KDADS ADCSP PUBLIC COMMENT MATRIX (V1.1) 7/14/2020

Waiver	BI	Date	10/1/2018 to 10/31/2018
Policy Name (if Applicable):	NA		

#	Sender	Public Comment	KDADS Response
1	Other Stakeholder	Comments on Brain Injury Waiver Renewal: We support the expansion of the waiver to include additional brain injury survivors as these services are critical to assist these individuals in the rehabilitative process.	
2	Other Stakeholder	Background Check Language – We have serious concerns that proposals to implement a finger print background check will cause undue burden on individuals residing in rural areas and over all, will serve as a disincentive for potential applicants who will only provide a few hours a week in care. With the current worker shortage, any barrier is a problem and finger print background checks will pose a significant barrier.	This is a statutory requirement under K.S.A. 39-2009
3	Other Stakeholder	Assistive Services – we appreciate the inclusion of language previously found in the HCBS Waivers that upholds the consumers' rights to access assistive technology that can help them live more independently. However, the failure to remove the restrictive language of the current Waiver negates the addition. The current waiver holds that an individual must meet "crisis criteria" in order to access assistive technology. The crisis criteria language should be removed and individuals on the Waiver should be able to work with the service coordinator to determine if assistive technology can be purchased to increase their independence.	Pose to leadership to remove crisis requirement for assistive technology.
4	Other Stakeholder	We would also like to see the Waivers more robustly address employment and implement some of the recommendations from the Employment Systems Change Project published and disseminated in September 2018 after years of data collection and analysis.	Waiver participants have access to Voc Rehab. At this time expanding employment supports wil result in a fiscal impact.
5	Other Stakeholder	Suggestions/Questions: *Suggestion for eligibility criteria Appendix B1b: Progress is evaluated every 6 months or more frequently and is deemed necessary by the MCO, using SMART goals developed by KDADS, providers, MCOs and stakeholders. (p. 28) Suggested wording "SMART goal structure developed by…" or "SMART goal format developed by…".	Progress is evaluated every six months or more frequently as deemed necessary by the MCO or as requested by the participant. S.M.A.R.T goals, developed by the provider, individual and MCO, are used to track habilitative and rehabilitative progress and maintenance of independent living skills. - completed
6	Other Stakeholder	*Please clarify on page 124 where it states at the top "Members do not have to finish their appeal with the MCO before requesting a State Fair Hearing". It is our understanding that the MCO's appeal must run through its completion, with an issued decision by the MCO to overturn or uphold their decision, before a State Fair Hearing can be requested.	This is in fact the requirement under CMS' new Managed Care Regulations.
7	Other Stakeholder	*Participant Centered Service Plan information listed in Appendix D1d regarding service plans being valid for 365 days (p. 93) Does this mean that authorizations should be issued by the MCO for services with an expiration after one year?	The authorization will only be issued for up to the amount of time the Service Plan is valid (365 days).
8	Other Stakeholder	*Assessment for Kids: B6d references working with the University of Kansas on an assessment for children age 4-20. (p. 40). What assessment tool is in the works for assessment of children age 0-3? *Suggestion for eligibility criteria Appendix B1b5: Have a documented medical diagnosis of a TBI or ABI. (p. 4)Suggest taking out, "documented medical diagnosis of a." There are thousands of ICD-10 diagnosis codes relevant to a brain injury.	pg. 4 and pg. 28 Add to eligibility criteria: ABI and TBI functional eligibility, for ages 0-3, will depend solely on a diagnosis of ABI or TBI from a licensed physician. Must list the diagnosis (not the ICD 10 code). - complete
9	Other Stakeholder	*Home Delivered Meals (p. 74). It's currently marked as a "service is not included in the approved waiver" but we understand it's a previous service and slated to continue. The same is true for Medication Reminder Services (p. 76).	check the correct bubble on both- complete
10	Other Stakeholder	*Service Plan Development in Appendix D1. The fourth paragraph states "The Service Plan must be completed and services in place within fourteen (14) business days of the MCO	14 days to get a finalized (signed plan), time standards state 14 days for in-home services, 30 days for some other services.

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		receiving notification via the 834…" we suggest modifying the it to read "The Service Plan must be completed and services in place and authorizations issued within fourteen (14) business days of the MCO receiving notification via the 834…" This is because an MCO may write anything on a PCSP and they might not actually draft an authorization for months, if at all.	
11	Other Stakeholder	*Post-Eligibility of Treatment of Income, Appendix B5b. The text states "the dollar amount for the allowance is $727." (p. 36) Due to the possible upcoming state legislation to significantly adjust the protected income limit, and the five year duration of the waiver, should this sentence be removed? The same sentence is located in Appendix B5d (p. 38).	Michele will push question to KDHE-number required in the waiver. Cannot make changes until legislation is final.
12	Other Stakeholder	*EPSDT coverage: Kansas will explore what is available through EPSDT to determine what can be provided without overlap or duplication. (p. 1) Our concern is that State Plan PT/OT/SLP and behavioral health benefits might be misconstrued as equivalent to BI waiver services. BI waiver therapies are an entirely different approach to rehabilitation when compared to State plan. State plan will coordinate with any primary insurance, whereas BI waiver bypasses this, allowing for fewer limitation placed on the consumer as it relates to medically unlikely edits (MUE). Also, State plan services are not required to be provided in the least restrictive environment which is out of compliance with the final settings rule. For example, State plan physical therapy would involve a child going to a therapy gym to complete exercises with a therapist, while attempting to simulate the child's natural environment. An example of BI waiver PT would be a child learning how to ride his bike again in order to go to a friend's house for community-based socialization. Another example would be that extended state plan speech therapy could likely mean that a child continues to access 30 minute speech therapy visits in a clinic rather than working on communication skills with their siblings at the neighborhood park. Please look at P. 53. There are sections under each BI waiver service similar to paragraph 4.	Waiver funding may cover those authorized waiver services that the child's primary insurance does no cover. However, waiver funding is the funding source of last resort accorng to federal law. Therefore State Plan and primary insurance must be exhausted before waiver funding can be used.
13	Other Stakeholder	*Eligibility criteria: Added #4-Show capacity for progress in habilitation/rehabilitation or a need for therapies to maintain independent living skills (p. 4). We are concerned that the maintenance component could increase the likelihood of a waiting list and might not be congruent with the rehabilitative/independent living focus of the waiver.	Need to re-word #4 and in the narrative- complete, legal to review-complete.
14	Other Stakeholder	The six-month ongoing formal review for program eligibility is in and of itself burdensome; information provided to the existing TBI Waiver workgroup from current program participants is that the process of eligibility determination, plan of care development, and associated processes for maintaining services under the current program are a barrier for program participants. Recommendation: A less burdensome process for consumers at all levels of eligibility determination should be employed to ensure meaningful access and participation for the people using the program.	Stakeholders have agreed that this method and timeframe of evaluation is necessary to accurately determine the progress of habilitation and rehabilitation and the on-going habilitative and rehabilitative needs.
15	Other Stakeholder	The State of Kansas changed the waiver structures from Agency with Choice to the Vendor/Fiscal Model for payment under the KanCare Demonstration. Attempts to place more control in the hands of consumers through movement to the Fiscal/Vendor model have been laudable. Recommendation: we encourage the State to expand service options to allow consumers Budget/Employer authority in management of their community-based services as well.	
16	Other Stakeholder	To the extent non-medical services comprise a significant aspect of services under the proposed renewal, the Provider Qualifications for Personal Care Service Worker Self-Directed are unacceptable. In particular, the state is imposing requirements that in-home direct support workers hired and managed as allowed by Kansas State law at KSA 39-7,100, Complete KDADS Approved Skill Training requirements, as well as any additional skill training as recommended by a qualified medical provider. Under state law, self-directing consumers, not KDADS, and not medical providers, have the right to select, train, and manage employing consumers' direct support workers. Recommendation: eliminate	Actual Language: Complete any additional skill trainings needed in order to care for the waiver recipient as recommended either by the participant, legal representative or a qualified medical provider.

		educational and training requirements for direct support workers beyond any identified by the employing consumer, or the employing consumer's representative.	
17	Other Stakeholder	The waiver proposes keeping the patient liability at the current amount of $727/month. This amount is extremely low, punishes beneficiaries who have worked in the past by taking any funds over the protected income level of $747, and discourages participants from exploring employment and greater economic self-sufficiency by taking "excess" funds from their pockets. Recommendation: The State could and should elect to change this to the option of 300% FPL, as allowed under the waiver application at section i.	Sent to Bobbie GH at KDHE.
18	Other Stakeholder	Thank you for the opportunity to submit comments and suggestions for changes to the State of Kansas' proposed Brain Injury (BI) Home and Community Based Services (HCBS) Waiver renewal/application. The Traumatic Brain Injury (now BI) Waiver stands out from the Kansas HCBS Waiver programs in its emphasis on more traditionally "medical model" services as part of a rehabilitation program. Notwithstanding the 2018 Legislative Proviso language, this distinction deserves very close scrutiny as renewal for non-medical long term services and supports waiver programs and services is pursued. Recommendation: To the extent medical services are provided through rehabilitation and habilitation, which services are appropriately encompassed within a non-medical long term services and supports program, and which might better be provided under the medical care offered through the Kansas Medicaid program merits discussion, review, and consideration. The roles and responsibilities of the State of Kansas and the private Managed Care Companies continue to be unclear in this most recent Waiver proposal. For example, under the six-month progress review each participant must complete to remain on the program, use of a state-approved standardized instrument that identifies goals is required, but who reviews progress made under the instrument (the State or the MCO) is completely unclear.	SMART is a standardized way of developing person-centered goals. Clarified who reviews progress. Legal will review changes.
19	Other Stakeholder	Sunflower agreed with United's recommendations and has the following: *We strongly agree that there needs to be a clear definition or stated expectation of progress for the person to remain on the waiver, and that the review of progress process be spelled out in the waiver.	
20	Other Stakeholder	*We recommend that there be a very clear definition of progress for continued therapies, and division of waiver therapies and TLS, especially with non-licensed/certified staff providing therapies. And, a clear expectation for when a member moves from therapy level of care to TLS and the coordination between them.	
21	Other Stakeholder	*We also strongly agree that providers other than CILs need to be able to provide Assistive Services. We have quality issues with CILs doing this and lack of access.	Separate out DME and Home Mods into different provider types in the portal- complete
22	Other Stakeholder	*We propose a discussion between KDADS and the three MCOs to review the first and third items before waiver amendment submission. These are the two areas with which we have the most issues. We will have our VP of Med Management and our therapist who does the therapy reviews participate.	
23	Other Stakeholder	TBI Waiver application Section (UHC) Application Reference UHC recommendations	
24	Other Stakeholder	Major changes- Progress reviews pg. 1 Individuals who receive services through the proposed BI waiver may continue to do so until it is determined that they are no longer making progress in rehabilitation or require therapies to maintain independent living skills. Progress will be reviewed and documented every six months through a formal review process to determine if the needs are being met by the program and the participant is continuing to make progress. Progress will be reviewed utilizing a State approved standard instrument that identifies goals and measures outcomes SMART (specific, measurable, achievable, realistic, time-oriented) tool. Recommend making the formal review process guidelines part of the waiver application. Recommend making the State approved standard instrument a part of the waiver application. Recommend adding language defining "progress" which includes specific language regarding how to define progress specific to habiliattive vs rehabilitative.	

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25	Other Stakeholder	Major changes- Peds tool pg. 1 To expand services to children under the age of 16, KDADS will identify and adopt a pediatric assessment tool – with stakeholder input. Recommend this tool be be submitted as part of the waiver application and that the tool incorporate KAN BE Healthy or identify where KAN BE Healthy would be the most appropriate service.	
26	Other Stakeholder	Eligibility Criteria pg. 4 The BI waiver is a habilitative /rehabilitation and independent living program with an emphasis on the development of new skills and/or relearning of lost skills. Individuals who receive services through this waiver may continue to do so until it is determined that they are no longer making habilitative /rehabilitative progress or require therapies to maintain independent living skills Recommend spelling out clearly the type or impact of the progress the State is looking for.	
27	Other Stakeholder	Appendix B Additional Criteria pg.28 The State will require a licensed professional assessment (for example, physician or neuropsychologist) for documentation that does not clearly support a brain injury. Recommend this be added to the annual level of care for those participants on the BI waiver without this documentation.	
28	Other Stakeholder	Appendix B Additional Criteria pg. 28 Participants that turn 65 while receiving BI waiver services may continue receiving services as long as the participant continues to demonstrate habilitative/rehabilitative progress. Any participant that does not show habilitative/rehabilitative process in waiver services, including those participants who are approaching the age of 65, may be eligible to transition to the appropriate waiver as described in the KDADS BI Transition Policy Recommend spelling out clearly the type or impact of the progress the State is looking for.	
29	Other Stakeholder	Appendix C- Services DME pg. 63 Environmental modifications may only be purchased in rented apartments or homes when the landlord agrees in writing to maintain the modifications for a period of not less than three years, and will give first rent priority to tenants with physical disabilities. Is the Landlord form sufficient here? If not please provide the process for meeting this limitation.	KDADS will review current forms for compliance
30	Other Stakeholder	Appendix C- Services- DME pg.64 If a related vendor, such as a Durable Medical Equipment provider, does not wish to contract with the MCO or FMS provider, the State will allow the vendor to receive direct payment from Medicaid. Recommend including this process and exceptions in the waiver. Does this count against funding limits?	
31	Other Stakeholder	Appendix C - services Assistive Services Must affiliate with a recognized Center for Independent Living or home health agency (as defined in K.S.A. 65-5001 et seq.) • Applicable work must be performed according to local and county codes General contractors must provide proof of certificate of Worker's Compensation and General Liability Insurance Recommend a standard affiliation agreement if one is to be required and an exception process for providers who are unable to contract with a CIL. In practice are we able to use any provider or does this require us to work though the CIL? If so we have had some quality issues that would need to be addressed here.	Remove this and look at what is in Appendix F- complete
32	Provider	HCBS Transition Policy **SKIL advocated a great deal for the MFP programs at the State and Federal levels since deinstitutionalization is a strong piece of our philosophy. Through the years we were able to assist many individuals utilizing this program. We agree with these changes.	
33	Other Stakeholder	Conflicts of Interest **We still do not understand how it is not a conflict of interest for the MCOs to develop the plan of care, oversee and assist in implementing the POC, and get paid to do all of it. We do not see the difference of community based organizations that did the same but it was a conflict of interest. At least with not for profit community based organizations, the reimbursements all went back into services in the local communities, rather than major for profit corporations.	

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34	Provider	Background Check Language **As commented earlier, background checks are causing numerous issues. First, the State is barring individuals who are not cleared by the prohibited offense list to work as a personal care attendant under Medicaid programs. So the State is making the decision to not select these applicants, hence not the employer, the person with the disability, who is given this right by law in K.S.A. 39-7,100 to select their own workers. We believe this violates the individuals rights and taking an immense amount of personal control away from them. This is dangerously impacting the workforce supply of personal care attendants which endangers individual's right to live in the community. The background checks should be done with the results being given to the individual so that they are informed to make the best decision for themselves. As said previously, a background check that comes back with a prohibitive offense means they got caught. In turn if a potential attendant comes back cleared, it may just mean that they have not gotten "caught". Second, currently an attendant cannot be hired until cleared through the background check. This leaves some individuals in very serious, unsafe situations because they probably do not have enough other avenues of assistance while waiting weeks for the potential attendant to get cleared. This is putting individuals health and safety at risk. There should be at least a 30 day window for the attendant to work to assure the individual gets the assistance they need. Although we strongly support our first point of individuals receiving the results of the background check to make an informed decision on their own as required in the State law since 1989. There are numerous facets of self-direction, including making daily decisions about their lives, but one of the first steps is having the right to make the decisions of who is coming into their home and providing very personal care, which starts with making an informed decision when selecting who they want to hire as personal care attendants. In addition, SKIL sees no reason for all of our staff to be required to go through background checks. We have staff who have no contact with customers at all, so requiring a background check on them is absolutely ridiculous and wasteful. SKIL has a staff person who has worked in Independent Living for over 25 years. She has managed and self-directed her personal care attendants for 40 years. She has worked for SKIL for 14 years. She works in a remote office on the other side of the State. She supervises a Support Staff person that assists her in the office and travels with her for work. The last couple of years she has had a great deal more trouble hiring Support Staff/Personal Care Attendants. This may not be only due to the background check but it has contributed. In all the attendants that have worked for her in 40 years, she has only had problems with two that stole, money and meds, but neither had records at all till she reported them. This same staff person is writing these comments for SKIL. We have other staff that do not have contact with customers also. This all being said we understand the requirement for the background checks for employees of facilities because they are working directly with individuals and the workers are employees of the facilities. The residents are not self-directing in institutional settings. Therefore we oppose the background checks in the HCBS waivers serving adults in the communities.	Background Checks are required by law. Prohobted offenses are set forth by statute.
35	Other Stakeholder	Name Change The proposed waiver would be called the Brain Injury Waiver. ** Good with the change.	
36	Provider	Legislative Proviso "The 2018 Kansas Legislature included a proviso in the budget bill directing KDADS to include acquired brain injuries (ABIs) into the current TBI waiver. The proviso also directed that the amended waiver serve children under the age of 16. Policy and procedural changes surrounding this expansion will emerge through the stakeholder engagement process and will be phased in over the five-year life of the waiver. The former traumatic brain injury waiver will migrate away from a strictly rehabilitative waiver to one the is both habilitative and rehabilitative in nature."	

		** SKIL is very pleased with these changes to the BI Waiver extending services to acquired injuries and children un age 16. This is will make for some very positive changes to many individuals if the policy and procedural changes are done correctly so as to make the most of the program and services to assist individuals to successfully in their homes. To change the waiver to include habilitative, will again be very beneficial to Kansans with brain injuries. We extend our appreciation for these changes but again lets assure the program is set up and implemented to greatest benefit for individuals.	
37	Other Stakeholder	Assistive Services The definition of assistive services has been broadened to include additional criteria. More people may be able to meet the threshold for this critical service. Details can be found in Appendix C of the renewal application, under Participant Services, Assistive Services. ** Any movement toward getting assistive services that will improve an individuals life and freedom toward independence is a positive step. It is important that these pieces to the puzzle (assistive services) are available when needed, because if not it can truly put someone's health and safety at risk and set them up for failure in the community. Ease of access is very important.	
38	Provider	Determining Progress Previous access to the waiver was limited to four years. Individuals who receive services through the proposed BI waiver may continue to do so until it is determined that they are no longer making progress in rehabilitation or require therapies to maintain independent living skills. Progress will be reviewed and documented every six months through a formal review process to determine if the needs are being met by the program and the participant is continuing to make progress. Progress will be reviewed utilizing a State approved standardized instrument that identifies goals and measures outcomes SMART (specific, measurable, achievable, realistic, time-oriented) tool. ** SKIL supports this review happening every six months.	
39	Provider	Transitional Living Skills Services Qualifications for Transitional Living Skills providers will be expanded to help enlarge the pool of available providers and improve access to service. PG. 79 Transitional Living Skills TLS can be authorized for up to four hours a day, and with a maximum of 3120 units per year. BI providers are not permitted to be dual providers for the same participant on the following services: Personal Care Services (PCS) and Transitional Living Specialist (TLS) OR Transitional Living Specialist (TLS) and Therapeutic Services (including behavioral, cognitive, speech-language, physical, and occupational) ** SKIL does not support BI providers not being able to be dual providers for the same participant. We have found on the past that t is much better to provide multiple services to individuals in that the staff are better able to coordinate working together in a way that beyond doubt is beneficial to the participant. We do not understand at all why this would ever be changed. Another benefit is that it is les providers in the life of the participant which is better for them most of the time. Too many providers can be very confusing and overwhelming when these participants are trying to rehabilitate from a very difficult experience that demands less opportunity for confusion. The other concern that SKIL has is that there has already been a terrible shortage of providers so this definitely impacts provider capacity even greater. We would ask that this be reconsidered.	This requirement was not changed.
40	Other Stakeholder	Transitional Living Skills Services Qualifications for Transitional Living Skills providers will be expanded to help enlarge the pool of available providers and improve access to service. ** Every effort is going to be needed to expand the number of TLS providers. There is currently a shortage already, so with the expansion of the waiver it is vital to the success of the participants that these services not be too restricted in any way including the fiscal	

		impact to the provider. SKIL has been asked to provide TLS to a number of individuals that is not financially feasible for us to have our closet TLS staff to travel 50+ miles one way to a participant to work four or less hours a day (sometimes 1 or 2). And we it is very difficult to hire a person that is qualified closer to the participant that is willing to work so few hours. Our State is extremely rural and it is difficult to get services to some of these areas. We have got to figure out how to make this feasible for providers. SKIL would love to be able to do this. We have served many individuals on the TBI waiver through the years, but our numbers have decreased immensely, very much because of this issue.	
41	Other Stakeholder	PG. 48 Freedom of Choice HCBS/BI Waiver Participant Choice forms are documented and maintained by the functional assessor and the participant's chosen KanCare MCO in the participant's case file. ** We do not believe that all individuals are being given the choice between institutional and community based services. Our institutions are full. We believe that it is a lot less work for the MCO to allow individuals to go into the institutional setting as opposed to the work it takes for them to get and maintain HCBS. The MCO is not making any more profit by supporting individuals in their homes and communities. MCOs are for-profit corporations, not community based organizations with missions, philosophy, and goals to advocate and support people with disabilities to live a life of freedom in their own homes and communities. They are not about Freedom of Choice!	
42	Other Stakeholder	PG. 51 Personal Care Service Worker-Self Directed Other Standard (specify): A. Must sign an agreement with a Medicaid-enrolled Financial Management Services (FMS) provider B. Must have a High School Diploma or equivalent OR be at least eighteen years of age or older; ** Why is it a must for a PCA to be required to have a High School Diploma or equivalent??? This is ridiculous!! This education level is absolutely unnecessary for a worker. It does not benefit them in any way to be able to assist someone with bathing, toileting, dressing or cleaning or cooking, etc. And once again, the State is making more restrictions on who the individual receiving the services, the employer, is able to select to hire. Again violating the KS Self-direction law. And again there is already such an immense shortage of workers. The State keeps narrowing further and further the potential pool of PCA applicants, not only is the State jeopardizing the health and safety of individuals and violating their right to self direct, we are not so certain the State really wants to make HCBS available and people with disabilities successful in the community. This continues to get more frustrating!! C. Complete KDADS Approved Skill Training requirements. ** Again, the State requiring their training requirements. K.S.A. 37-100 Self-direction law says (a)(2)(2) individuals in need of in-home care who are recipients of attendant care services and the parents or guardians of individuals who are minors at least 16 years of age and who are in need of in-home care shall have the right to choose the option to make decisions about, direct the provisions of and control the attendant care services received by such individuals including, but not limited to, selecting, training, managing, paying and dismissing of an attendant; Again not following the law. D. Complete any additional skill training needed in order care for the waiver recipient as recommended either by the participant, legal representative or qualified medical provider. All HCBS providers are required to pass background checks consistent with the KDADS' Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation. Any provider found to have been substantiated for a prohibited offense as listed in KSA 39-2009 is not eligible for reimbursement of services under Medicaid funding. Prospective providers are not permitted to provide services to a participant until verification of background clearance is available for review by the participant in accordance with the list of prohibited offenses (KSA 39-2009 & 65-5117). ** As stated previously, the background checks violate the self-direction and puts individuals health and safety at risk. This should absolutely stop. If the State wants to require the background checks and provide the results to the participants to	Provider qualification says Highschool diploma or 18 years of age.

		make an informed choice then that could be beneficial but currently it is wrong. And again reducing the already drastically shrinking workforce.	
43	Other Stakeholder	PG. 60 FMS Service Definition (Scope): Within the self-directed model and Kansas State law, K.S.A. 39-7, 100, participants have the right to make decisions about, direct the provisions of, and control the personal care services received by such individuals including but not limited to selecting, training, managing, paying and dismissing of a direct support worker. Financial Management Services (FMS) is provided through a third party and is designed to assist the waiver participant under the employer authority using the CMS approved Vendor Fiscal Agent model. Services in support of participant direction are offered whenever a waiver affords participants the opportunity to direct some or all of their waiver services. The participant is the sole employer of the direct service worker. The FMS provider is responsible for the provision of Information and Assistance tasks to assist the participant with understanding his or her role and responsibilities as the employer and his or her responsibilities under self-direction. The FMS Kansas Medical Assistance Program (KMAP) manual details the responsibilities of the FMS provider, waiver participant and the MCO. FMS is an agency directed service. **As we stated earlier, the State is interfering with the rights of individuals to be able to self-direct. We also know that many times when the MCO Care Coordinator is meeting with individuals to get them started on services that the MCO is not really giving the individual to choose their providers. We have had customers relate this to us and with only help from our staff then had to go through the process of changing providers. Again this violates the rights of individuals under K.S.A. 37-100.	
44	Other Stakeholder	PG. 60 MCO Responsibilities The FMS Kansas Medical Assistance Program (KMAP) manual and State policy detail the responsibilities of the MCO, in relation to FMS. The MCO will ensure that individuals seeking or receiving self-directed services have been informed of the benefits and responsibilities of the self-direction and provide the participant with a choice of FMS providers. The choice will be presented to the individual initially at the time self-direction is chosen and annually during the creation of his/her Person-Centered Service Plan, or at any time requested by the participant or the individual directing services on behalf of the participant. The MCO is responsible for documenting the provider chosen by the individual. In addition, The MCO is responsible for informing the participant of the process for changing or discontinuing an FMS provider and the process for ending self-direction. The MCO is responsible for informing the participant that they can change to agency-directed services at any time if the participant no longer desires to self-direct his/her service(s).This service does not duplicate other waiver services. Where the possibility of duplicate provision of services exists, the participant's Person-Centered Service Plan shall clearly delineate responsibilities for the performance of activities. ** As stated several times previously, we know this is not always occurring.	
45	Other Stakeholder	PG. 92 Service Plan Development ** There must be a better way developed to really assure that individuals are truly being given the full choice of providers.	
46	Other Stakeholder	PG. 95 f. Informed Choice of Providers. The State assures that each participant will be given free choice of all qualified providers of each service included in his/her written Person-Centered Service Plan. The MCO provides each eligible participant with a list of providers from which the participant can choose a service provider. The MCO assists the participant with accessing information and supports from the participant's preferred provider. These service access agencies have, and make available to the participant, the names and contact information of qualified providers for waiver services identified in their Person-Centered Service Plan. ** Again need to figure out a better way to really assure that individuals are truly being given the full choice of providers. MCOs must be held to this because it is not always happening.	
47	Other Stakeholder	PG. 112 Appendix E: Participant Direction of Services Description of Participant Direction	

		This opportunity includes specific responsibilities required of the participant, including: • Recruitment and selection of Personal Care Attendants (PCAs), back-up PCAs and ECS workers • Financial Management Service (FMS) providers; • Assignment of service provider hours within the limits of the authorized services; • Complete an agreement with an enrolled Financial Management Services (FMS)provider; • Referral of providers to the participant's chosen FMS provider; • Provider orientation and training; • Maintenance of continuous service coverage in accordance with the Plan of CarePerson-Centered Service Plan, including assignment of replacement workers during vacation, sick leave, or other absences of the assigned attendant; • Verification of hours worked and assurance that time worked is forwarded to the FMS provider; • Other monitoring of services; and • Dismissal of attendants, if necessary. ** Great this is included but just including it does not mean the law is followed.	
48	Other Stakeholder	PG. 114 e. Information Furnished to Participant. a.) Participants are informed that, when choosing participant direction (self direction) of services, they must exercise responsibility for making choices about attendant care services, understand the impact of the choices made, and assume responsibility for the results of any decisions and choices they make. Participants are provided with, at a minimum, the following information about the option to self direct services: • the services covered and limitations; • the need to select and enter into an agreement with an enrolled Financial Management Services (FMS) provider; • related responsibilities (outlined in E-1-a); • potential liabilities related to the non-fulfillment of responsibilities in self-direction; • supports provided by the managed care organization (MCO) they have selected; • the requirements of personal care attendants; • the ability of the participant to choose not to self direct services at any time; and • other situations when the MCO may discontinue the participant's participation in the self-direct option and recommend agency directed services **The information that individuals are provided to make a decision about whether to self-direct are very negative. We understand that individuals must be fully informed but talking about the limitation of PCAs and liabilities, this can easily scare someone that may already be apprehensive or never self-directed before. We believe this one again discourages self-direction. b) The MCO is responsible for sharing information with the participant about self-direction of services by the participant. The FMS provider is responsible for sharing more detailed information with the participant about self-direction of services once the participant has chose this option and identified an enrolled provider. This information is also available from the BI Program Manager, KDADS Regional Field Staff, and is also available through waiver policies and procedures manual. c) Information regarding self-directed services is initially provided by the MCO during the Person-Centered Service Plan process, at which time the Participant Choice form is completed and signed by the participant, and the choice is indicated on the participant's Person-Centered Service Plan . This information is reviewed at least annually with the member. The option to end self direction can be discussed, and the decision to choose agency-directed services can be made at any time. ** We do not believe the MCOs really understand self-direction so it really does not make sense to have them explain it to participants. It should be explained by peers and community based organizations that live it daily. In conclusion we have some real concerns about what has been happening to self-direction of HCBS in KS given all the various changes whittling away at K.S.A. 37-100. Individuals are not always being given choices of providers. The background checks of workers violates the individual's right to select. SKIL hopes that you will take serious consideration to the comments we have provided on the BI Waiver Renewal application to slow down and make some changes. We appreciate the opportunity to provide comments.	
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