KDADS STANDARD POLICY

Policy Name:	HCBS Quality Assurance (QA) Policy	**Policy Number:**	E2024-059
Commission:	Home and Community-Based Services (HCBS)	**Date Established:**	08/01/2024
Applicability:	All HCBS Waiver Programs	**Date Last Revised:**	05/25/2024
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Purpose

The purpose of this policy is to provide quality assurance oversight for Medicaid 1915(c) Home and Community Based Services (HCBS) in the State of Kansas.

Summary

This policy serves as a basis for the State's Quality Assurance Unit's review of the HCBS Waiver Programs based on HCBS Performance Measures, program policies, and waiver requirements per waiver type.

Entities/Individuals Impacted

- **Department of Children and Families (DCF)**
- **HCBS Waiver Programs' Assessing Entities in the State**
- **Home and Community Based Service (HCBS) providers**
- **Kansas Department for Aging and Disability Services (KDADS)**
- **Kansas Department of Health and Environment (KDHE)**
- **Managed Care Organizations (MCOs)**

I. Policy

A. Quality Reviews

1. KDADS shall conduct quality reviews on Level of Care (LOC) assessments and Managed Care Organizations' (MCOs) records for participants receiving HCBS Programs to determine:
    a) KanCare Quality Performance Measure Outcomes
        i. The Performance Measures are included in all current/approved HCBS waivers
    b) KDADS HCBS Waiver Program Requirement Outcomes
        i. May include, but not limited to, State Plan requirements, HCBS waivers requirements

B. As a condition of Centers for Medicaid and Medicare Services (CMS) waiver approval of each HCBS waiver program, the State of Kansas shall have and comply with defined and approved Quality Assurance (QA) policies and procedures contained in this policy.

1. The following sub-assurances of the State's HCBS waiver shall have defined and approved QA requirements:
    a) Administrative Authority.
    b) Evaluation/Reevaluation Level of Care.
    c) Qualified Providers ;
    d) Service Plan ;
    e) Health and Welfare; and
    f) Financial Accountability

C. KDADS shall conduct QA checks through staff designated as Quality Management Specialists (QMS).
    1. KDADS may conduct QA checks through, but not limited to, any of the following methods and data sources:
        a) Level of Care (LOC) Assessor file reviews
        b) MCO file reviews
        c) Participant's survey feedback
        d) Provider's Credentialing, Training, and Background Checks
        e) Data found in the following systems:
            i. Kansas Aging Management Information System (KAMIS)
            ii. Kansas Modular Medicaid System (KMMS)
            iii. Medicaid Management Information System (MMIS)
            iv. Quality Review Tracker (QRT)
            v. Kansas Adverse Incident Reporting and Management System (AIRS)

II. Procedures

A. KDADS Financial and Information Services Commission (FISC) will select and assign a representative sample of HCBS waiver participants case files to the QMS Unit for review on a quarterly basis.

B. Documentation Required
    1. Documentation required for each waiver can be found in part III. Documentation.

C. Authorized Signature
    1. Signatures must be an original handwritten, including digital, signature and dated by the recipient and/or their representative .
        a) Signature on File and/or a signature that converts to a "typed" signature is not acceptable.
        b) If a recipient has a legal guardian, representative, or activated durable power of attorney (DPOA), the legal guardian or DPOA must sign all required document(s).
            i. In the event of representation through a DPOA, supporting documentation showing DPOA activation is required.
            ii. If an electronic signature is used, it must comply with the KDHE KMAP Provider Bulletin Number 782: Electronic Documentation. Demonstration to this policy must be provided to KDADS HCBS Director, Policy Program Oversight Manager, and Quality Assurance Manager.

2. In the event a participant is unable to manually/hand sign their own name due to physical or other limitations, one or more of the following methods may be utilized:
    a) The use of a distinct mark representing the participant's signature.
    b) The use of the participant's signature stamp; and/or
    c) The use of an identified designated signatory.

3. If a participant is utilizing any of the three options in II.C.2., documentation supporting the method selected must be uploaded with the QA review.

4. Each "authorized signature" must be dated.

D. Procedure for conducting quality reviews shall be as follows:

1. File reviews:
    a) KDADS shall review documentation uploaded in Quality Review Tracker (QRT) by the MCOs and/or Assessing Entities using the established KDADs protocols.
        i. KDADS QMS shall record findings from file reviews in the QRT for the MCO's/Assessor's remediation.

E. Record Submission

1. MCO files are to be uploaded to the QRT database.

2. Level of Care (LOC) Assessing Entity must upload documents for all HCBS waivers.
    a) LOC Assessment documentation for all HCBS waivers, unless an exception is granted for a specific waiver, may be found in KAMIS or QRT.

3. Case file documentation must be:
    a) Properly labeled with document name and the completion date (month and year); and
    b) Documentation must be legible.

4. KDADS will send out specific information regarding documentation required to be uploaded for the audit at the beginning of each upload period.

5. When documentation is uploaded to QRT, the MCO/Assessing Entity must mark the upload as "complete".

6. Documentation uploaded after the deadline will not be considered for the quality review.

F. Deadline for Record Submission
1. Case files for review shall be listed in the QRT for the review period.
    a) KDADS QA Manager shall notify the MCOs and Assessing Entity of the required upload ;
    b) MCOs and Assessing Entity shall have fifteen (15) calendar days from the time of upload notification to upload the required documentation.
    c)

G. An example of the timeline for a Quality Review is outlined in the following chart:

Review Period (look back period)	Samples Pulled *Posted to QRT	Notification to MCO/Assessing Entity Samples posted	MCO/Assessing Entity Upload Period *(15 days)	Review of data *(60 days)
01/01 – 03/31	4/1 – 4/15	4/16	4/16 – 4/30	5/1 – 7/1
04/01 – 06/30	7/1 – 7/15	7/16	7/16– 7/31	8/1 – 10/1
07/01 – 09/30	10/1 – 10/15	10/16	10/16 – 10/31	11/1 – 1/1
10/01 – 12/31	1/1 – 1/15	1/16	1/16 – 1/31	2/1 - 4/1

H. Findings and Remediation

1. Protocol Scoring Options:
    a) "Compliant" documentation is provided and meets compliance requirements;
    b) "Non-compliant" documentation was not provided or was not correct or complete;
        i. Missing Document (Document/documentation not provided for review);
        ii. No valid signature and/or date ("Valid signature" means by the individual and/or representative/guardian or Care Coordinator/Case Manager. Must have both signature and date);
        iii. Incomplete (form was not completed in its entirety);
        iv. Inaccurate (Scoring or eligibility is not correct; or services listed are not being received as outlined in the PCSP; or the process for developing a PCSP was not followed); or
        v. Timeline not met.
    c) "N/A" when not applicable to the protocol question.
2. Findings from file reviews will be recorded in QRT.

I. Remediation and Response Process

1. KDADS (FISC) shall generate and provide reports regarding findings to HCBS Program Managers for review and remediation as necessary.

2. CMS requires states to submit remediation language and a Quality Improvement Plan for any HCBS Performance Measure when the statewide average for a waiver is less than 86%. Therefore, KDADS shall complete data analysis for use in ensuring that each quality assurance or sub-assurance less than 86% is remediated. Further, CMS also requires the state to internally remediate any "non-compliant" (less than 100%) for a Performance Measure even though it may not be below the 86% threshold requiring the data analysis:
    a) KDADS shall notify the MCO and Assessing Entity of quality assurance or sub-assurance below 86% with details of each finding.
    b) KDADS shall notify the provider of each non-compliance of a Performance Measure.
    c) Upon notification of remediation requirement for quality assurance, sub-assurance or Performance Measure, providers must respond within 10 business days with a detailed plan for correction/remediation strategies and a timeline for completion.
    d) KDADS staff shall review received remediation plan for approval.

If a remediation plan is not approved, KDADS shall notify the provider and request that an acceptable remediation be resubmitted.

e) Once a remediation plan is approved with a timeline for compliance, KDADS will monitor for compliance.

3. KDADS shall immediately forward/report issues of Abuse, Neglect or Exploitation (ANE) to the designated state reporting agency.

4. If QMS finds issues or concerns on a specific case during a review:

a) The issues or concerns shall be entered in QRT;
b) The QRT system will send an alert to the HCBS Program Manager for the Program Manager's review. Issues that may cause an alert to HCBS Program Manager include, but are not limited to, the following:
   i. Participant being served could not be located, or no longer resides at the address provided in the case record;
   ii. Case should be reviewed for potential closure;
   iii. Assessment is not current;
   iv. Participant being served stated they would like their Care Coordinator to contact them;
   v. There is a Protective Service concern;
   vi. Spouse cannot serve as a Personal Care Service Worker or in any other paid capacity, without a "Spousal Exception;"
   vii. Activated DPOAs/Legal Guardians are not allowed to provide any direct services without Court documentation approving them to do so;
   viii. Assessor is not on the qualified assessor list.

J. Quality Reviews of Credentialing; Background Checks; Provider's Training

1. Refer to Policies posted on the KDADS website.

2. Credentials such as provider specifications applicable to each HCBS waiver; background checks; and trainings are to be provided per direction of KDADS.

3. Provider qualification audit review process per direction of KDADS and waiver standards

III. Documentation

A. Forms

1. All forms and templates will be sent to the appropriate assessing entity or MCO at the beginning of the upload period, via secure email. Specific required documentation for the audit will be listed in the following documents:
   (a) HCBS LOC Review: Required Documentation for QA Reviews (FE, PD, BI);
   (b) HCBS LOC Review: Required Documentation for QA Reviews (AU);
   (c) HCBS LOC Review: Required Documentation for QA Reviews (IDD);

(d) HCBS LOC Review: Required Documentation for QA Reviews (TA);
(e) HCBS LOC Review: Required Documentation for QA Reviews (SED);
(f) HCBS MCO Record Review: Required Documentation for QA Reviews (Except SED);
(g) HCBS MCO LOC and Record Review: Required Documentation for SED QA Reviews;
(h) QMS official record of case review and findings are located in QRT.

2. Required documentation is subject to change and will be updated on the specific Record Review document, that is sent out via email at the beginning of every upload period.
3. For the required documentation – assessing entities/MCOs must provide all current & prior documentation that demonstrates compliance with CFR Regulations, Performance Measures, Applicable Policies & Program Mandates – for every day of the review period.

B. Level of Care Performance Measure Documentation

1. The Level of Care Assessing Entity is responsible for providing appropriate documentation for this section of the audit review.
2. Requests for Level of Care Documentation may include, but is not limited to:
   (a) Specific waiver eligibility assessment, applicable re-assessments, any medical documentation if required for eligibility;
   (b) Initial Intake/Referral Form;
   (c) 3160 approval/Functional Eligibility Assessment request from the specific waiver program manager – if coming off a waitlist or is a crisis/exception, when the initial assessment has expired and will need a new assessment to be eligible for the waiver.

C. Service Plan & Health and Welfare Performance Measure Documentation

1. The MCOs are responsible for providing the appropriate documentation for this section of the audit review.
2. Requests for Service Plan and Health & Welfare Documentation may include, but is not limited to:
   (a) 3160 and 3161 – include the initial notification from eligibility worker of a new member;
   (b) Person Centered Service Plan for current and prior Person Centered Service Plan to determine timeliness. The following is considered part of the individual's Person Centered Service Plan and is subject for review:
      i. Documentation of participant choice, as directed by the waiver;
      ii. Physical, Functional, and Behavioral Assessment;
      iii. Back Up Plan;
      iv. Evidence of information provided on reporting suspected abuse, neglect and exploitation; and
      v. Goals.
   (c) Physician/RN Statement (if applicable);
   (d) Legal Representative, Durable Power of Attorney and/or Guardianship paperwork
   (e) Physical Exam;
   (f) Evidence of rights and responsibilities discussed with participant and/or representative/guardian;
   (g) Evidence of appeal and grievance rights/processes discussed with participant and/or representative/guardian;
   (h) Notice of Actions (for any updates or changes in Service Plans, including annual reviews and/or adverse actions);
   (i) Log or case notes (inclusive of verification of services being received in the type, scope, amount, duration and frequency specified in the Service Plan);
   (j) Brain Injury Waiver only - Progress Notes for Transitional Living Skills and/or Therapies.

(k) SED Only: Documentation on Critical Incidents/APS/CPS reports regarding restraints; seclusion; or other restrictive interventions and/or anything in AIR system.

IV. Definitions

SFY—State Fiscal Year, July 1st to June 30th of the following calendar.

Designated state management information system of record—In this policy, this system of record shall be KMMS and KAMIS

Service Plan Terminology—For this QA Policy, the term "Person Centered Service Plan," shall replace all previous terminology (i.e.…Integrated Service Plan (ISP); Service Plan; Plan of Care) for the document that identifies services and supports for participants receiving HCBS waiver services.

Person Served Terminology—Participant/Consumer/Customer/Beneficiary/Member/Recipient/Individual: These terms have been utilized to determine who the person is receiving the waiver service. For this QA Policy, the terminology used is "Participant."

Staff Terminology—The term Personal Care Services (PCS) has been standardized across the HCBS waiver populations and shall replace all previous terms for this service and/or worker. Previous terms being replaced include: Personal Services; Personal Care Attendant; Personal Assistant Services; Attendant Worker; Direct Services Worker; Supportive Home Care; and Attendant Care Services.

Authority

Currently effective HCBS waivers in Kansas

Related Information

Kansas Department for Aging and Disability Services
503 S. Kansas Ave
Topeka, Kansas 66603

Resources

KDADS website (www.kdads.gov)
CMS (www.cms.gov)
KAMIS (www.aging.ks.gov)
KMAP (www.kmap-state-ks.us)
KMAP Bulletins (www.kmap-state-ks.us/Documents/Content/Bulletins)
KDADs policies (HCBS Policies (ks.gov)