected requests for services for a six-week period using the Intake Process described below. Then BAS randomly assigned a number to each Priority 1 individual for whom services were requested during the six-week period. Applications have been sent to all Priority 1 individuals who received a randomly assigned number. There are no Priority 1 individuals on the interest list for the Adult Autism Waiver from the initial six-week period.

“BAS also randomly assigned a number to each Priority 2 individual for whom services were requested during the six-week period. Priority 2 individuals who received a randomly assigned number remain on the interest list for the Adult Autism Waiver.

“- Date and Time of Requests for Service Received After the Initial Six-Week Period

“The Intake Process described below continues to be used. Within each priority group and region, BAS sends applications in chronological order based on the date and time BAS received a request for services.

“Intake Process

“BAS accepts requests for services using a publicized, toll-free telephone number. Recorded prompts ask the callers for basic information about the caller and the person for whom services are requested. BAS checks DPW management information systems to identify whether the person is currently receiving on-going long-term support services in order to establish whether the person is a Priority 1 or Priority 2 individual. BAS also contacts the person’s County Mental Health Agency to identify whether the person is currently receiving services in a Community Residential Rehabilitation Services; services in a Long-Term Structured Residence; Residential Treatment Facility; and extended acute care for people with serious mental illness

“BAS returns each phone call to verify the person’s (and, if applicable, representative’s) contact information. BAS prioritizes requests for services based on the criteria described in the Prioritization Criteria section above.

“When waiver capacity is available to a person, BAS sends the person and representative (if applicable) an application. BAS assists the person or representative if necessary to complete the application and the person or representative may call BAS for assistance. When the person and/or representative returns the application, DPW staff, with assistance as necessary from the functional eligibility contractors described in Appendix A, determine whether the person meets the eligibility requirements specified in Appendix B-1. If DPW determines the person is not eligible for the waiver, BAS contacts the next person based on the criteria described in the Prioritization Criteria section above.

“Interest List Procedure

“If the waiver capacity in a region is filled, individuals requesting services will be placed on an interest list until capacity is available. If waiver capacity becomes available in a region, Priority 1 individuals on the interest list in that region will receive applications in chronological order based on the date and time BAS received a request for waiver services.

“If waiver capacity remains available in a region after all Priority 1 requests from that region have been processed, BAS will apply the Unused Capacity Procedure.

“Unused Capacity Procedure

“If a region does not have enough Priority 1 applicants to use available waiver capacity, BAS will monitor the number of Priority 1 requests for services received in the next 90 calendar days. BAS will send applications to Priority 1 individuals who request services during this time in chronological order until the region’s waiver capacity is used. If the region still has waiver capacity after 90 calendar days, BAS will reallocate unused capacity to regions where Priority 1 individuals are on an interest list. BAS will reallocate capacity to these regions in proportion to each region’s population age 21 or older based on the most recently available version of the U.S. Census Bureau’s Current Population Estimates.

“If waiver capacity remains available after all Priority 1 individuals have had their applications processed, BAS will return the remaining waiver capacity to the original region (i.e., the region that did not have enough Priority 1 individuals to use its capacity). BAS will first send applications to Priority 2 individuals in this region who requested services during the initial six-week period, in order of their randomly assigned number. If capacity remains available, BAS will send applications to Priority 2 individuals in this region who requested services after the six-week period, in chronological order. If the region still has waiver capacity after processing all requests from Priority 2 individuals in that region, BAS will reallocate unused capacity to regions where Priority 2 individuals are on an interest list. BAS first will send applications to Priority 2 individuals who requested services during the initial six-week period, in order of their randomly assigned number. BAS will then send applications to Priority 2 individuals who requested services after the six-week period, in chronological order.”

PROMISe™ is Pennsylvania’s CMS-certified Medicaid Management Information System (MMIS) and HIPAA-compliant claims processing and financial management information system implemented by the state in March 2004. PROMISe™ is a single system that processes human services claims and manages information for numerous Commonwealth of Pennsylvania human services programs. PROMISe™ incorporates claims processing and financial information management activities.

The reimbursement logic built into Pennsylvania’s MMIS ensures that providers are not paid more than the rate that is stored in the system, that waiver participants were eligible for services

on the date the service was provided, and that services paid are authorized in the waiver participant's approved ISP. If a provider requests assistance in resolving a billing issue, the ODP Claims Resolution Section conducts research to identify if (a) the reimbursement rate was incorrect; (b) the eligibility information was incorrect, or (c) services paid are inconsistent with the services authorized in the ISP. If a problem is validated, appropriate corrective action is identified promptly. Systemic errors are corrected in collaboration with the MMIS contractor and, if necessary, with the contractor who supports HCSIS. Rates or eligibility information entered into the system incorrectly are corrected and the universe of paid claims that was processed using the incorrect information is identified. If an overpayment was made, a recovery plan is developed. If an underpayment was made, the provider is contacted to void and resubmit in order to obtain the increased rate.

During claims processing, PROMISE™ verifies participant information in DHS's Client Information System (CIS), such as the participant's Master Client Index (MCI) number, name, the participant's eligibility status on date of service, and effective eligibility dates. PROMISE™ also verifies that the provider(s) and service(s) on the claim are enrolled providers of the services that are available to participants in the Adult Autism Waiver. PROMISE™ also ensures that the correct reimbursement rate is paid for the service billed. In addition, PROMISE™ checks claims against any applicable limitations, edits or audits for the services being billed.

After validation of the above listed items occurs, the claim information is sent to HCSIS (the data base system which contains all AAW participant support plans) to be verified against the participant's ISP, specifically, that the service is authorized on the participant's ISP, that the provider who is billing is the provider listed on the ISP for that service and that there were available units of the service available on the date of service. If any of the information on the PROMISE™ claim is in conflict with the ISP, HCSIS sends an error code to PROMISE. PROMISE™ then suspends or rejects the claim and notifies the provider. Each denied claim has one or more denial codes associated with it that show the reasons for rejections. Providers may contact the ODP Claims Resolution Unit for technical assistance to work through the denied claims to correct the error or errors and resubmit them. When required, BAS staff works in tandem with the Claims Resolution Unit to resolve claims-related issues.

For a random sample of participants, as part of the annual monitoring of providers, BAS compares paid claims data to provider records such as time sheets and reports of services rendered. BAS also interviews participants to assess whether participants' reporting of service delivery is consistent with claims data.

For the Supports Coordination service, all contacts by the Supports Coordinators must be recorded as service notes in HCSIS. BAS reviews a sample of Supports Coordinator records each year to assess whether billing reflects the amount of Supports Coordination activity recorded in the notes.

Of all paid claims, 100% were paid:

- At the appropriate waiver service reimbursement rate
- For services to participants eligible on the date of service

- For services and to providers specified on the participant’s ISP.

To date, the BAS has received no complaints from any waiver participant regarding provider billing. To date, the BAS has received no appeal by any waiver provider regarding billing or recoupment of funds.

In Pennsylvania, providers have 180 days from the date of service to submit an initial claim. If the claim is denied for any reason, the provider has 365 days from the date of initial claim submission to correct and resubmit the claim.

To encourage timelier billing by AAW providers, BAS implemented an improvement project in FY 2011-2012. This project consisted of identifying providers who had more than 50 percent unused service units as of April 2011 and contacting their billing department to notify them of the low rate of their billing and asking for justification. Technical assistance to address problems was also offered. . This same process was repeated in FY 2011-2012 and FY 2013-2014, after which billing increased by 73 percent. The provider billing rate has reached approximately 80 percent and BAS considers late billing to be remediated. During the period of this improvement project, average time between date of service and payment of claim was reduced from 58 days in FY 2011-2012 to 52 days in FY 2012-2013 to 47 days in FY 2013-2014.

In addition to verifying the rate, presence of the service and provider on the ISP and participant eligibility through PROMISE™ for every claim, during annual monitoring activities, the BAS monitoring staff reviews documentation to substantiate service delivery for paid claims. In FY 2011-2012 and FY 2012-2013, BAS reviewed paid claims submitted for all services delivered to the participants in the monitored sample (in FY 2011-2012 the sample was 54 participants; in FY 2012-2013 the sample was 56 participants) over the two quarters prior to the monitoring visit. For the FY 2013-2014 annual monitoring (the sample was 56 participants), BAS reviewed “either a minimum of 10% of claims for each service or a month of claims for each service for each participant” for one quarter prior to monitoring. Where concerns were raised from that review, BAS staff expanded the number of claims reviewed, either by expanding the time period of claims reviewed for the participant in the sample or by reviewing claims of additional participants served by the same provider for the same service. The review included examination of time sheets, monthly progress notes and encounter forms against paid claims. For Supports Coordination agencies, review includes service notes entered into HCSIS on an ongoing basis. The BAS reviews for consistency of day and time between the documentation and the claim as well as documentation supporting the number of units billed.

Table I/FA1 reports the aggregate number of all services across all monitored participants where all the reviewed claims were substantiated by documentation in the numerator. The denominator reflects the aggregate number of all services received by all participants included in the sample during each year that were reviewed by the BAS. The remediation data in the sample is expressed in terms of numbers of services where remediation was required due to insufficient documentation at the time of review.

The BAS acknowledges that the performance measure for FA1 is expressed in terms of numbers of individual claims, not services. In future monitoring activities, the BAS will document review of claims data consistent with the current performance measure and report results in terms of numbers of claims. The BAS intends to add additional performance measures for the financial accountability assurance in the waiver renewal application.

All paid claims of the sampled participants were clean insofar as the rate, service, units, provider and participant eligibility. The following represents the total paid claims for the three fiscal years covered in this report. The source documents are “Paid and Denied Claim Count Summary” annual reports pulled from PROMISE. This information is offered to the CMS in response to questions regarding the universe of claims submitted for the Adult Autism Waiver.

Total paid claims for FY 2011-2012 = 56,487
 Total paid claims for FY 2012-2013 = 75,754
 Total paid claims for FY 2013-2014 = 96,147

The collaboration with the ODP, in consultation with the Bureau of Financial Operations, to improve oversight processes and documentation requirements specific to billing and remediation for financial accountability is expected to be completed in Fall 2015.

THIS CHART IS OFFERED BY BAS AS A REFERENCE FOR TABLES IN THE AAW REPORT

TABLE	PERFORMANCE MEASURE	SAMPLING APPROACH	DENOMINATOR	DETAILS
I/FA1	Number of claims for which provider documentation indicates services were provided as billed divided by total number of claims for a sample of participants.	Less than 100% Review A random sample of participants. Confidence interval 90% Review services provided to the sample of participants.	156, 135, 149	All individual services reviewed during monitoring

CMS Final Response: The state does not meet this assurance because of a failure to report, remediate and incorporate system improvements for the individual claims billed and paid during this review period. The state reported on services and not total claims which does not meet the performance measure outlined in the approved waiver to meet the financial assurance. The CMS has concerns regarding the state’s oversight of the processes and documentation requirements for the financial accountability required under this assurance.

Required Recommendations:

- The state is required to develop and submit a waiver specific work plan for the CMS review no later than 90 days from the date of the report. The CMS expects the waiver specific work plan will assist the state in preparations for this waiver renewal regarding this assurance. The work plan shall include:



- a plan for designing and implementing a quality improvement system (QIS) for the waiver to assist the state in meeting and demonstrating the financial assurance for this waiver, and should include:
 - quantifiable performance measures tied to the assurance;
 - PMs demonstrating that claims are coded and paid for in accordance with the reimbursed methodology specified in the approved waiver;
 - PMs demonstrating that claims are paid for only those services rendered;
 - PMs demonstrating that rates remain consistent with the approved rate methodology throughout the five year waiver cycle; and
 - The QIS for this assurance is designed and implemented to assure accountability of claims monitoring, financial reporting, and reconciliation.
 - tools to gather and analyze data for the performance measures;
 - remediation actions for noncompliant findings; and
 - processes that will assure systems improvements.
 - A timeline for designing and implementing the QIS for the financial assurance.
- The state is required to seek technical assistance (TA) for the following:
 - development of the waiver specific work plan;
 - design and implementation of the QIS, and
 - facilitation of state's awareness of CMS expectations in meeting the statutory requirements.
- The state is required to participate in monitoring calls with CMS to monitor progress on the work plan and the financial assurance. Call frequency and purpose may be adjusted based on progress in meeting mile posts for this assurance.
- The state is required to provide quarterly data for the PMs in the approved waiver showing compliance levels. The quarterly data including aggregation and analysis is due 45 days after the quarter ends.
- A report regarding the collaboration with the ODP, in consultation with the Bureau of Financial Operations, to improve oversight processes and documentation requirements specific to billing and remediation as noted in state's response to the draft report is required to the CMS by December 1, 2015 showing what changes will be commencing with the renewal of this waiver.
- The state is required to develop additional PMs for the financial accountability assurance at the time of the waiver renewal application that will assist in demonstrating compliance with the assurance. The development of the additional PMs should include oversight for claims review/analysis, lifecycle of claims, information of cost to program, and other measures that clarify the states accountability and financial oversight.

