KANSAS HCBS WAIVER AMENDMENTS PACKAGE 2020

CONTENTS

I. UNBUNDLING ASSISTIVE SERVICE

Rationale for Change:
Between Q3 through the end of the year 2019, the state had started a process to unbundle Assistive Services in the HCBS Brain Injury waiver. At that time, other impacted waivers, particularly PD and FE waivers, were going through the renewal processes and could not be amended. A timeline was created and presented to CMS. After pursuing an amendment to the Brain Injury waiver to the point of submission, the state discovered a critical addition that needed to be included in the new services replacing Assistive Services.

At this time, the state opts to temporarily suspend the proposed amendment to unbundle assistive services in the BI waiver, make the necessary changes to the proposed new services, and restart the traditional amendment process.

The state intends to apply this amendment to all applicable HCBS waivers listed in the Table below:

Waiver				
Brain Injury	**FE**	**I/DD**	**PD**	**TA***
***Applying new service definition to HOME MODIFICATION on the TA Waiver**				

A. HOME MODIFICATION SERVICES: BILLING CODE: S5165

Home Modification Service will be a standalone service. The service shall be used to apply physical adaptations to the private residence of a participant or participant's family. The adaptation is deemed necessary to enable the participant to function with greater independence in the home. The adaption is noted as a requirement in the participant's service plan. This service may be substituted for Personal Services only when they have been identified as a cost-effective alternative to Personal Services on the participant's Person-Centered Service Plan.

Reimbursement for this service is limited to the participants assessed level of service and based on the person-centered service plan. Participants will have complete access to choose any qualified provider with consideration given to the most economical option available to meet the participant's assessed needs. Provision of this service is arranged and paid for by the participant's chosen KanCare managed care organization, or by the participant's FMS provider. In the event of a related vendor operating under a federally recognized Tribal entity that does not wish to contract with the MCO or FMS provider, the state shall provide a separate provider agreement which will allow the vendor to receive direct payment from Medicaid.

This service is limited to those services not covered through the Medicaid State Plan and which cannot be procured from other formal or informal resources (such as Vocational Rehabilitation, Rehabilitation Act of 1973, or the Educational System.) HCBS waiver funding is used as the funding source of last resort and requires prior authorization from the participant's chosen KanCare MCO.

1. Home modifications may not add to the total square footage of the home except when necessary to complete the modification. Examples include an increase in square footage to improve entrance/egress in a residence or to configure a bathroom to accommodate a wheelchair.
2. Home 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.
3. Home modifications may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services. The MCO may grant an informed, written exception, but will require the agency (provider) to pay for the costs associated with the removal, transfer, and re-installation

of modifications to the participant's new home. Participant specific items such as portable lifts and wheelchair modifications would be covered regardless of where the participant lives.

Purchases under this service, when added to/or combined with DME and Vehicle Modification Services, shall remain limited to a maximum lifetime expenditure of $7,500 per participant across waivers except for the I/DD Waiver.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

To avoid overlap of services, this service is limited to those services not covered through the Medicaid State Plan or other HCBS services and which cannot be procured from other formal or informal resources. Waiver funding shall be the funding source of last resort and requires prior authorization from the MCO via the participant's Person-Centered Service Plan.

Agency Provider Type: Center for Independent Living; and/or Individual Contractor

1. **Center for Independent Living**: Medicaid-enrolled provider. Applicable work must be performed according to local and county codes. General contractors must provide proof of a certificate of Worker's Compensation and General Liability Insurance and if required, must meet the local city and state building codes. All non-licensed general contractors must present a current certification of worker's compensation and general liability insurance, including proof of business establishment for a minimum of two (2) consecutive years. 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.
    a. **Entity Responsible for Verification:** Managed Care Organizations in accordance with the Provider Qualification policy M2017-171 Frequency of Verification: The MCOs, with oversight by KDADS, shall verify provider qualifications annually.

2. **Provider Category: Individual Contractor:** The contractor may or may not be an affiliate or subcontract with a recognized Center for Independent Living (CIL) or licensed Home Health Agency (as defined in KSA 65- 5001 et seq.).
    a. Individual contractors not affiliated or subcontracted with a CIL must enroll as a KanCare Provider.
3. Applicable work must be performed according to local and county codes. All non-licensed general contractors must present a current certification of worker's compensation and general liability insurance, including proof of business establishment for a minimum of two (2) consecutive years.
4. 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.
    a. **Entity Responsible for Verification:** Managed Care Organizations in accordance with the Provider Qualification policy M2017-171 Frequency of Verification: The MCOs, with oversight by KDADS, shall verify provider qualifications annually.

B. VEHICLE MODIFICATION SERVICES: BILLING CODE: T2039

Vehicle Modification service shall be a standalone service that applies adaptations or alterations to a vehicle to accommodate the special needs of the participant. The vehicle modified shall be the waiver participant's primary means of transportation. This service will replace Van Lifts presently provided through Assistive

Services. This service may be substituted for Personal Services only when they have been identified as a cost-effective alternative to Personal Services on the participant's Person-Centered Service Plan.

Reimbursement for this service is limited to the participant's assessed level of service and based on the person-centered service plan. Participants will have complete access to choose any qualified provider with consideration given to the most economical option available to meet the participant's assessed needs. Provision of this service is arranged and paid for by the participant's chosen KanCare managed care organization, or by the participant's FMS provider. In the event of a related vendor operating under federally recognized Tribal entity does not wish to contract with the MCO or FMS provider, the state shall provide a separate provider agreement which will allow the vendor to receive direct payment from Medicaid.

This service is limited to those services not covered through the Medicaid State Plan and which cannot be procured from other formal or informal resources (such as Vocational Rehabilitation, Rehabilitation Act of 1973, or the Educational System.) HCBS waiver funding is used as the funding source of last resort and requires prior authorization from the participant's chosen KanCare MCO.

1. Van lifts under vehicle modification services must meet engineering and safety requirements recognized by the Secretary of the US Department of Transportation.
2. Van lifts can only be installed in family vehicles or vehicles owned or leased by the participant.
3. A van lift may not be installed in an agency vehicle unless an informed, written exception is provided by the MCO.

Purchases under this service, when added to/or combine with DME and Home Modification, shall remain limited to a maximum lifetime expenditure of $7,500 per participant across waivers except for the I/DD Waiver.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

To avoid overlap of services, this service is limited to those services not covered through the Medicaid State Plan or other HCBS services and which cannot be procured from other formal or informal resources. Waiver funding shall be the funding source of last resort and requires prior authorization from the MCO via the participant's Person-Centered Service Plan.

Agency Provider Type: Center for Independent Living; and/or Individual Contractor

1. **Center for Independent Living**: Medicaid-enrolled provider. Applicable work must be performed according to local and county codes. General contractors must provide proof of a certificate of Worker's Compensation and General Liability Insurance and if required, must meet the local city and state building codes. All non-licensed general contractors must present a current certification of worker's compensation and general liability insurance, including proof of business establishment for a minimum of two (2) consecutive years. 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.
    a. **Entity Responsible for Verification:** Managed Care Organizations in accordance with the Provider Qualification policy M2017-171 Frequency of Verification: The MCOs, with oversight by KDADS, shall verify provider qualifications annually.

2. **Provider Category: Individual Contractor:** The contractor may or may not be an affiliate or subcontract with a recognized Center for Independent Living (CIL) or licensed Home Health Agency (as defined in KSA 65- 5001 et seq.).
    a. Individual contractors not affiliated or subcontracted with a CIL must enroll as a KanCare Provider.

3. Applicable work must be performed according to local and county codes. All non-licensed general contractors must present a current certification of worker's compensation and general liability insurance, including proof of business establishment for a minimum of two (2) consecutive years.
4. 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.
    a. **Entity Responsible for Verification:** Managed Care Organizations in accordance with the Provider Qualification policy M2017-171 Frequency of Verification: The MCOs, with oversight by KDADS, shall verify provider qualifications annually.

C. DURABLE MEDICAL EQUIPMENT (DME): BILLING CODE: T2029

DME shall be unbundled from Assistive Services to cover augmentative communication devices and other Durable Medical Equipment needs. State Plan coverage shall be accessed first to satisfy DME needs, and waiver provisions shall only supplement the State Plan.

Reimbursement for this service is limited to the participant's assessed level of service and based on the person-centered service plan. Participants will have complete access to choose any qualified provider with consideration given to the most economical option available to meet the participant's assessed needs. Provision of this service is arranged and paid for by the participant's chosen KanCare managed care organization, or by the participant's FMS provider. In the event of a related vendor operating under federally recognized Tribal entity does not wish to contract with the MCO or FMS provider, the state shall provide a separate provider agreement which will allow the vendor to receive direct payment from Medicaid.

This service is limited to those services not covered through the Medicaid State Plan and which cannot be procured from other formal or informal resources (such as Vocational Rehabilitation, Rehabilitation Act of 1973, or the Educational System.) HCBS waiver funding is used as the funding source of last resort and requires prior authorization from the participant's chosen KanCare MCO.

1. All DME must be prescribed by a licensed physician or licensed therapist.
2. DME shall meet the definition in KSA 65-1626.
3. DME shall meet the definition of medical necessity in KAR 30-5-58. When DME items provided under the waiver are not covered in the State Plan, the billing code shall be T2029.
4. Communication Devices shall be covered under DME, and is defined as devices, electronic or otherwise, that assist or enable the individual to communicate. All communication devices must be recommended by a speech pathologist. Communication devices are purchased for use by the individual only, not for use as agency equipment.

Purchases under this service when added to/or combine with Vehicle Modification and Home Modification, shall remain limited to a maximum lifetime expenditure of $7,500 per participant across waivers except for the I/DD Waiver.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

To avoid overlap of services, this service is limited to those services not covered through the Medicaid State Plan or other HCBS services and which cannot be procured from other formal or informal resources. Waiver funding shall be the funding source of last resort and requires prior authorization from the MCO via the participant's Person-Centered Service Plan.

Agency Provider Type: DME Provider
Provider Qualifications License (specify):

DME may be provided by all of the following:

1. Licensed Home Health Agency
2. Durable Medical Equipment provider
3. Pharmacy
4. Rural Health Clinic (medical supplies only)
5. Welding Shop (oxygen only)

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. A provider of services for a participant in foster care, adopted, part of Kan Be Healthy, or with special needs may be excluded from the above requirements if a determination is made that a medically necessary piece of durable medical equipment can be cost-efficiently obtained only from a provider not otherwise eligible to be enrolled according to the current program guidelines.

1. **Entity Responsible for Verification:** Managed Care Organizations in accordance with the Provider Qualification policy M2017-171 Frequency of Verification: The MCOs, with oversight by KDADS, shall verify provider qualifications annually.

II. STANDARDIZING PERFORMANCE MEASURES

This amendment applies to the following waivers listed in the table below. For a more comprehensive list of the proposed standardized performance measures, along with the proposed data collection points, please see the excel spreadsheet (Attachment 1):

Waiver						
Autism	**Brain Injury**	**FE**	**I/DD**	**PD**	**SED**	**TA**

A. AUTISM WAIVER

ADMINISTRATIVE AUTHORITY

- # and % of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency.
- # and % of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS by the State Medicaid Agency.
- # and % of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency.
- # and % of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports

FINANCIAL ACCOUNTABILITY

- # and % of clean claims that are paid by the managed care organization within the timeframes specified in the contract
- # and % of MCO capitated payment rates that were certified to be actuarially sound by the state's actuary and approved by CMS

PROVIDER QUALIFICATION

- # and % of newly enrolled waiver provider organizations that are licensed/certified by the state that met all licensure/certification requirements and other standards
- # and % of enrolled waiver provider organizations that are licensed/certified by the state that continues to meet all licensure/certification requirements, and other standards
- # and % of newly enrolled waiver provider organizations that are not licensed/certified by the state and met all provider organizational level waiver standards
- # and % of enrolled Waiver provider organizations that are not licensed/certified by the state and continue to meet all provider organizational level waiver standards

LEVEL OF CARE

- # and % of newly enrolled waiver participants who were determined to meet Level of Care (LOC) requirements prior to receiving HCBS services
- # and % of initial Level of Care (LOC) determinations that used the state's approved screening tool
- # and % of initial Level of Care (LOC) determinations made by a qualified assessor

SERVICE PLAN

- # and % of waiver participants whose person-centered service plans address participants' goals
- # and % of waiver participants whose person-centered service plans address their assessed needs and capabilities as indicated in the assessment
- # and % of waiver participants whose person-centered service plans address health and safety risk factors
- # and % of person-centered service plans (initial and annual updates) signed and dated within approved timeframes
- # and % of waiver participants who received services and supports as authorized in their person-centered service plans
- # and % of waiver participants whose record contains documentation indicating a choice of waiver service providers
- # and % of waiver participants whose record contains documentation indicating a choice of waiver services
- ~~# and % of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care.~~ This Performance Measure does not apply to the Autism waiver and the SED waiver, but applies to others.

HEALTH AND WELFARE

- # and % of unexpected deaths reported to KDADS for which review resulted in the identification of non-preventable causes
- # and % of unexpected deaths reported to KDADS for which review/investigation followed the appropriate policies and procedures
- # and % of adverse incidents reported to KDADS year to date (YTD) that were initiated and reviewed within required timeframes
- # and % of reported adverse incidents reported to KDADS for which review/investigation followed the appropriate policies and procedures
- # and % of restraint applications, seclusion or other restrictive interventions reported to KDADS that followed procedures as specified in the approved waiver

B. BRAIN INJURY – BI WAIVER

ADMINISTRATIVE AUTHORITY

- # and % of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency.
- # and % of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS by the State Medicaid Agency.
- # and % of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency.
- # and % of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports

FINANCIAL ACCOUNTABILITY

- # and % of clean claims that are paid by the managed care organization within the timeframes specified in the contract

- # and % of MCO capitated payment rates that were certified to be actuarially sound by the state's actuary and approved by CMS

PROVIDER QUALIFICATION

- # and % of newly enrolled waiver provider organizations that are licensed/certified by the state that met all licensure/certification requirements and other standards
- # and % of enrolled waiver provider organizations that are licensed/certified by the state that continues to meet all licensure/certification requirements, and other standards
- # and % of newly enrolled waiver provider organizations that are not licensed/certified by the state and met all provider organizational level waiver standards
- # and % of enrolled Waiver provider organizations that are not licensed/certified by the state and continue to meet all provider organizational level waiver standards

LEVEL OF CARE

- # and % of newly enrolled waiver participants who were determined to meet Level of Care (LOC) requirements prior to receiving HCBS services
- # and % of initial Level of Care (LOC) determinations that used the state's approved screening tool
- # and % of initial Level of Care (LOC) determinations made by a qualified assessor

SERVICE PLAN

- # and % of waiver participants whose person-centered service plans address participants' goals
- # and % of waiver participants whose person-centered service plans address their assessed needs and capabilities as indicated in the assessment
- # and % of waiver participants whose person-centered service plans address health and safety risk factors
- # and % of person-centered service plans (initial and annual updates) signed and dated within approved timeframes
- # and % of waiver participants who received services and supports as authorized in their person-centered service plans
- # and % of waiver participants whose record contains documentation indicating a choice of waiver service providers
- # and % of waiver participants whose record contains documentation indicating a choice of waiver services
- # and % of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care

HEALTH AND WELFARE

- # and % of unexpected deaths reported to KDADS for which review resulted in the identification of non-preventable causes
- # and % of unexpected deaths reported to KDADS for which review/investigation followed the appropriate policies and procedures
- # and % of adverse incidents reported to KDADS year to date (YTD) that were initiated and reviewed within required timeframes
- # and % of reported adverse incidents reported to KDADS for which review/investigation followed the appropriate policies and procedures

- # and % of restraint applications, seclusion or other restrictive interventions reported to KDADS that followed procedures as specified in the approved waiver

C. FRAIL ELDERLY – FE WAIVER

ADMINISTRATIVE AUTHORITY

- # and % of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency.
- # and % of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS by the State Medicaid Agency.
- # and % of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency.
- # and % of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports

FINANCIAL ACCOUNTABILITY

- # and % of clean claims that are paid by the managed care organization within the timeframes specified in the contract
- # and % of MCO capitated payment rates that were certified to be actuarially sound by the state's actuary and approved by CMS

PROVIDER QUALIFICATION

- # and % of newly enrolled waiver provider organizations that are licensed/certified by the state that met all licensure/certification requirements and other standards
- # and % of enrolled waiver provider organizations that are licensed/certified by the state that continues to meet all licensure/certification requirements, and other standards
- # and % of newly enrolled waiver provider organizations that are not licensed/certified by the state and met all provider organizational level waiver standards
- # and % of enrolled Waiver provider organizations that are not licensed/certified by the state and continue to meet all provider organizational level waiver standards

LEVEL OF CARE

- # and % of newly enrolled waiver participants who were determined to meet Level of Care (LOC) requirements prior to receiving HCBS services
- # and % of initial Level of Care (LOC) determinations that used the state's approved screening tool
- # and % of initial Level of Care (LOC) determinations made by a qualified assessor

SERVICE PLAN

- # and % of waiver participants whose person-centered service plans address participants' goals
- # and % of waiver participants whose person-centered service plans address their assessed needs and capabilities as indicated in the assessment
- # and % of waiver participants whose person-centered service plans address health and safety risk factors

- # and % of person-centered service plans (initial and annual updates) signed and dated within approved timeframes
- # and % of waiver participants who received services and supports as authorized in their person-centered service plans
- # and % of waiver participants whose record contains documentation indicating a choice of waiver service providers
- # and % of waiver participants whose record contains documentation indicating a choice of waiver services
- # and % of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care

HEALTH AND WELFARE

- # and % of unexpected deaths reported to KDADS for which review resulted in the identification of non-preventable causes
- # and % of unexpected deaths reported to KDADS for which review/investigation followed the appropriate policies and procedures
- # and % of adverse incidents reported to KDADS year to date (YTD) that were initiated and reviewed within required timeframes
- # and % of reported adverse incidents reported to KDADS for which review/investigation followed the appropriate policies and procedures
- # and % of restraint applications, seclusion or other restrictive interventions reported to KDADS that followed procedures as specified in the approved waiver

D. INTELLECTUAL AND DEVELOPMENTAL DISABILITY - I/DD WAIVER

ADMINISTRATIVE AUTHORITY

- # and % of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency.
- # and % of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS by the State Medicaid Agency.
- # and % of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency.
- # and % of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports

FINANCIAL ACCOUNTABILITY

- # and % of clean claims that are paid by the managed care organization within the timeframes specified in the contract
- # and % of MCO capitated payment rates that were certified to be actuarially sound by the state's actuary and approved by CMS

PROVIDER QUALIFICATION

- # and % of newly enrolled waiver provider organizations that are licensed/certified by the state that met all licensure/certification requirements and other standards

- # and % of enrolled waiver provider organizations that are licensed/certified by the state that continues to meet all licensure/certification requirements, and other standards
- # and % of newly enrolled waiver provider organizations that are not licensed/certified by the state and met all provider organizational level waiver standards
- # and % of enrolled Waiver provider organizations that are not licensed/certified by the state and continue to meet all provider organizational level waiver standards

LEVEL OF CARE

- # and % of newly enrolled waiver participants who were determined to meet Level of Care (LOC) requirements prior to receiving HCBS services
- # and % of initial Level of Care (LOC) determinations that used the state's approved screening tool
- # and % of initial Level of Care (LOC) determinations made by a qualified assessor

SERVICE PLAN

- # and % of waiver participants whose person-centered service plans address participants' goals
- # and % of waiver participants whose person-centered service plans address their assessed needs and capabilities as indicated in the assessment
- # and % of waiver participants whose person-centered service plans address health and safety risk factors
- # and % of person-centered service plans (initial and annual updates) signed and dated within approved timeframes
- # and % of waiver participants who received services and supports as authorized in their person-centered service plans
- # and % of waiver participants whose record contains documentation indicating a choice of waiver service providers
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HEALTH AND WELFARE

- # and % of unexpected deaths reported to KDADS for which review resulted in the identification of non-preventable causes
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- # and % of restraint applications, seclusion or other restrictive interventions reported to KDADS that followed procedures as specified in the approved waiver

E. PHYSICAL DISABILITY – PD WAIVER

ADMINISTRATIVE AUTHORITY

- # and % of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency.
- # and % of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS by the State Medicaid Agency.
- # and % of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency.
- # and % of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports

FINANCIAL ACCOUNTABILITY

- # and % of clean claims that are paid by the managed care organization within the timeframes specified in the contract
- # and % of MCO capitated payment rates that were certified to be actuarially sound by the state's actuary and approved by CMS

PROVIDER QUALIFICATION

- # and % of newly enrolled waiver provider organizations that are licensed/certified by the state that met all licensure/certification requirements and other standards
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LEVEL OF CARE

- # and % of newly enrolled waiver participants who were determined to meet Level of Care (LOC) requirements prior to receiving HCBS services
- # and % of initial Level of Care (LOC) determinations that used the state's approved screening tool
- # and % of initial Level of Care (LOC) determinations made by a qualified assessor

SERVICE PLAN

- # and % of waiver participants whose person-centered service plans address participants' goals
- # and % of waiver participants whose person-centered service plans address their assessed needs and capabilities as indicated in the assessment
- # and % of waiver participants whose person-centered service plans address health and safety risk factors
- # and % of person-centered service plans (initial and annual updates) signed and dated within approved timeframes
- # and % of waiver participants who received services and supports as authorized in their person-centered service plans
- # and % of waiver participants whose record contains documentation indicating a choice of waiver service providers

- # and % of waiver participants whose record contains documentation indicating a choice of waiver services
- # and % of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care

HEALTH AND WELFARE

- # and % of unexpected deaths reported to KDADS for which review resulted in the identification of non-preventable causes
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- # and % of restraint applications, seclusion or other restrictive interventions reported to KDADS that followed procedures as specified in the approved waiver

F. TECHNOLOGY ASSISTED – TA WAIVER

ADMINISTRATIVE AUTHORITY

- # and % of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency.
- # and % of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS by the State Medicaid Agency.
- # and % of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency.
- # and % of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports

FINANCIAL ACCOUNTABILITY

- # and % of clean claims that are paid by the managed care organization within the timeframes specified in the contract
- # and % of MCO capitated payment rates that were certified to be actuarially sound by the state's actuary and approved by CMS

PROVIDER QUALIFICATION

- # and % of newly enrolled waiver provider organizations that are licensed/certified by the state that met all licensure/certification requirements and other standards
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- # and % of enrolled Waiver provider organizations that are not licensed/certified by the state and continue to meet all provider organizational level waiver standards

LEVEL OF CARE

- # and % of newly enrolled waiver participants who were determined to meet Level of Care (LOC) requirements prior to receiving HCBS services
- # and % of initial Level of Care (LOC) determinations that used the state's approved screening tool
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SERVICE PLAN

- # and % of waiver participants whose person-centered service plans address participants' goals
- # and % of waiver participants whose person-centered service plans address their assessed needs and capabilities as indicated in the assessment
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- # and % of person-centered service plans (initial and annual updates) signed and dated within approved timeframes
- # and % of waiver participants who received services and supports as authorized in their person-centered service plans
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- # and % of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care

HEALTH AND WELFARE

- # and % of unexpected deaths reported to KDADS for which review resulted in the identification of non-preventable causes
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- # and % of adverse incidents reported to KDADS year to date (YTD) that were initiated and reviewed within required timeframes
- # and % of reported adverse incidents reported to KDADS for which review/investigation followed the appropriate policies and procedures
- # and % of restraint applications, seclusion or other restrictive interventions reported to KDADS that followed procedures as specified in the approved waiver

G. SERIOUS EMOTIONAL DISTURBANCE – SED WAIVER

ADMINISTRATIVE AUTHORITY

- # and % of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency.
- # and % of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS by the State Medicaid Agency.
- # and % of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency.
- # and % of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports

FINANCIAL ACCOUNTABILITY

- # and % of clean claims that are paid by the managed care organization within the timeframes specified in the contract
- # and % of MCO capitated payment rates that were certified to be actuarially sound by the state's actuary and approved by CMS

PROVIDER QUALIFICATION

- # and % of newly enrolled waiver provider organizations that are licensed/certified by the state that met all licensure/certification requirements and other standards
- # and % of enrolled waiver provider organizations that are licensed/certified by the state that continues to meet all licensure/certification requirements, and other standards
- # and % of newly enrolled waiver provider organizations that are not licensed/certified by the state and met all provider organizational level waiver standards
- # and % of enrolled Waiver provider organizations that are not licensed/certified by the state and continue to meet all provider organizational level waiver standards

LEVEL OF CARE

- # and % of newly enrolled waiver participants who were determined to meet Level of Care (LOC) requirements prior to receiving HCBS services
- # and % of initial Level of Care (LOC) determinations that used the state's approved screening tool
- # and % of initial Level of Care (LOC) determinations made by a qualified assessor

SERVICE PLAN

- # and % of waiver participants whose person-centered service plans address participants' goals
- # and % of waiver participants whose person-centered service plans address their assessed needs and capabilities as indicated in the assessment
- # and % of waiver participants whose person-centered service plans address health and safety risk factors
- # and % of person-centered service plans (initial and annual updates) signed and dated within approved timeframes
- # and % of waiver participants who received services and supports as authorized in their person-centered service plans
- # and % of waiver participants whose record contains documentation indicating a choice of waiver service providers
- # and % of waiver participants whose record contains documentation indicating a choice of waiver services
- ~~# and % of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care.~~ This Performance Measure does not apply to the SED waiver but to the other waivers.

HEALTH AND WELFARE

- # and % of unexpected deaths reported to KDADS for which review resulted in the identification of non-preventable causes
- # and % of unexpected deaths reported to KDADS for which review/investigation followed the appropriate policies and procedures
- # and % of adverse incidents reported to KDADS year to date (YTD) that were initiated and reviewed within required timeframes
- # and % of reported adverse incidents reported to KDADS for which review/investigation followed the appropriate policies and procedures
- # and % of restraint applications, seclusion or other restrictive interventions reported to KDADS that followed procedures as specified in the approved waiver

III. REQUIRING PROVISIONAL PLAN OF CARE

CMS requires that functional and financial eligibility, as well as a plan of care, be in place before HCBS waiver services can be paid. A Provisional Plan of Care allows for this requirement to be met, expediting the HCBS approval.

This amendment applies to the following waivers:

Waiver						
Autism	**Brain Injury**	**FE**	**I/DD**	**PD**	**SED**	**TA**

1. A Provisional Plan of Care must be on file for all individuals newly eligible to receive HCBS after January 1, 2020, before services can be authorized, except in the event of an HCBS Institutional Transition.
    a. If the participant is found eligible for a waiver, their information is sent to the Managed Care Organization (MCO) to establish and/or finalize the person-centered service plan.
        i. Since a person-centered service plan may require additional time to develop and complete; therefore, the assessing entities (ADRCs, CMHCs, CDDOs, MATLOC Assessors, KVC Assessors etc.) will develop and provide a provisional plan of care/person-centered service plans for individuals newly eligible to receive services under any of the HCBS waivers.
    b. The assessing entity is required to provide KDHE with a provisional plan of care and any other required documentation prior to HCBS authorization.
        i. If the provisional plan of care/person-centered service plan has not been submitted alongside other required documentation, the State Medicaid Agency shall contact the assessing entity responsible for conducting the functional eligibility assessment requesting proper documents.
    c. The state may create and circulate a fillable template to all HCBS waiver functional eligibility assessing entities for the purpose of completing a provisional plan of care at the time of assessment.
        i. Where such is created for a waiver, the assessing entity must properly complete the provisional plan of care template at the time of the functional assessment and must submit the completed document alongside other required documentation.

2. QUESTION FOR CMS: Where in the waiver will this information be posted?

IV. AUTHORIZING RESIDENTIAL SERVICES FOR MARRIED COUPLES ON I/DD WAIVER

Allow married IDD Waiver participants to both receive residential services in the same home. This amendment applies to the following waivers:

Waiver
I/DD

Adult Residential Supports are provided to waiver individuals who live in a residential setting and do not live with their birth or adoptive parents, or a person that meets the definition of family. Family, in this service, is defined as any person immediately related to the participant, such as parents/legal guardian, spouse, siblings, adult children, aunts, uncles, first cousins, and any step-family relationships, with the exception of a spouse also receiving HCBS I/DD waiver services.

- A legally married couple, both participants of the HCBS I/DD waiver services, may both receive residential services in the same home.

This service provides assistance with and acquisition, retention and/or improvement of skills related to activities of daily living such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting.

Adult Residential Supports may be provided in one of the following ways:

1. A participant lives in his or her own home or apartment without an individual meeting the definition of family or a service provider.
2. A participant lives in his or her own home or apartment with other individuals who do not meet the definition of family or a service provider
3. A participant lives in his or her own home or apartment while legally married to another individual who is also a participant of the I/DD waiver.

Adult Residential Supports may be provided in a licensed Group Home or Shared Living Setting.

Children's Residential Supports services provide direct assistance to participants in order to meet their daily living situation and serve to maintain or increase adaptive capabilities, independence, integration, and participation in the community. Children's Residential supports are for children who are not in the custody of DCF and who are between the ages of 5 and 21.

Access to these services ends on the participant's 22nd birthday. These services are designed to avoid placement in an institution, congregate residential setting, or DCF custody when the participant cannot remain in their natural family home.

These services are provided outside the family home in a home which:

1. Is licensed by KDHE as a family foster home, meets all State or KDADS requirements, or is another residential setting that is approved in writing by KDADS.
2. Serves no more than two (2) children unrelated to the waiver participant, and;
3. Is located in or near the child's home community and school, so the child remains in contact with the natural family, if appropriate, and maintains established community connections such as the

child's school and teachers, friends and neighbors, community activities, church, and health care professionals.

4. Is compliant with the HCBS Settings Final Rule.

Children's Residential providers must also cooperate with the MCO, the CDDO, the school district, and any consultants in designing and implementing specialized training procedures for the participant. They must also actively participant participate in IEP development and the public-school education program, as well as in the Person-Centered Support Planning and Person-Centered Service Planning processes for the participant. Kansas began a new stakeholder engagement process in summer 2019 to enhance several HCBS waiver programs, including the I/DD waiver. The stakeholder re-engagement period will focus on improving waiver service delivery, ensuring waiver participant freedom of choice, and supporting community inclusion. Changes to the waivers resulting from the stakeholder re-engagement process will be implemented via forthcoming amendments.

Residential Supports services cannot be provided in the participant's family home except in the case of a legally married couple both on the waiver.

Payments for Residential Supports are not made for room and board, the cost of facility maintenance, upkeep, and improvement, other than such costs for modifications or adaptations to the facility required to assure the health and safety of individuals or to meet the requirements of the applicable life safety code. Payments will not be made for routine care and supervision, which would be expected to be provided by family members or for which payment is made by a source other than Medicaid. The method by which the costs of room and board are excluded from payment for residential supports is specified in Appendix I-5.

To avoid overlap of services, Adult and Child Residential Habilitation Services are limited to those services not covered through EPSDT, the Medicaid State Plan, or other HCBS services and which cannot be procured from other formal or informal resources. Waiver funding shall be the funding source of last resort and requires prior authorization from the MCO via the participant's Person-Centered Service Plan. Participants of Adult and Child Residential Supports cannot also receive Personal Care Services, Overnight Respite, or Enhanced Care Services (ECS).

Room, board, and transportation costs are excluded in the cost of any IDD services except overnight facility-based respite.

Residential Supports services cannot be provided to anyone who is an inpatient of a hospital, a nursing facility, or an ICF-IID. Residential Supports for adults are provided for individuals 18 years of age or older and must occur in a setting where the person does not live with someone who meets the definition of family and are provided by entities licensed by KDADS. This setting must be ADA compliant, as well as compliant with the HCBS Settings Final Rule.

Children's Residential Supports cannot be provided in a home where more than two participants funded with State or Medicaid money reside.

For the provider to bill the daily rate for residential supports, the participant must have received a residential support service on the date that the provider is billing for. Residential Support services cannot exceed the specific services authorized on the participant's Service Plan. However, a provider of Residential Supports may respond to a residential crisis as prescribed by the participant's backup plan. A crisis is defined as a situation in which the participant or participant's representative requests assistance

due to him/herself feeling unsafe, medical emergencies, mental health emergencies, and/or law enforcement involvement.

V. AMENDMENTS TO SPECIALIZED MEDICAL CARE(SMC) TIME LIMITS

This amendment applies to the following waivers:

Waiver	
I/DD	TA

This service provides long-term nursing support for medically fragile and technology-dependent participants. The required level of care must provide medical support for participants needing ongoing, daily care that would otherwise require the participant to be in a hospital. The intensive medical needs of the participant must be met to ensure that the participant can live outside of a hospital or Intermediate Care Facility for Individuals with an Intellectual Disability (ICF-IID).

For the purpose of this waiver, a provider of Specialized Medical Care (SMC) must be an RN or an LPN under the supervision of an RN. Providers of this service must be trained with the medical skills necessary to care for and meet the medical needs of participants within the scope of the State's Nurse Practice Act. The service may be provided in all customary and usual community locations, including where the participant resides and socializes. It is the responsibility of the provider agency to ensure that qualified nurses are employed and able to meet the specific medical needs of the participant. Providers of this service will be reimbursed for medically appropriate and necessary services relative to the level of need, as identified in the participant's Service Plan.

Access to Specialized Medical Care Services is limited to those participants whose needs can only be met by an RN or LPN as determined by a Needs Assessment based on how often and to what extent a person's needs can only be met through the use of medical technology.

This waiver service is only provided to individuals age 21 and over. All medically necessary Specialized Medical Care services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

Specialized Medical Care is limited to those services which cannot be procured from other formal or informal resources. Waiver funding shall be the funding source of last resort and requires prior authorization from the MCO via the participant's Person-Centered Service Plan.

1. Specialized Medical Care Services participants may not also receive Residential Supports or Personal Care Services as an alternative to Specialized Medical Care Services.
2. Individuals who are eligible to receive EPSDT services may access Specialized Medical Services through the Medicaid state plan. Waiver limits do not apply to individuals receiving benefits under EPSDT.
3. Specialized Medical Care services authorized for children in DCF custody cannot be provided by the waiver participant's foster parent as a waiver-funded service.
4. Room, board, and transportation costs are excluded.
5. Specialized Medical Care services may not be provided by a participant's spouse or by a parent of a participant who is a minor child under 18 years of age.
6. A participant can receive Specialized Medical Care services from more than one worker, but no more than one worker can be paid for services at any given the time of day. A Specialized Medical Care provider cannot be paid to provide services to more than one participant at any given the time of day.
7. Specialized Medical Care services are limited to a maximum of twelve hours per day or 1448 units per month. One unit is equal to 15 minutes.
    a. The MCO may authorize more units, exceeding this limit, based on the person-centered needs.
8. Services furnished to a participant who is an inpatient or resident of a hospital, nursing facility, ICF-IID, or IMD are not reimbursable.

9. Per the KanCare contracts, the MCOs are responsible for ensuring the individual's needs are met with a combination of waiver, State Plan, and community resources. The MCO would ensure via the Person-Centered Service Plan and monitoring of the plan that the needs of the participant are being met.

VI. REVISING DAY SERVICES DEFINITION TO PRE-RENEWAL DEFINITION

Revert to the old definition.
This amendment applies to the following waivers:

Waiver
I/DD

Definition from HCBS I/DD Waiver March 1, 2016:

Day Supports are regularly occurring activities that provide a sense of participation, accomplishment, personal reward, personal contribution, or remuneration and thereby serve to maintain or increase adaptive capabilities, productivity, independence, or integration and participation in the community. Day Supports also includes the provision of pre-vocational services which are aimed at preparing a participant for paid or unpaid employment but are not job-task oriented. These services include teaching such concepts as compliance, attendance, task completion, problem solving and safety.

Such activities shall be appropriate for or lead to a lifestyle as specified in the participant's Person Centered Support Plan. These opportunities can include socialization, recreation, community inclusion, adult education, and skill development in the areas of employment, transportation, daily living, self-sufficiency, and resource identification and acquisition.

Day Supports are provided in a variety of settings in the community at large. Services must be provided outside of the participant's residence unless the person has been determined frail or fragile and the provided has a signed statement from the participants' physician that receiving the supports outside the home would put the participants' health at risk.

The state will develop a timeline for submitting an amendment that will comply with CMS guidelines to separate Prevocational Services from Day Habilitation effective July 1, 2016.

A. HCBS I/DD Day Supports can NOT be provided to anyone who is an inpatient of a hospital, a nursing facility, or an ICF-I/DD
B. Participants eligible for services through the local education authority shall not have access for reimbursement unless they are at least 18 years of age, are graduating from high school before the age of 22 and a transition plan is developed by a transition team that includes the CDDO representative or the CDDOs designee.
C. Participants must be out of their home during times that Day Supports is being billed except when;
    a. participant operates a home based business, or;
    b. a participant is unable to be out of their home due to a medical necessity or significant physical limitations related to frailty and for which a physician has provided current (within the past 6 months and reviewed at least every 6 months thereafter) written verification for the necessity to remain in the home
    c. a participant is unable to be out of his or her home due to extreme weather conditions or another extenuating circumstance occurs and an exception is granted in writing by the KDADS HCBS program manager.

Those participants eligible to receive services while they remain in the home must participate in activities consistent with their person-centered support plan and to the extent possible, replicate activities in which the person would be participating if they were out of the home.

D. Pre-vocational services cannot duplicate services funded under the Rehabilitation Act of 1973 or under the provisions of IDEA.

Those persons eligible to receive services while they remain in the home must participate in activities consistent with their person-centered support plan and to the extent possible, replicate activities in which the person would be participating if they were out of the home.

VII. SUMMARY DOCUMENT

A. Unbundling Assistive Service

The Kansas Department for Aging and Disability Services, KDADS, is submitting an amendment to the 1915(c) Waiver for the Brain Injury program.

The proposed effective date of the amendment is 05/01/2021.

Purpose of the Amendment:

The purpose of this amendment is to unbundle Assistive Services as it currently stands in the Kansas 1915(c) HCBS FE, I/DD, PD, TA waivers replacing the service with the following services: Durable Medical Equipment (DME), Vehicle Modification, and Home Modifications as separate waiver services. This change is consequent of a recent interpretation by CMS of the 42 CFR 441.301(b)(4) requirement that multiple services that are generally considered to be separate services may not be consolidated under a single definition, as applicable to Assistive Services.

B. Standardizing Performance Measures

The purpose of this amendment is to standardize the performance measures in all Kansas 1915(c) HCBS waivers. Please see the amendment document for a summary of the proposed standard performance measures.

C. Requiring a Provisional Plan of Care

CMS requires that functional and financial eligibility, as well as a plan of care, be in place before HCBS waiver services can be paid. A Provisional Plan of Care allows for this requirement to be met, expediting the HCBS approval.

This amendment applies to all Kansas 1915(c) HCBS waivers. It requires functional eligibility assessing entities in the state to provide the State Medicaid Agency with a provisional plan of care and any other required documentation prior to HCBS authorization. The state may create and circulate a fillable template to all HCBS waiver functional eligibility assessing entities for the purpose of completing a provisional plan of care at the time of assessment.

D. Authorizing Residential Services for Married Couples On I/DD Waiver

This amendment applies to the Kansas 1915(c) HCBS I/DD waiver. It allows married I/DD Waiver participants to both receive residential services in the same home.

The amendment adds an exception to the definition of family. In the proposed amendment, the definition of a Family is as follows:

Family, in this service, is defined as any person immediately related to the participant, such as parents/legal guardian, spouse, siblings, adult children, aunts, uncles, first cousins, and any step-family relationships, with the exception of a spouse also receiving HCBS I/DD waiver services.

- *A legally married couple, both participants of the HCBS I/DD waiver services, may both receive residential services in the same home.*

E. Amendments To Specialized Medical Care (SMC) Time Limits

This amendment applies to the Kansas 1915(c) HCBS I/DD and TA waivers. The amendment adds an exception to the daily limits of Specialized Medical Care (SMC), allowing the managed care organizations in the state to authorize more units for SMC based on participants' PCSP.

1. Specialized Medical Care services are limited to a maximum of twelve hours per day or 1448 units per month. One unit is equal to 15 minutes.
    a. The MCO may authorize more units, exceeding this limit, based on the person-centered needs.

F. Revising Day Services Definition to Pre-Renewal Definition

This amendment applies to the Kansas 1915(c) HCBS I/DD waiver. It changes the definition of Day Services to the definition of the service as of March 2016 while the state draws up a plan