

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

Section B: Clarified that the BI waiver is a short-term therapeutic waiver. This renewal will establish the BI waiver as a 3-year therapeutic waiver. During the three-year period the participant will identify their overall transition goal they would like to achieve by the end of year three on the waiver. Therapy goals center around that. Active participation in therapies and making progress towards their goals remains a criterion throughout the 3-year time frame.

Included degenerative conditions as not being served in the waiver. These conditions, along with conditions that are Congenital and Chromosomal are not Acquired Brain Injuries.

Established criteria and process for former participants seeking to return to the waiver after closure if negative symptoms return or a new BI occurs.

The eligibility process was clarified to show the progression of the 3 eligibility steps and who is responsible for each step.

A minimum of 6 months active participation in therapies is required to be able to determine inability to make progress on the established therapy goals and/or be ready to transition to another waiver. Participants must meet the 6 month active participation eligibility criteria for a waiver-to-waiver transition, this can include bypassing the waitlist, if a waitlist is present for the waiver the participant wishes to transition to.

Participants of the BI waiver who choose to transition from the BI waiver to the WORKS program may transition back to the BI Waiver, or directly to another HCBS waiver that they meet the eligibility requirements for if they are not in need of active BI Therapies, at the closure of their enrollment in the Works Program.

Section C: Personal Care services is clarified as follows: Services are delivered in an acute care setting to align with the CARES Act. Personal Care Services provided in a home school setting must not be educational in purpose. The MCO Care Coordinator is to identify those personal care services requiring the PCS provider be available while attending therapies and medical appointments in the person-centered support plan.

The Transitional Living Service (TLS) language was clarified, and the limit of 4 hours daily was adjusted to 260 Units/65 hours. Unused units may roll over month to month until reaching the end of their annual service plan. As designated by the participant. This is not a change in the scope, duration or limits. It allows for increased flexibility and person-centered planning and delivery of the service.

Section D-in regard to the person-centered service plan: Clarified the MCO Care Coordinator is responsible for explaining the Brain Injury Waiver Therapy Services available as well as other services available to the participant while actively engaged in therapies. The assessments utilized in the person-centered service planning process has been clarified. Also specified that the participant should choose first choice and second choice of provider in event the first choice has barriers to initiate therapies timely.

Section F: Clarified the Notice of Action for Eligibility Decisions regarding eligibility grievances and fair hearings.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The State of Kansas requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (optional - this title will be used to locate this waiver in the finder):

Kansas HCBS Brain Injury Waiver

C. Type of Request: renewal

Requested Approval Period: (For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)

3 years 5 years

Original Base Waiver Number: KS.4164

Draft ID: KS.012.07.00

D. Type of Waiver (select only one):

Regular Waiver

E. Proposed Effective Date: (mm/dd/yy)

07/01/24

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (*check each that applies*):

Hospital

Select applicable level of care

Hospital as defined in 42 CFR §440.10

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

Brain Injury Rehabilitation Facility and hospital

Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160**Nursing Facility**

Select applicable level of care

Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I

Waiver(s) authorized under §1915(b) of the Act.

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates (*check each that applies*):

§1915(b)(1) (mandated enrollment to managed care)

§1915(b)(2) (central broker)

§1915(b)(3) (employ cost savings to furnish additional services)

§1915(b)(4) (selective contracting/limit number of providers)

A program operated under §1932(a) of the Act.

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

A program authorized under §1915(i) of the Act.

A program authorized under §1915(j) of the Act.

A program authorized under §1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

This waiver provides services for individuals who are eligible for both Medicare and Medicaid.

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Brain Injury (BI) waiver provides clinically prescribed habilitation/rehabilitation therapy services on a short-term/transitional basis to eligible Kansans following the occurrence of, and treatment for their brain injury. The program offers an alternative to seeking services from more expensive, non-inclusive, institutional settings when negative symptoms of a brain injury rise to the level the social determinants of health are negatively impacted. Kansans both in the community or in institutional settings who have a brain injury are given the option to receive the HCBS Brain Injury Waiver services in their private home and community in a cost-efficient manner. Those actively engaged in the BI Waiver therapies are also able to utilize a comprehensive package of other waiver services, as well as medical services offered by the KanCare health plans through the Managed Care Organizations (MCO). BI Waiver services provided by the KanCare health plans Managed Care Organizations (MCO) will be paid as part of a capitated rate.

Therapies offered to the Brain Injury Waiver Participants: Behavior and Cognitive Therapies as well as extended state plan Occupational, Physical, Speech and Language, and Transitional Living Skills.

Other waiver services offered while actively engaged in therapies: Personal Care Services, Financial Management Services, Enhanced Care Services, Home and Environmental Modification Services (HEMS), Home Delivered Meal Services, Medication Reminder Services, Personal Emergency Response Systems and Installation, Specialized Medical Equipment (SMES), Transitional Living Skills, and Vehicle Modification Services (VMS)

Eligibility is completed in 3 steps: 1) The contracting assessing entity completes the functional assessment, confirms the functional assessment level of care (LOC) threshold outcome and gathers supporting documents. 2) KDADS HCBS BI Waiver Program Manager or Specialist determines if Program Eligibility criteria has been met. 3) KDHE KanCare determines Disability and Financial Eligibility and holds the authority in determining all eligibility steps have been completed and the criteria has either not been met, resulting in a denial, or has been met and entrance to the HCBS BI Waiver Program is approved. KDHE/KanCare submits the approved individual to the MCO selected by the applicant, or if none was chosen KDHE KanCare will make the initial selection.

Eligibility Criteria:

- Be a resident of the state of Kansas.
- Applicants ages 0 thru 3 parent(s) or legal guardian must complete section one of the Youth Medicaid Functional Eligibility Instrument (MFEI) with a qualified assessor.
- Ages 4 thru 18 years must meet level of care eligibility based on the State approved Youth Medicaid Functional Eligibility Instrument (MFEI) administered by a qualified assessor, reflecting the youth meets the criteria for placement in a hospital,
- Ages 18 thru 64 years must meet level of care eligibility based on the State approved Adult Medicaid Functional Eligibility Instrument (MFEI) administered by a qualified assessor, reflecting the criteria for placement in a hospital or Brain Injury Rehabilitation Facility is met.
- Ages 0 thru 64 are required to provide their assessor with medical documentation from a qualified Medical Professional that:
 - 1) Provides a medical diagnosis of a Traumatic Brain Injury (TBI), and/or, Acquired Brain Injury (ABI), that occurred post-birth and is not a degenerative disease or the result of a congenital or chromosomal disorder.
 - 2) Current recommendations of the habilitation (youth)/rehabilitation therapy(s) to address the current rehabilitative and independent living skills for adults and assist youth in relearning and developing skills their peers of same age have acquired.
- Ages 19 and older must be determined disabled by Social Security Standards.
- All applicants must apply for and meet the eligibility financial criteria for KanCare's Medicaid Long Term Care Services for the Elderly and Persons with a Disability program.

Individuals who have previously been enrolled in the HCBS Brain Injury Waiver services may request to return to the waiver if there is a relapse of negative symptoms, or a new brain injury occurs with negative symptoms impacting social determinants of health that may lead to placement in an institutional setting. Individuals returning to the waiver must have a Medicaid Functional Eligibility Instrument completed in the last 365 days showing the level of care criteria has been met, as well as providing current diagnostic documentation with recommendations of needed therapies.

Participants who have engaged in a minimum of 6 months of active participation in therapies may meet the transition eligibility requirements for one of KDADS long-term waivers as outlined in KDADS BI Transition Policy.

The participant's person-centered service plan will reflect their service and provider choices as well as establish goals they hope to meet by the end of their 3rd years of therapy. At the beginning of the 3rd year the participant and supporting team will identify a targeted transition plan timeline to ensure steps are taken to ensure a smooth transition at the end of their BI waiver services. BI Waiver participants may choose to transition to one of the long-term HCBS waivers if eligibility criteria are met.

For eligibility to the transition to the IDD waiver, according to State Statute (K.S.A. 39-1801 et seq.), the disability must be diagnosed before the age of 22 to qualify as a developmental disability, regardless of the cause of the disability. Individuals meeting that criteria may be assessed for programmatic and functional eligibility for the IDD waiver to ensure the individual can remain in the community.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the state provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):
- Yes. This waiver provides participant direction opportunities.** Appendix E is required.

No. This waiver does not provide participant direction opportunities. Appendix E is not required.
- F. Participant Rights.** Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy.** Appendix H contains the Quality Improvement Strategy for this waiver.
- I. Financial Accountability.** Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

- A. Comparability.** The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.
- B. Income and Resources for the Medically Needy.** Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):
- Not Applicable
- No
- Yes
- C. Statewidelessness.** Indicate whether the state requests a waiver of the statewidelessness requirements in §1902(a)(1) of the Act (*select one*):
- No

Yes

If yes, specify the waiver of statewideness that is requested (*check each that applies*):

Geographic Limitation. A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.

Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

Limited Implementation of Participant-Direction. A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.

Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the state provides the following assurances to CMS:

- A. Health & Welfare:** The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The state assures that, for any year that the waiver is in effect, the average per capita

expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are inpatients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee

schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

The Kansas Department for Aging and Disability Services is seeking public comments from February 15th 2024-March 16th 2024

The proposed renewal is posted on the KDADS website at www.kdads.ks.gov or may be requested from:

o Kansas Department for Aging and Disability Services kdads.hcbs-ks@ks.gov

Comments may be made in any one of the following ways:

- Online (KDADS website):
- o www.kdads.ks.gov under the Community Services and Programs page
- By Email: To Kansas Department for Aging and Disability Services kdads.hcbs-ks@ks.gov
- By standard mail:
- o Kansas Department for Aging and Disability Services Attn: HCBS Programs 503 S. Kansas Avenue, Topeka, KS 66603

Comments may be made in any one of the following ways:

- Online (KDADS website):
- o www.kdads.ks.gov under the Community Services and Programs page
- By Email:
- o Kansas Department for Aging and Disability Services kdads.hcbs-ks@ks.gov
- By standard mail:
- o Kansas Department for Aging and Disability Services Attn: HCBS Programs 503 S. Kansas Avenue, Topeka, KS 66603

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

Weiter

First Name:

Kurt J

Title:

Waiver Program Manager

Agency:

Kansas Department of Health and Environment

Address:

Landon State Office Building, Suite 900 North

Address 2:

900 SW Jackson Street

City:

Topeka

State:

Kansas

Zip:

66612-1220

Phone:

(785) 296-8623

Ext:

TTY

Fax:

(785) 296-4813

E-mail:

Kurt.Weiter@ks.gov

B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

Segelquist

First Name:

Susan

Title:

BI Program Manager

Agency:

Kansas Department for Aging & Disability Services

Address:

New England Building

Address 2:

503 S. Kansas Ave.

City:

Topeka

State: **Kansas**

Zip:

66603-3404

Phone:

(785) 368-6302

Ext:

TTY

Fax:

(785) 296-0256

E-mail:

Susan.Segelquist2@ks.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under §1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are **readily** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

Kansas

Zip:

	<input type="text"/>		
Phone:	<input type="text"/>	Ext:	<input type="text"/> TTY
Fax:	<input type="text"/>		
E-mail:	<input type="text"/>		
Attachments	<input type="text"/>		

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

Replacing an approved waiver with this waiver.

Combining waivers.

Splitting one waiver into two waivers.

Eliminating a service.

Adding or decreasing an individual cost limit pertaining to eligibility.

Adding or decreasing limits to a service or a set of services, as specified in Appendix C.

Reducing the unduplicated count of participants (Factor C).

Adding new, or decreasing, a limitation on the number of participants served at any point in time.

Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.

Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

In clarifying the BI waiver as a short-term waiver and identifying the 3-year participation window may impact some participants who have been on the BI waiver beyond that time frame and do not feel ready to transition from the BI waiver. A special services review can be requested by the MCO to the KDADS BI program manager including their person-centered service plan outlining their current goals and steps that will be taken to accomplish them and the projected length of time needed to complete them. KDADS will review the plan to determine if an extension of the time on the waiver can be extended, and to identify options/timelines for transition if an extension is not approved. The participant maintains the right to appeal any adverse action.

Waiver-to-waiver transition eligibility criteria requires the BI waiver participant to complete the initial 6 months of therapy as outlined on their person-centered service plan. If during a case review it is determined that progress is no longer being made, or therapies are no longer wanted, the MCO will engage in a transition process to ensure needs will be met after BI waiver services are ended.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The transition period has expired.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Virtual Delivery PCS is available for agency-directed PCS only.

Virtual delivery of a service (VDS) is an electronic method of service delivery. The purpose of virtual delivery of a service is to maintain or improve a participant's functional abilities, enhance interactions, support meaningful relationships, and meaningfully participate in their community.

The participant must have other opportunities for integration in the community via other services the participant receives.

VDS shall mean the provision of supports through equipment with the capability for live real-time audio-visual connection that allows the staff member to both see and hear the participant.

Direct support can be provided through the virtual delivery of the service when all of the following requirements are met:

- a. The virtual delivery of the service ensures the participant's rights of privacy, dignity and respect, and freedom from coercion and restraint.
- b. The virtual delivery of the service does not isolate the participant from the community or interacting with people without disabilities.
- c. The virtual delivery of the service has been agreed to by the participant and their team and outlined in the Person-Centered Service Plan;
- i. Participants must have an informed choice between in person or the virtual delivery of the service;
- ii. The virtual delivery of a service cannot be the only service delivery provision for a participant seeking the given service; and
- iii. Participants must affirmatively choose virtual delivery of the service over in-person supports.
- e. VDS is not and shall not be used for the provider's convenience. The virtual delivery of the service shall be used to support a participant to reach identified outcomes in the participant's service plan;
- f. Virtual delivery of a service must be documented appropriately as any other service being delivered, including start and end times.
- g. The virtual delivery of a service must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations to protect the privacy and security of the participant's protected health information.
- h. VDS, including using phones, cannot be used to assess a participant for a medical emergency. The provider must develop and maintain written policies, train direct support staff on those policies, and advise participants and their person-centered planning team regarding those policies that address:
 - i. Identifying individuals to intervene (such as uncompensated caregivers present in the participant's home), and ensuring they are present during provision of virtual delivery of the service in case the participant experiences an emergency; and processes for requesting such intervention if the participant experiences an emergency during provision of virtual supports, including contacting 911 if necessary.
 - i. The virtual supports meets all federal and State requirements, policies, guidance, and regulations.
- j. Providers furnishing this Waiver program service via virtual delivery of service must include virtual delivery of a service in their provider Program Service Plan prior to implementing outside of the Appendix K authority.
- k. The provider must develop, maintain, and enforce written policies, approved by the state, which address:
 - i. Identifying whether the participant's needs, including health and safety, can be addressed safely via virtual delivery of the service.
 - ii. How the provider will ensure the participant's rights of privacy, dignity and respect, and freedom from coercion and restraint during virtual delivery of the service.
 - iii. How the provider will ensure the virtual delivery of the service meets applicable information security standards; and
 - iv. How the provider will ensure the provision of virtual delivery of the service complies with applicable laws governing individuals' right to privacy.

Instances, Instructions, and Limitations

- The participant's service plan must indicate the use of the virtual delivery of the service.
- The MCO must document the frequency of the virtual delivery of the service.
- When virtual delivery of the service is provided, the provider shall only render the service or support on a one-on-one/individualized basis.
- VDS may leverage the existing technologies or devices belonging to the waiver participant.
- The provider shall be responsible for the maintenance, upkeep and assurance the device is in working order.
- Where virtual delivery of a service is requested by the participant and authorized by the MCO, the following requirements shall be met to ensure the delivery method does not lead to isolating or regimenting the participant from the greater community. The virtual delivery of the service shall be provided in the participant's preferred setting.
- The participant's choice for virtual delivery of a service shall be documented and included in their service plan.

The participant shall be able to rescind their choice of virtual delivery of a service at any time.

When this occurs, the MCO shall ensure service continuity via a non-virtual delivery method and confirm that the participant's service plan reflects the participant's choice change.

The MCO shall be responsible for ensuring that the provider is educating and informing the participant on the scope of the virtual delivery of the service prior to documenting the choice of the individual.

- Where virtual delivery of a service is requested by the participant and authorized by the MCO, the provider shall train the

participant to use the solution or application and device (where a new device is provided).

The training shall assist the participant in attaining the knowledge required to operate technologies that facilitate successful virtual delivery of the service.

- One unit of a service delivered virtually, shall be equivalent to one unit of in person service delivery (the same) when provided through virtual delivery of a service and shall be reimbursed equivalently.

- MCOs shall require providers delivering virtual services to have backup plans in the event of failure of the virtual delivery of service solution.

The state may require MCOs to present a sample of their provider backup plans for virtual delivery of a service.

- If a technology or device is provided to the participant for the primary purpose of virtual delivery of a service, placement of such devices/equipment/technology shall be solely determined by the participant.

- The participant shall have total control of the device, including turning it off or on.

- It shall be documented in the service plan what happens if and when a participant decides to turn off the equipment.

- Virtual delivery of service would not be authorized for a person who required hands on or physical assistance. The approved task, frequency and duration of virtual delivery of service will be documented in the Person Centered Service Plan.

- Virtual supports may only be permitted in bedrooms and bathrooms when an evaluation of multiple factors show that the technology increases independence and facilitates each participant's right to privacy of person and possession.

Virtual Services in bedrooms and bathrooms can only be provided with signed consent of the participant/guardian, the person's support team and the MCO.

Virtual delivery of service in bedrooms and bathrooms must be approved in the Person Centered Service Plan with a plan to fade the service as appropriate.

Telehealth services will promote community integration: Virtual delivery of services allows the participant more autonomy and independence in choice making. It incentivizes community integration in step with the ADA Integration Mandate and Olmstead Decision which prioritizes services in the most integrated settings for individuals with disabilities.

Telehealth will ensure the health and safety of an individual: The provider and MCO are required to ensure health and safety can be maintained with this mode of service delivery.

Regarding services for individuals who need hands-on or physical assistance: Services that require hands on or physical assistance will not be approved for virtual delivery of service.

The state will support individuals who need assistance with using the technology required for telehealth delivery of the services: The level of support required via training or education will be defined in the Person Centered Service Plan. Each participant who utilizes virtual delivery of a service needs to be assessed for their level of independence for this mode of service delivery.

Regarding the percentage of time telehealth will be the delivery method for each service: Each participant will make this determination via their Person Centered Service Plan.

Regarding the requirement for in-person visits: Each participant will make this determination via their Person Centered Service Plan. Participants will have a choice of in person or virtual delivery of services.

Regarding telehealth delivery of each service meeting HIPAA requirements: Telehealth delivery of service will meet HIPAA requirements.

Virtual delivery of services will meet the privacy of the individual, especially in instances of toileting, dressing, etc., as video cameras/monitors are not permitted in bedrooms and bathrooms: The participant will design their own privacy parameters for virtual delivery use per services; this will be outlined in the Person Centered Service Plan.

Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver (*select one*):

The waiver is operated by the state Medicaid agency.

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one*):

The Medical Assistance Unit.

Specify the unit name:

(Do not complete item A-2)

Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.

Specify the division/unit name:

Kansas Department for Aging and Disability Services / Community Services and Programs Commission

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

Kansas Department of Health and Environment (KDHE), which is the single state Medicaid agency (SSMA), and the Kansas Department for Aging and Disability Services (KDADS) have an interagency agreement which, among other things:

- Specifies that the SSMA is the final authority on compensatory Medicaid costs.
- Recognizes the responsibilities imposed upon the SSMA as the agency authorized to administer the Medicaid program, and the importance of ensuring that the SSMA retains final authority necessary to discharge those responsibilities.
- Requires the SSMA approve all new contracts, MOUs, grants or other similar documents that involve the use of Medicaid funds.
- Notes that the agencies will work in collaboration for the effective and efficient operation of Medicaid health care programs, including the development and implementation of all program policies, and for the purpose of compliance with all required reporting and auditing of Medicaid programs.
- Requires the SSMA to provide KDADS with professional assistance and information, and both agencies to have designated liaisons to coordinate and collaborate through the policy implementation process.
- Delegates to KDADS the authority for administering and managing certain Medicaid-funded programs, including those covered by this waiver application.
- Specifies that the SSMA has final approval of regulations, State Plan Amendments (SPAs) and Medicaid Management Information System (MMIS) policies, is responsible for the policy process, and is responsible for the submission of applications/amendments to CMS in order to secure and maintain existing and proposed waivers, with KDADS furnishing information, recommendations and participation. (The submission of this waiver application is an operational example of this relationship. Core concepts were developed through collaboration among program and operations staff from both the SSMA and KDADS; functional pieces of the waiver were developed collectively by KDHE and KDADS staff; and overview/approval of the submission was provided by the SSMA, after review by key administrative and operations staff and approval of both agencies' leadership.) The state leadership-level meetings occur weekly and additional meetings occur as needed.

In addition to leadership-level meetings to address guiding policy and system management issues (both ongoing periodic meetings and as needed, issue-specific discussions), the SSMA ensures that KDADS performs assigned operational and administrative functions by the following means:

- a. Regular meetings are held by the SSMA with representatives from KDADS to discuss:
 - Information received from CMS;
 - Proposed policy changes;
 - Waiver amendments and changes;
 - Data collected through the quality review process
 - Eligibility, numbers of providers being served
 - Fiscal projections; and
 - Any other topics related to the waivers and Medicaid.
- b. All policy changes related to the waivers are approved by KDHE. This process includes a face to face meeting with KDHE staff.
- c. Waiver renewals, 372 reports, any other federal reporting requirements, and requests for waiver amendments must be approved by KDHE.
- d. Correspondence with CMS is copied to KDHE.

Kansas Department of Health and Environment, as the single state Medicaid agency, has oversight responsibilities for all Medicaid programs, including direct involvement or review of all functions related to HCBS waivers. KDHE has oversight of all portions of the program and the KanCare MCO contracts, and does collaborate with KDADS regarding HCBS program management, including those items identified in part (a) above. The key component of that collaboration has been through the long term care meetings, KanCare Steering meetings, joint policy meetings, are all important parts of the overall state's KanCare Quality Improvement Strategy, which provides quality review and monitoring of all aspects of the KanCare program – engaging program management, contract management, and financial management staff from both KDHE and KDADS. The services in this waiver are part of the state's KanCare comprehensive Medicaid managed care program. The quality monitoring and oversight for the program, and the interagency monitoring (including the SSMA's monitoring of delegated functions to the Operating Agency) is guided by the joint long-term care (LTC) meetings. A critical component of that strategy is the engagement of the LTC stakeholders, which brings together leadership, program management, contract management, fiscal management and other staff/resources to collectively monitor the extensive reporting, review results and other quality information and data related to the

KanCare program and services. Because of the managed care structure, and the integrated focus of service delivery/care management, the core monitoring processes – including LTC meetings – is on a quarterly basis. Continuous monitoring is being conducted, including on monthly and other intervals, the aggregation, analysis and trending processes will be built around that quarterly structure.

All oversight activities delegated by KDHE to KDADS are expressly identified in the standard operating procedures as well as in the body of the Memorandum of Understanding (MOU) between KDHE and KDADS. The MOU will be reviewed and updated at a minimum 5 years from the effective date (section XIV.a). This does not preclude the parties from reviewing and updating the MOU at any time after the effective date by mutual agreement of the parties. Also the SOP's can be updated at any time without having to amend the MOU.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

KDADS contracts with the Aging and Disability Resource Centers (ADRC) to:

- Disseminate waiver information to potential consumers.
- Complete a standardized intake/receive HCBS referrals
- Provide options counseling and assess for reasonable indicators:
 - a recent Brain Injury, or the return of negative symptoms from an old brain injury that is not degenerative, or determined as a chromosomal or congenital disorder, that is having a negative impact on the social determinants of health that may jeopardize living in a private home setting in the community.
 - a need for one or more of the extended BI waiver therapies offered on the waiver.
 - indicate they will be able to provide the required medical documentation, and if over the age of 19 have or will apply for Social Security Disability.
 - The applicant is seeking to, or is living in their private residence, not a provider agency owned/group setting.
 - Are between the ages of 0 thru 64.
- Qualified assessors conduct the Medicaid Functional Eligibility Instrument (MFEI) for those seeking admission to a Brain Injury Rehabilitation Facility (BIRF) or the HCBS BI waiver, and gather the required documents needed by KDADS to determine Program Eligibility.

The MCOs, or their designee:

- Conducts a comprehensive needs assessment.
- Utilizing the Participant Interest Inventory (PII) the participant completes, develop the Person-Centered Service Plan based on the choices of the participant or their legal representative. This may include EPSDT and State Plan, BI waiver services, and/or identifies BI related therapy services being obtained through the educational system and any needed waiver services to supplement this in the home and community settings.
- Offers participants the choice between self or agency direction, providers offering the services the participant is seeking, assistance with becoming established with the provider and ensuring services authorizations are provided timely.
- Completing reviews of the Person-Centered Service plan and goals as requested by the participant or at least every 6 months, gathering documentation from providers to review progress towards their transitional goals and ensure any needed services and supports are obtained.
- Provides oversight and transitional supports for individuals who are in institutional settings such as the BIRF, rehabilitation facilities, or skilled nursing facilities and are seeking the community-based brain injury waiver services.
- Ensures transitional needs are identified and sought when the BI waiver services are nearing completion.
- Ensure Provider Capacity.
- Conducts provider credentialing and provider training.
- Monitoring of service delivery and participates in the comprehensive state quality improvement strategy for the KanCare program.
- Collaborate with the BI Program Manager, KDADS, and KDHE to continue to improve the quality of services and compliance to the standards established in the BI waiver.
- Participate in Community outreach informing Kansans across the state about the HCBS BI waiver mission and services.

Managed Care Organizations conduct Service Plan development and related service authorization, assist with utilization management, conduct provider credentialing, create and provide the provider manual, and other provider guidance; and participate in the comprehensive state quality improvement strategy for the KanCare program, including this waiver.

The MCOs' engage the participant to develop a Person-Centered Service Plan. The MCO's are responsible for ensuring paid support staff or other professionals carry out the Service Plan that supports the participant's inclusion in the community. Once the MCOs complete the Person-Centered Service Plan, a review is completed to ascertain the specific services, frequency and duration required to meet the needs of the participant as identified in the service plan.

Some approved waiver services do require prior authorizations before the services are administered. The MCOs' provide utilization management and oversight of the service plans for waiver participants.

KDHE contracts with a Medicaid fiscal agent to enroll providers in the Medicaid program in compliance with federal law. The Medicaid fiscal agent and KDHE review the provider application prior to approving the provider's enrollment in the Medicaid program. The MCOs contract and credential providers within their network.

KDHE contracts with an EQRO to perform the EQRO defined functions for managed care.

The KDHE DHCF contracted actuary analyzes the MCOs' paid claims to determine the capitation rate (PMPM) for the waiver.

KDHE DHCF's contract with the MCOs requires the MCOs to provide medically necessary services to eligible Medicaid members. The MCOs' are contractually required to provide reporting to the State and address quality concerns.

No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

Not applicable

Applicable - Local/regional non-state agencies perform waiver operational and administrative functions.
Check each that applies:

Local/Regional non-state public agencies perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

KDADS contracts with the Aging and Disability Resource Centers (ADRC) to:

- Disseminate waiver information to potential consumers.
- Complete a standardized intake/receive HCBS referrals
- Provide options counseling and assess for reasonable indicators:
 - a recent Brain Injury, or the return of negative symptoms from an old brain injury that is not degenerative, or determined as a chromosomal or congenital disorder, that is having a negative impact on the social determinants of health that may jeopardize living in a private home setting in the community.
 - a need for one or more of the extended BI waiver therapies offered on the waiver.
 - indicate they will be able to provide the required medical documentation, and if over the age of 19 have or will apply for Social Security Disability.
 - The applicant is seeking to, or is living in their private residence, not an agency owned/group setting.
 - Are between the ages of 0 thru 64.
- Qualified assessors conduct the Medicaid Functional Eligibility Instrument (MFEI) for those seeking admission to a Brain Injury Rehabilitation Facility (BIRF) or the HCBS BI waiver, and gather the required documents needed by KDADS to determine Program Eligibility.

The MCOs, or their designee:

- Conducts a comprehensive needs assessment.
- Utilizing the Participant Interest Inventory (PII) the participant completes, develop the Person-Centered Service Plan based on the choices of the participant or their legal representative. This may include EPSDT and State Plan, BI waiver services, and/or identifies BI related therapy services being obtained through the educational system and any needed waiver services to supplement this in the home and community settings.
- Offers participants the choice between self or agency direction, providers offering the services the participant is seeking, assistance with becoming established with the provider and ensuring services authorizations are provided timely.
- Completing reviews of the Person-Centered Service plan and goals as requested by the participant or at least every 6 months, gathering documentation from providers to review progress towards their transitional goals and ensure any needed services and supports are obtained.
- Provides oversight and transitional supports for individuals who are in institutional settings such as the BIRF, rehabilitation facilities, or skilled nursing facilities and are seeking the community-based brain injury waiver services.
- Ensures transitional needs are identified and sought when the BI waiver services are nearing completion.
- Ensure Provider Capacity.
- Conducts provider credentialing and provider training.
- Monitoring of service delivery and participates in the comprehensive state quality improvement strategy for the KanCare program.
- Collaborate with the BI Program Manager, KDADS, and KDHE to continue to improve the quality of services and compliance to the standards established in the BI waiver.
- Participate in Community outreach informing Kansans across the state about the HCBS BI waiver mission and services.

Local/Regional non-governmental non-state entities conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities. Specify the

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state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

KDHE holds the contract for the Managed Care Organizations. KDHE holds regular quality assurance and oversight activities for the MCOs'. KDHE contracts with an EQRO to review MCO's contracts and compliance with those contracts. KDHE is responsible for the financial eligibility before the participants are granted access to the waiver. KDHE issues eligibility determination letters and appeal rights if not found eligible.

The State contracts with a number of entities to assist with carrying out needed waiver administration and operation activities.

- Level of care evaluation (initially, annually and when there is a change in condition) Assessment is completed by the CDDO. Determination is made by KDADS. KDADS oversees this eligibility function through our QA process.
- Review of participant service plans, KDHE contracts with an EQRO to review MCO's contracts and compliance with those contracts. KDADS participates in the contract review process headed by KDHE. KDADS also has a QA process and produces a quarterly QA report reviewed by KDHE. Each MCO has an internal PCSP review process.
- Prior authorization of waiver services, KDHE provides oversight of the prior authorization systems KDHE through their clinical team including the Medicaid Medical Director work with the MCOs through the annual MCO contractual audit. The KDHE staff and the KDADS staff participate in the annual contract review.
- Utilization management, The MCOs provide UM services in oversight of the service plans for waiver participants. KDADS runs a monthly report directly from the KMMS data warehouse. During the annual MCO contractual audit, the KDHE clinical team reviews a statistical sample of medical records for utilization review.
- Qualified Provider enrollment, KDHE uses a contracted entity to enroll providers in KanCare and the MCOs to contract and credential service providers.
- Execution of Medicaid provider agreements, MCOs contract and credential with Medicaid service providers. KDHE provides oversight.
- Establishment of Statewide Rate Methodology, by a KDHE/KDADS state contracted actuary.

Appendix A: Waiver Administration and Operation

6. Assessment Methods and Frequency. Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

Contracted entities and the state's KanCare managed care organizations are monitored through the State's KanCare Quality Improvement Strategy, which provides quality review and monitoring of all aspects of the KanCare program – engaging program management, contract management, and financial management staff from both KDHE and KDADS. All functions delegated to contracted entities are included in the State's comprehensive quality strategy review processes. In addition, the SSMA and State operating agency KDADS will continue to operate collaboratively under an interagency agreement, as addressed in part A.2.b above, and that agreement includes oversight and monitoring of all HCBS programs, the KanCare MCOs and independent assessment contractors. The KanCare Quality Improvement Strategy ensure that the entities contracting with KDADS (the Waiver Operating Agency) are operating within the established parameters. These parameters include CMS rules/guidelines, the approved KanCare managed care contracts and related CMS 1915B waiver regulations and guidelines and Kansas statutes and regulations, and related policies. Included in the QIS is an ongoing assessment of the results of onsite monitoring and reviews with a sample of HCBS waiver participants. KDADS oversees the contract with the qualified assessor to ensure that assessors meet current educational and training requirements to conduct the MFEI assessment with children and adults in Kansas. The Level of care assessment, the MFEI assessment, is completed by the assessing entity. The functional assessment LOC and all required documentation are reviewed for Program Eligibility by the KDADS Program Manager. Program Eligibility outcomes are sent to KDHE for review and for disability and financial eligibility determination. KDHE has the sole authority to enroll those found eligible and submit their enrollment to the chosen MCO. KDHE as the SSMA manages the contracts with the Managed Care Organizations in Kansas. KDADS oversees a quarterly review process with each MCO in Kansas. KDADS oversees this quarterly review process to ensure accuracy and appropriateness of the Person-Centered Service Plan, to ensure health and welfare of the waiver participants, to ensure adequacy of qualified providers and to ensure financial accuracy in billing. KDADS Quality Assurance Team reviews quarterly submissions from the contracted assessor to ensure accurate information is being obtained and the MFEI assessments are being completed correctly within the appropriate timeframe. KDADS Quality Assurance Team requires the contracted assessor to provide the following documents for each participant assessed: 1. MFEI assessments 2. Referral form from KDADS for the assessment. 3. Approved form from KDADS Program Manager 4. Recommended Service Plan KDADS Quality Assurance Team reviews quarterly submissions from the Managed Care Organizations to ensure accuracy and appropriateness of the Person-Centered Service Plan, to ensure health and welfare of the participants, to ensure adequacy of qualified providers and to ensure financial accuracy in billing.

Appendix A: Waiver Administration and Operation

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment				
Waiver enrollment managed against approved limits				
Waiver expenditures managed against approved levels				
Level of care evaluation				
Review of Participant service plans				
Prior authorization of waiver services				
Utilization management				
Qualified provider enrollment				
Execution of Medicaid provider agreements				

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Establishment of a statewide rate methodology				
Rules, policies, procedures and information development governing the waiver program				
Quality assurance and quality improvement activities				

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of waiver policies developed by the Operating Agency that were approved by the State Medicaid Agency prior to implementation. N=Number of waiver policies developed by the Operating Agency that were approved by the State Medicaid Agency prior to implementation. D=Number of waiver policies implemented by the Operating Agency

Data Source (Select one):

Other

If 'Other' is selected, specify:

Presentation of waiver policy changes

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review

Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):

Performance Measure:

Number and percent of MCO quality improvement plans developed by the MCO, reviewed (and approved) by the State, that compile aggregate data detailing authorized services and services utilized. N=Number of quality improvement plans reviewed by the SSMA and Operating Agency. D=Number of quality improvement plans created by the MCO

Data Source (Select one):

Other

If 'Other' is selected, specify:

QIPs

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="MCOs"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Number and percent of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports
 N = Number of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports
 D = Number of Long-Term Care meetings

Data Source (Select one):**Meeting minutes**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify:	Annually	Stratified Describe Group:

<input type="text"/>		<input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Kansas Department of Health and Environment, Division of Health Care Finance (KDHE), the single state Medicaid agency, and Kansas Department for Aging and Disability Services (KDADS) work together to develop state operating agency priority identification regarding all waiver assurances and minimum standards/basic assurances. The state agencies work in partnership with participants, advocacy organizations, provider groups and other interested stakeholders to monitor the state quality strategy and performance standards and discuss priorities for remediation and improvement. The state quality improvement strategy includes protocols to review cross-service system data to identify trends and opportunities for improvement related to all Kansas waivers, policy and procedure development and systems change initiatives.

Data gathered by KDADS Regional Staff during the Quality Survey Process is compiled quarterly for evaluation and trending to identify areas for improvement. Upon completion of identified areas of improvement this information is compiled into reports and shared both internally and externally, including with KDHE. As the KanCare program was operationalized, staff of the three plans were engaged with state staff to ensure strong understanding of Kansas' waiver programs and the quality measures associated with each waiver program. These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

State staff and/or KanCare MCO staff request, approve, and assure implementation of provider corrective action planning and/or technical assistance to address non-compliance with waiver and performance standards as detected through on-site monitoring, survey results and other performance monitoring. These processes are monitored by both program managers and other relevant state and MCO staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy. Monitoring and survey results are compiled, trended, reviewed, and disseminated consistent with protocols identified in the statewide quality improvement strategy. Each provider receives annual data trending which identifies Provider specific performance levels related to statewide performance standards and statewide averages. Corrective Action Plan requests, technical assistance and/or follow-up to remediate negative trending are included in annual reports where negative trending is evidenced.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div></div>	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

No**Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

--

Appendix B: Participant Access and Eligibility**B-1: Specification of the Waiver Target Group(s)**

- a. Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
Aged or Disabled, or Both - General					
		Aged			
		Disabled (Physical)			
		Disabled (Other)			
Aged or Disabled, or Both - Specific Recognized Subgroups					
		Brain Injury	0	64	
		HIV/AIDS			
		Medically Fragile			
		Technology Dependent			
Intellectual Disability or Developmental Disability, or Both					
		Autism			
		Developmental Disability			
		Intellectual Disability			
Mental Illness					
		Mental Illness			
		Serious Emotional Disturbance			

- b. Additional Criteria.** The state further specifies its target group(s) as follows:

- Be a resident of the state of Kansas.
- Applicants ages 0 thru 3 parent(s) or legal guardian must complete section one of the youth Medicaid Functional Eligibility Instrument (MFEI) with a qualified assessor.
- Ages 4 thru 18 years must meet level of care eligibility based on the State approved Youth Medicaid Functional Eligibility Instrument (MFEI) administered by a qualified assessor, reflecting the youth meets the criteria for placement in a hospital.
- Ages 18 thru 64 years must meet level of care eligibility based on the State approved Adult Medicaid Functional Eligibility Instrument (MFEI) administered by a qualified assessor, reflecting the criteria for placement in a hospital Brain Injury Rehabilitation Facility is met.
- Ages 0 thru 64 are required to provide their assessor with their documented medical diagnosis of a Traumatic Brain Injury (TBI), and/or, Acquired Brain Injury ABI), that is not a degenerative, birth trauma, congenital or chromosomal disorder from a qualified medical professional. This documentation should also include recommendation of which extended rehabilitation therapy(s) are needed to regain physical and independent living skills for adults and assist youth in relearning and developing skills their peers of same age have acquired. This may be clinical or hospital records or KDADS Attestation Form.
- Ages 19 and older must be determined disabled by Social Security Standards.
- All applicants must apply for and meet the eligibility financial criteria for KanCare's Medicaid Long Term Care Services for the Elderly and Persons with a Disability program.

BI waiver services are provided as part of a comprehensive package of services provided by the KanCare health plans Managed Care Organizations (MCO) and will be paid as part of a capitated rate. The eligibility determination steps are completed as follows for each applicant:

- The contracted ADRC's screen for reasonable indicators of the need for BI Waiver therapies. A qualified ADRC Assessor conducts the Medicaid Functional Eligibility Instrument (MFEI) to determine Functional Eligibility based on the participant meeting the program level of care threshold and gathers all required documentation and upload them in the designated state management information system. Administrative Case Management may be utilized to obtain needed documentation and to apply for KanCare.
- The KDADS BI Program Manager or Eligibility Specialist holds the sole authority to ensure the completed Medicaid Functional Assessment Instrument and the diagnostic documentation has been completed and meets the Program Eligibility requirements. KDADS may require additional documentation if the submitted diagnostic documentation by a licensed medical professional does not clearly support a brain injury, or rule out if it is degenerative, or a consequence of a chromosomal or congenital disorder.
- The KDHE KanCare Eligibility Department is responsible for ensuring that the Social Security Disability or Presumptive Disability has been approved and if the Financial Eligibility for Long Term Care Services for the Elderly and Disabled is met. KDHE KanCare determines Disability and Financial Eligibility and holds the authority in determining all eligibility steps have been completed and the criteria has either not been met, resulting in a denial, or has been met and entrance to the HCBS BI Waiver Program is approved. KDHE/KanCare submits those names to the MCO selected by the applicant, or if none was chosen KDHE/KanCare will make the initial selection. The MCO Care Coordinator will complete the Service Needs Assessment and work with the individual to establish their person-centered service plan.

Participants who have engaged in a minimum of 6 months thru 3 years of active participation in therapies may meet the transition eligibility requirements for one of KDADS long-term waivers as outlined in KDADS BI Transition Policy.

Individuals who have previously been enrolled in the HCBS Brain Injury Waiver services may request to return to the waiver if:

1. There is a relapse of negative symptoms from their brain injury that is impacting social determinants of health that may lead to a placement in an institutional setting without additional therapies.
- OR-
2. A new brain injury occurs with negative symptoms impacting social determinants of health that may lead to placement in an institutional setting without additional therapies.
- AND-
3. Diagnostic Documentation and recommendation of needed therapies is submitted by a qualified medical professional

for the current relapse or new injury.

-AND-

4 The level of care of the State approved Adult Medicaid Functional Eligibility Instrument (MFEI), administered by a qualified assessor, is met.

According to State Statute (K.S.A. 39-1801 et seq.) the disability must be diagnosed before the age of 22 to qualify as a developmental disability, regardless of the cause of the disability. Individuals with a brain injury before the age of 22, may be diagnosed with a developmental disability. In those cases, the individual may be assessed for programmatic and functional eligibility for the IDD waiver when the supports offered are needed to ensure the individual can remain in the community.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

Not applicable. There is no maximum age limit

The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.

Specify:

Participants who turn 65 are entitled to complete the full 3 years on the BI waiver unless:

The participant determines they are ready to end their BI therapy services.

Or

They have plateaued at a therapy milestone for 3 months.

Through the person-centered planning process, as age 65 approaches the MCO Care Coordinator will review the services and settings of the BI Waiver and the Frail Elderly Waiver. At that time the participant will determine if they wish to continue on the BI waiver if eligible, or transition to the Frail Elderly waiver. The policy requires the request to transition be submitted to KDADS a minimum of 30 days prior to the transition date (I.G.) It is the responsibility of the MCO to update the Person Center Service Plan to reflect the choices offered and chosen, reason for the transition, desired outcome, tasks to complete and timelines, and any barriers or concerns that are to be addressed.

The BI Transition policy defines the minimum requirements the MCO must discuss with the participant related to differences in services, reimbursement rates for workers and value-added services (II.B.), as well as the procedure for requesting the transition through KDADS Program Manager or Transition Team.

The TBI Transition policy can be accessed for your review at <https://kdads.ks.gov/kdads-commissions/long-term-services-supports/hcbs-policies>.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*). Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

No Cost Limit. The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

Cost Limit in Excess of Institutional Costs. The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

The limit specified by the state is *(select one)*

A level higher than 100% of the institutional average.

Specify the percentage:

Other

Specify:

Institutional Cost Limit. Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

Cost Limit Lower Than Institutional Costs. The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the state is *(select one)*:

The following dollar amount:

Specify dollar amount:

The dollar amount *(select one)*

Is adjusted each year that the waiver is in effect by applying the following formula:

Specify the formula:

May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.

The following percentage that is less than 100% of the institutional average:

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

The participant is referred to another waiver that can accommodate the individual's needs.

Additional services in excess of the individual cost limit may be authorized.

Specify the procedures for authorizing additional services, including the amount that may be authorized:

Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	<div>1445</div>
Year 2	<div>1445</div>
Year 3	<div>1445</div>
Year 4	<div>1445</div>

Waiver Year	Unduplicated Number of Participants
Year 5	1445

b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: (*select one*) :

The state does not limit the number of participants that it serves at any point in time during a waiver year.

The state limits the number of participants that it serves at any point in time during a waiver year.

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. **Reserved Waiver Capacity.** The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State (*select one*):

Not applicable. The state does not reserve capacity.

The state reserves capacity for the following purpose(s).

Purpose(s) the state reserves capacity for:

Purposes	
WORK Program Transitions	
Military Inclusion	
Temporary Institutional Stay	
Institutional Transitions	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose (*provide a title or short description to use for lookup*):

WORK Program Transitions

Purpose *(describe):*

The State reserves capacity for BI program participants who have participated in the WORK program to transition to the BI Waiver in accordance with the WORK Transition policy. If BI waiver therapies are not needed at the time of transition back to HCBS services, the participant may transition to another HCBS Waiver that they meet eligibility for.

Describe how the amount of reserved capacity was determined:

This is a projected reserve capacity.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	5
Year 2	5
Year 3	5
Year 4	5
Year 5	5

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Military Inclusion

Purpose *(describe):*

The State reserves capacity for military participants and their immediate, dependent family members to access the BI waiver in accordance with the Military Inclusion policy.

Describe how the amount of reserved capacity was determined:

There are no data to support this projection of reserved capacity. If the amount of need exceeds reserve capacity, Kansas will submit an amendment to appropriately reflect the number unduplicated persons served.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	5
Year 2	5
Year 3	5
Year 4	5
Year 5	5

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Temporary Institutional Stay

Purpose *(describe):*

The state reserves capacity to maintain continued waiver eligibility for participants who enters an institution such hospitals, or TBIRF for the purpose of seeking treatment for acute, habilitative or rehabilitative conditions on a temporary basis less than 60 consecutive days. Temporary stay is defined as a stay that includes the month of admission and one month following admission. Participants who remain in the institution following the two-month allotment will be terminated from the HCBS program. Any time after 60 consecutive days, the participant can choose to transition to the community following the process in the HCBS Institutional Transition policy.

Describe how the amount of reserved capacity was determined:

The amount of reserved capacity was determined by historical data regarding the average number of participants who have been admitted for Temporary Institutional Stays.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	150
Year 2	150
Year 3	150
Year 4	150
Year 5	150

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Institutional Transitions

Purpose *(describe):*

The State reserves capacity for individuals transitioning from an approved institutional setting to the BI Waiver in accordance with the HCBS Institutional Transition Policy.

Describe how the amount of reserved capacity was determined:

Institutional transition reserve capacity is based upon historical experience as to people who have chosen to transition from an approved institutional setting to the BI waiver.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	5
Year 2	5
Year 3	5
Year 4	5
Year 5	5

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):

- ☐ The waiver is not subject to a phase-in or a phase-out schedule.
- ☐ The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity.

Select one:

- ☐ Waiver capacity is allocated/managed on a statewide basis.
- ☐ Waiver capacity is allocated to local/regional non-state entities.

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

1. BI waiver eligibility criteria are defined in the KDADS Brain Injury Eligibility Policy.
 2. The HCBS Institutional Transition policy identifies the process and procedures for allowing eligible individuals discharging from an approved institutional setting to access the BI waiver.
 3. The Military Inclusion policy identifies the process and procedures for eligible military participants and their immediate dependent family members (as defined by IRS) to access BI waiver services.
 4. The KDADS WORK Transition policy details the process for individuals to access the waiver from the WORK program.
- Entry into the waiver is based on a first-come, first-served basis for applicants determined eligible. In the event there is a waiting list, entry is based on the time and date the assessment is completed. Responsibility for managing the waiting list remains with the State (KDHE and KDADS).
1. Participants may supersede the waiting list if they meet any one of the following groups:
 2. Participants transferring directly from another HCBS waiver;
 3. Participants transferring directly from the WORK program;
 4. Applicants identified and approved as Crisis Exceptions to the waiting list as established by Kansas Department for Aging and Disability Services/ Community Services and Program Commission (KDADS);
 5. Participants exiting a Medicaid approved nursing facility through the Institutional Transition program, who previously gained access in this manner, will now gain access under reserve capacity;
 6. Military participants and their immediate dependent family members (as defined by IRS) who have been determined program eligible may bypass waitlist upon approval by KDADS if the individual meets the following criteria:
 - a. A resident of Kansas or has maintained residency in Kansas as evidenced by tax return or other documentation demonstrating proof of residency
 - b. Must be active or recently separated (within 30 days) military personnel or dependent family members who are eligible to receive TriCare Echo
 - c. Have been receiving Tricare Echo prior to separation from the military
 - d. Received an honorable discharge as indicated on the DD form 214
- For the purpose of the military inclusion, IRS defines immediate family as a spouse, child, parent, brother or sister of the individual in the military (IRS 1.25.1.2.2).
- All individuals are held to the same criteria when qualifying for a crisis exception as in accordance with statewide policies and guidelines.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

- a. **1. State Classification.** The state is a (*select one*):
 - §1634 State**
 - SSI Criteria State**
 - 209(b) State**
- 2. Miller Trust State.**

Indicate whether the state is a Miller Trust State (*select one*):

 - No**
 - Yes**
- b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

Low income families with children as provided in §1931 of the Act

SSI recipients**Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121****Optional state supplement recipients****Optional categorically needy aged and/or disabled individuals who have income at:***Select one:***100% of the Federal poverty level (FPL)****% of FPL, which is lower than 100% of FPL.**Specify percentage: **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)****Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)****Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)****Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)****Medically needy in 209(b) States (42 CFR §435.330)****Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)****Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)***Specify:*

Parents and other caretaker relatives (42 CFR 435.110); pregnant women (42 CFR 435.116); and children (42 CFR 435.118).

Special home and community-based waiver group under 42 CFR §435.217) Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed

No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.**Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.***Select one and complete Appendix B-5.***All individuals in the special home and community-based waiver group under 42 CFR §435.217****Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217***Check each that applies:***A special income level equal to:***Select one:***300% of the SSI Federal Benefit Rate (FBR)****A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

A dollar amount which is lower than 300%.

Specify dollar amount:

Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)

Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)

Medically needy without spend down in 209(b) States (42 CFR §435.330)

Aged and disabled individuals who have income at:

Select one:

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

- a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.

In the case of a participant with a community spouse, the state elects to (select one):

Use spousal post-eligibility rules under §1924 of the Act.

(Complete Item B-5-b (SSI State) and Item B-5-d)

Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The state uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (select one):

The following standard included under the state plan

Select one:

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

(select one):

300% of the SSI Federal Benefit Rate (FBR)

A percentage of the FBR, which is less than 300%

Specify the percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the state Plan

Specify:

The following dollar amount

Specify dollar amount: If this amount changes, this item will be revised.

The following formula is used to determine the needs allowance:

Specify:

Other

Specify:

ii. Allowance for the spouse only (select one):

Not Applicable

The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:

Specify:

Specify the amount of the allowance (select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The following dollar amount:

Specify dollar amount: If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

iii. Allowance for the family (select one):

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

Other

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

Not Applicable (see instructions)*Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

The state does not establish reasonable limits.

The state establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

A percentage of the Federal poverty level

Specify percentage:

The following dollar amount:

Specify dollar amount:

If this amount changes, this item will be revised

The following formula is used to determine the needs allowance:

Specify formula:

Other

Specify:

300% of SSI

- ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

Allowance is the same

Allowance is different.

Explanation of difference:

- iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

Not Applicable (see instructions) *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

The state does not establish reasonable limits.

The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B: Participant Access and Eligibility

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: SSI State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is:

ii. Frequency of services. The state requires (select one):

The provision of waiver services at least monthly

Monthly monitoring of the individual when services are furnished on a less than monthly basis

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

Directly by the Medicaid agency

By the operating agency specified in Appendix A

By a government agency under contract with the Medicaid agency.

Specify the entity:

Other

Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Qualifications of functional eligibility assessors:

Four-year degree from an accredited college or university with a major in gerontology, nursing, health, social work, counseling, human development, family studies, or related area as defined by the contractor; or a Registered Nurse licensed to practice in the state of Kansas. The contractor is responsible for verifying assessor experience, education and certification requirements are met for assessors identified. The contractor must maintain these records for five (5) years following termination of employment.

Functional eligibility assessors must attend initial certification and recertification training sessions according to KDADS' Policy. Functional eligibility assessors must successfully complete MFEI and Kansas Aging Management Information System (KAMIS) training prior to performing any functional eligibility assessment.

A functional eligibility assessor that has not conducted any assessments within the last six months must repeat the training and certification requirements for the Medicaid Functional Eligibility Instrument (MFEI).

KDADS shall have the responsibility for conducting all training sessions, certification and recertification of all MFEI assessors. KDADS shall provide training materials and written documentation of successful completion of training.

Assessors must participate in all state-mandated trainings to ensure proficiency of the program, services, rules, regulations, policies and procedures set forth by KDADS. Tracking staff training is the responsibility of the contractor and should be recorded in the manner required by KDADS.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

Level of Care criteria

1. For ages 0-3, level of care is based on completing section 1 of the State Medicaid Functional Eligibility Instrument and a physician's diagnosis of BI
2. For ages 4 thru 17 the individuals with a qualifying BI must meet the youth level of care required for either a Traumatic Brain Injury Rehabilitation Facility placement or Hospital, determined by the State's Youth Medicaid Functional Eligibility Instruments (MFEI).
3. For ages 18 thru 64, individuals with a qualifying BI must meet the adult level of care required for a Traumatic Brain Injury Rehabilitation Facility placement, determined by the State's Adult Medicaid Functional Eligibility Instrument (MFEI).

The MFEI is an assessment of an individual's capacity for Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). The MFEI measures an individual's behavioral/emotional deficits and cognitive limitations that may be the foundation of their Person-Centered Service Plan. Kansas uses the MFEI, based on the InterRAI standardized assessment instrument for the BI waiver. The InterRAI tool is diagnosis neutral. The youth MFEI for ages 4 thru 17, that accommodates for differences in participant age but remains diagnosis neutral. By using this approach, approved transitions between waivers are more effective and support needs are more accurately identified.

The MFEI assessment tool and functional eligibility criteria is the same for initial assessments and annual reassessments. For outcomes quality control, the MFEI outcome score is calculated by the program software designed specifically to determine if the LOC is met. The participant and the assessor will be notified at the end of the assessment if the LOC outcome was found to be functionally "eligible" or "ineligible". KDADS Program Manager review's and verifies the computation outcome. If the validity is in question a manual calculation is done to ensure the software calculated the assessment as intended. KDADS holds the sole authority to determine that the Functional LOC is valid and able to be used to determine Program Eligibility.

- e. Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):

The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.

A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

- f. Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The assessing entity shall perform conflict free functional assessments to determine if the BI level of care criteria is met. The BI level of care criteria utilized for both initial and annual reassessments is the level of care criteria utilized by TBIRFs and hospitals. The contracted assessors will screen for reasonable indicators that the impact of the qualifying brain injury may rise to the level of care to meet eligibility criteria and requires habilitative (youth)/rehabilitative therapies prior to administering the functional eligibility instrument.

The level of care assessment and reassessment process is conducted by qualified assessors contracted with the State. Information contributing to the BI MFEI can come from a variety of sources. The participant is the primary source of information. Family members and other individuals who might have relevant information about the participant may also be interviewed at the request of the participant. The functional eligibility contractor uses interview techniques that are considerate of any limitations the participant or others might have with hearing, eyesight, cognition, etc. The contracted assessors also submit diagnostic documentation from qualified medical providers.

The participant must show the capacity to engage in therapies and make progress in their habilitative/rehabilitative progress toward developing or maintaining their independent living skills. Progress is evaluated every six months or more frequently as deemed necessary by the MCO or as requested by the participant. The person-centered service plan will have S.M.A.R.T. goals, developed by the individual and their support network to reflect their targeted transition goals they hope to meet by the end of their 3rd year. These therapy goals are written with obtainable objectives/steps that allow the individual to experience success as well as track habilitative and rehabilitative progress in restoring or developing new independent living skills that are in line with their transition goals.

If aged 21 or younger, a BI waiver participant must have a KAN-Be-Healthy (EPSDT) screening completed on an annual basis.

Individuals, or any interested party may contact the contracted assessing entity directly to inquire about the Brain Injury Waiver Functional Assessment. The contractor conducts a Standard Intake which documents the reasonable indicators for having a qualifying diagnosed brain injury and meeting the level of care criteria. Once the intake staff completes the Standard Intake, they will forward the referral to the functional eligibility assessor. The assessor will schedule face to face visit with the Individual to conduct the Medicaid Functional Eligibility Instrument (MFEI) Assessment using the State approved MFEI. The assessor is responsible for updating any needed information pertaining to the individual file in the KDADS System of record and submit the completed assessment, the diagnostic and other supporting documentation in the KDADS system of record. If additional documentation is needed, KDADS will request additional documentation from the functional assessor or the participant as necessary.

The KDADS HCBS BI Program Manager or Eligibility Specialist will review the completed MFEI, and all submitted documentation entered by the contracting assessor. To render the Program Eligibility determination, the MFEI must be completed by a qualified assessor and the brain injury diagnostic documentation must reflect the diagnosis of a qualifying brain injury by a qualified medical professional and need for habilitative (youth)/rehabilitative therapies.

- g. Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):

Every three months

Every six months

Every twelve months

Other schedule

Specify the other schedule:

- h. Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations (*select one*):

The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.

The qualifications are different.

Specify the qualifications:

- i. Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care (*specify*):

Timely re-evaluation requirements, as stated in the 1915(c) waiver are also included in the State's contract with the assessing entity. Assurance that timely re-evaluations are conducted are monitored through the KDADS quarterly quality review process. In the event the contractor does not meet the requirements, KDADS issues a corrective action plan which requires the contractor to detail their remediation strategy to come into compliance. The contractor receives a monthly reassessment report from KDADS with a list of all waiver participants that have assessments expiring within 30 days.

- j. Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Written and/or electronically retrievable documentation of all evaluations and reevaluations is maintained in the Kansas Assessment Management Information System (KAMIS).

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

- a. Sub-assurance:** *An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of newly enrolled waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services. N=Number of newly enrolled waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services D=Total number of newly enrolled waiver participants

Data Source (Select one):

Other

If 'Other' is selected, specify:

State Data Systems

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

Number/% of applicants with a reasonable indicator that waiver services may be needed in the near future are assessed Numerator: Number/% of applicants with a reasonable indicator that waiver services may be needed in the near future are assessed Denominator: Total number of applicants with reasonable indication that services may be needed in the near future Start date 7/1/2025

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Record Review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> 95% confidence level +/- 5% margin of error. </div>
Other Specify:	Annually	Stratified Describe Group:

<input type="text"/>		Proportionate by MCO
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

- b. Sub-assurance:** *The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

- c. **Sub-assurance:** *The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of initial Level of Care (LOC) determinations made by a qualified assessor: End 12/31/23
N=Number of initial Level of Care (LOC) determinations made by a qualified assessor
D=Number of initial Level of Care determinations

Data Source (Select one):

Other

If 'Other' is selected, specify:

Assessor and Assessment Records

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="Contracted assessors"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and	Other

	Ongoing	Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div>Contracted assessors participate in analysis of this measure's results as determined by the State operating agency</div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

Performance Measure:

Number and percent of waiver participants whose Level of Care (LOC) determinations used the state's approved screening tool
N=Number of waiver participants whose Level of Care determinations used the approved screening tool
D=Number of waiver participants who had a Level of Care determination reviewed

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Record review

Responsible Party for	Frequency of data	Sampling Approach
------------------------------	--------------------------	--------------------------

data collection/generation (check each that applies):	collection/generation (check each that applies):	(check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95% +/-5% margin of error</div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div>Proportionate by MCO</div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

These performance measures will be included as part of the comprehensive KanCare State Quality Improvement Strategy, and assessed quarterly with follow remediation as necessary. In addition, the performance of state's contracted assessor will be monitored on an ongoing basis to ensure compliance with the contract requirements.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through the KanCare QIS, which includes program managers, contract managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

State staff request, approve, and assure implementation of contractor corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through on-site monitoring, survey results and other performance monitoring. These processes are monitored by both contract managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually

Responsible Party (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 40px; margin-top: 5px;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

The State has a workplan to gather reasonable indicators through our assessing entities; this is to be implemented by July 2025.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and
- ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The contracted functional assessor informs eligible participants, or their legal representatives, of feasible alternatives for long-term care, and documents their choice of either institutional or home and community-based waiver services utilizing the State approved choice form. The form or forms are available to CMS upon request.

Additionally, the MCO confirms choice of either institutional or home and community-based waiver services utilizing the State approved choice form.

Similarly, the KanCare MCO selected by the participant is responsible for providing or explaining the freedom of choice and "Participant Rights and Responsibilities" to the participant, parent or legal guardian. As part of the Person Centered Service Plan meeting the MCO Care Coordinator will review and gain signature from member or guardian the participant choice form and the Rights and Responsibilities form.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

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.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

KDADS has taken steps to assist staff in communicating with their Limited English Proficient Persons, and to meet the provisions set out in the Department of Health and Human Services Policy Guidance of 2000 requiring agencies which receive federal funding to provide meaningful access to services by Limited English Proficient Persons. In order to comply with federal requirements that individuals receive equal access to services provided by KDADS and to determine the kinds of resources necessary to assist staff in ensuring meaningful communication with Limited English Proficient participants, states are required to capture language preference information. This information is captured in the demographic section of the standard intake completed by the contracted assessors prior to completing the functional eligibility assessment.

The State of Kansas defines prevalent non- English languages as languages spoken by significant number of potential enrollees and enrollees. Potential enrollee and enrollee materials will be translated into the prevalent non-English languages.

Each contracted provider is required by Kansas regulation to make every reasonable effort to overcome any barrier that participants may have to receiving services, including any language or other communication barrier. This is achieved by having staff available to communicate with the participant in his/her spoken language, and/or access to a phone-based translation services so that someone is readily available to communicate orally with the participant in his/her spoken language. (K.A.R. 30-60-15).

Access to a phone-based translation system is under contract with KDADS and available statewide.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service		
Statutory Service	Personal Care		
Extended State Plan Service	Occupational Therapy		
Extended State Plan Service	Physical Therapy		
Extended State Plan Service	Speech and Language Therapy		
Supports for Participant Direction	Financial Management Services		
Other Service	Behavior Therapy		
Other Service	Cognitive Rehabilitation		
Other Service	Enhanced Care Services		
Other Service	Home and Environmental Modification Services (HEMS)		
Other Service	Home-Delivered Meals Service		
Other Service	Medication Reminder Services		
Other Service	Personal Emergency Response System and Installation		
Other Service	Specialized Medical Equipment and Supplies (SMES)		
Other Service	Transitional Living Skills		
Other Service	Vehicle Modification Services (VMS)		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08030 personal care

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

PCS are one-to-one, individualized services provided during times when the participant is not typically sleeping, as self-directed (SD) or agency-directed (AD) supports. PCS hours are directly related to ADLS and IADLS which are provided when a participant is awake. If exceptions are needed to cover needs medical in nature, an exception needs to be present. Exceptions can be made to ensure the health and safety of the participant.

PCS services can be delivered in a hospital setting per Section 3715 of the CARES Act, PL116-136 to support participants with ADLs and IADLs. Services cannot be duplicative of services provided by the hospital. Personal care needs requiring the PCA to assist during medical and therapeutic appointment are to be listed in the care plan.

Scope, duration and amount of services authorized by the MCO shall be consistent with the participant's assessed need as documented in the Person-Centered Service Plan (service plan). PCS include participant support in the following areas, as per K.A.R. 30-5-300, K.A.R.28-51-113, K.S.A 65-115, and the PCS and Limitations Policy:

1. Activities of Daily Living (ADLs)
2. Health maintenance activities (HMA) in accordance with the Personal Care Services and Limitations policy.
3. Instrumental Activities of Daily Living (IADLs)
4. Supervision: health, safety and welfare of non-foster care participants
5. Assistance and accompaniment: exercise, socialization, recreation activities
6. Assistance accessing medical care

The State delegates to the MCOs the management of agency direct listings to be provided to participants as each MCO could differ in contracted entities and the most up to date listing can be provided by the participant's MCO. Court appointed guardians and conservators shall not be paid to provide waiver services unless all potential conflicts of interest have been mitigated as per K.S.A. 59-3068.

a. The court appointed guardian is responsible to report any potential conflicts to the court in the annual or special report per guardianship law and to maintain documentation of the court determination.

•b. In order to be paid to provide PCS to the participant, the court appointed guardian shall provide the special or annual report copy disclosing the conflict of interest and the judge's approval order of said report, plus determination of no guardian conflict of interest to the MCO and FMS provider.

•2. If the court determines that all potential conflict of interest concerns are not mitigated, the legal guardian can:

•a. Pick someone else to provide the HCBS services to the participant. The participant's MCO or FMS provider may assist the legal guardian to find a PCS worker, or to seek other HCBS service providers in the community; OR

•b. Appoint someone as a Designated Representative to develop and direct the participant's HCBS Person Centered Service Plan.

•3. An activated durable power of attorney is not permitted to be a paid provider for participant unless a Designated Representative is appointed to direct the individual's care and workers.

4. An exception to the criteria may be granted by the MCO when a participant/guardian lives in a rural setting and the nearest agency-directed service provider available to provide services is in excess of 50 miles from the participant residence or the location is so remote that HCBS Program Services would otherwise not be available to For waiver purposes, relatives are defined as parents of minors, and spouses of waiver participants. PCS may be used to pay parents or participant's spouse. Parents of minors and spouses must meet the provider qualifications for PCS.

PCS must:

- Meet the definition of PCS as outlined in the federal waiver plan.
- be specified in the participant's Service Plan
- be provided by a person who meets the necessary identified qualifications and training standards in the participant's Service Plan;
- Complete training from the participant or their representative via the PCS checklist developed by the participant and/or their representative and aided by their Care Coordinator as necessary. This document will be in kept in the person's home, be part of the Service Plan, and reviewed at least annually and updated as needed to indicate change in the participant's service needs.
- All employers must act in accordance with the Fair Labor Standards Act. This cannot be supplemented by the member or natural supports.
- parents and spouses must utilize the EVV system for hours paid;
- married participants must be offered a choice of providers. If they choose a spouse as their care provider, it must be documented in the Service Plan.

Units and delivery for virtual delivery is found in Main 8 B

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

The services under the Brain Injury Waiver are limited to additional services not otherwise covered under the state plan, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT), but consistent with waiver objectives of avoiding institutionalization.

Personal Care Services provided in a home school setting must not be educational in purpose.

Personal Care Services are limited to the assessed level of service need, as specified in the Person-Centered Service Plan, up to 12 hours per 24-hour day. The need to exceed the maximum service limit is subject to approval by the participant's MCO.

The MCO may authorize services exceeding the 12 hours per 24-hour day accommodation if the participant meets one or more of the following criteria:

1. The additional request for PCS is critical to the remediation of the participant's abuse neglect, exploitation, or domestic violence issue.
2. The additional request for PCS is critical to the participant's ability to remain in the community in lieu of an institution.
3. The time additional request for PCS is a necessary support for the participant to return to the community from an institutional setting.

All Personal Care Services will be arranged for, reviewed, and approved by the KanCare MCO's Care Coordinator with the participant's written authorization, & paid for through an enrolled home health agency, when services are agency-directed, or an enrolled Financial Management Service (FMS) provider, when services are participant-directed. Payment for services must be made within the minimum approved reimbursement established by the state.

A person may have several PCS workers providing him/her care on a variety of days at a variety of times, but a person may not have more than one PCS worker providing care at any given time, unless the need for an additional PCS worker is necessary to meet the health and welfare needs of the participant. Children receiving care in licensed foster care settings do not have the option to self-direct services unless established exception criteria are met. Unless otherwise approved by KDADS, all services must be provided through the agency directed service model.

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Home Health Agency
Individual	Direct Support Worker

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Personal Care

Provider Category:

Agency

Provider Type:

Licensed Home Health Agency

Provider Qualifications

License (*specify*):

K.S.A. 65-5001 et seq.

Certificate (*specify*):

n/a

Other Standard (*specify*):

Must be employed by and under the direct supervision of a home health agency licensed by the Kansas Department of Health and Environment, enrolled as a Medicaid provider and contracted with a KanCare MCO (In accordance with K.S.A 65-5115 and K.A.R. 28-51-113).

- a. Must have a High School Diploma/GED OR be at least eighteen years of age or older
- b. Complete KDADS Approved Skill Training requirements.
- c. 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.

Verification of Provider Qualifications

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.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Personal Care

Provider Category:

Individual

Provider Type:

Direct Support Worker

Provider Qualifications

License (*specify*):

n/a

Certificate (*specify*):

n/a

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;

C. Complete KDADS Approved Skill Training requirements.

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.

Verification of Provider Qualifications

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.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Occupational Therapy

HCBS Taxonomy:

Category 1:	Sub-Category 1:
<div>11 Other Health and Therapeutic Services</div>	<div>11080 occupational therapy</div>
Category 2:	Sub-Category 2:
<div></div>	<div></div>
Category 3:	Sub-Category 3:
<div></div>	<div></div>
Category 4:	Sub-Category 4:
<div></div>	<div></div>

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (*Scope*):

Occupational Therapy is a treatment approach that focuses on the effects of injury on the social, emotional, and physiological condition of the participant, and evaluates an individual's balance, motor skills, posture, and perceptual and cognitive abilities within the context of functional, everyday activities. Occupational Therapy helps participants with BI achieve greater independence in their lives by regaining some or all the physical, perceptual, and/or cognitive skills needed to perform activities of daily living through exercises and other related activities.

When skills and strength cannot be adequately developed or improved, Occupational Therapy offers creative solutions and alternatives for carrying out daily activities. This is done by manipulating the participant's environment or by obtaining or designing special adaptive equipment and training the participant in its use. In every case, the goal of Occupational Therapy is to help people develop the living skills necessary to increase independence and, thus, enhance self-satisfaction with the persons quality of life.

Virtual delivery of a service is an electronic method of service delivery. The purpose of virtual delivery of a service is to maintain or improve a participant's functional abilities, enhance interactions, support meaningful relationships, and meaningfully participate in their community. The participant should have other opportunities for integration in the community via other services the participant receives.

Virtual Delivery of a service shall mean the provision of services through equipment with the capability for live real time audio-visual connection that allows the staff member to both see and hear the participant. (e.g., Skype, Zoom, Facetime, telephonic, or another device that facilitates live two-way communication). Text messaging and e-mailing do not constitute virtual services and, therefore, will not be considered provision of direct services under specified HCBS Services.

Direct service can be provided through the virtual delivery of the service when all the following requirements are met:

- a. The virtual delivery of the service ensures the participant's rights of privacy, dignity and respect, and freedom from coercion and restraint.
- b. The virtual delivery of the service does not isolate the participant from the community or interacting with people without disabilities.
- c. The virtual delivery of the service has been agreed to by the participant and their team and outlined in the Person-Centered Plan:
 - i. Participants must have an informed choice between in person or the virtual delivery of the service;
 - ii. The virtual delivery of a service cannot be the only service delivery provision for a participant seeking the given service; and
 - iii. Participants must affirmatively choose virtual delivery of the service over in-person services.
- d. Virtual delivery of a service is not, and will not be, used for the provider's convenience. The virtual delivery of the service must be used to support a participant to reach identified outcomes in the participant's Person-Centered Plan.
- e. Virtual delivery of a service must be documented appropriately as any other service being delivered, including start and end times.
- f. The virtual delivery of a service must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations to protect the privacy and security of the participant's protected health information.
- g. Virtual delivery of a service, including using phones, cannot be used to assess a participant for a medical emergency. The provider must develop and maintain written policies, train direct support staff on those policies, and advise participants and their person-centered planning team regarding those policies that address:
 - i. Identifying individuals to intervene (such as uncompensated caregivers present in the participant's home), and
 - ii. ensuring they are present during provision of virtual delivery of the service in case the participant experiences an emergency; and
 - iii. processes for requesting such intervention if the participant experiences an emergency during provision of virtual services, including contacting 911 if necessary.
- h. The virtual services meet all federal and State requirements, policies, guidance, and complies with 42 CFR 442.301 (c)(4)(vi)(A) through (D) related to privacy, control of schedule, activities, and access to visitors.
- g. Providers furnishing a HCBS waiver service via virtual delivery of service must include virtual delivery of a service in their provider Program Service Plan prior to implementing outside of the Appendix K authority.

- i. Identifying whether the participant's needs, including health and safety, can be addressed safely via virtual delivery of the service.
- ii. How the provider will ensure the participant's right of privacy, dignity and respect, and freedom from coercion and restraint during virtual delivery of the service.
- iii. How the provider will ensure the virtual delivery of the service meets applicable information security standards; and
- iv. How the provider will ensure the provision of virtual delivery of the service complies with applicable laws governing individuals' right to privacy.

Instances

Virtual Delivery of a service will only be authorized when a waiver participant requests the service to be delivered virtually and the technology or device appropriate to support the virtual delivery of the service is available.

Instructions and Limitations

- The program participant's person-centered service plan must indicate the use of the virtual delivery of the service.
- The managed care organization must document the frequency of the virtual delivery of the service.
- The provider must also document and track how the service is delivered. Documentation must be done in the same manner as if it was delivered in person.
- Virtual delivery of a service shall be provided in real-time, not via a recording.
- When virtual delivery of the service is provided, the provider shall only render the service on a one-on-one/individualized basis.
- The service provider shall be responsible for providing the device or technology required to support the virtual delivery of the service. The Waiver program will not fund any costs associated with the provider's virtual delivery of the service such as obtaining, installing, and implementing equipment, internet, software applications, and other related expenses. These costs, in the virtual delivery of the service are part of the provider's operating costs.

Technology and Devices

- Virtual delivery of a service may leverage the existing technologies or devices belonging to the waiver participant.
- HCBS waiver funding shall NOT be used to purchase technologies or devices or internet connectivity for the primary purpose of virtual delivery of a service.
- The provider shall be responsible for the maintenance, upkeep, and assurance the device is in working order.

Community Integration and Participant's Choice

- Where virtual delivery of a service is requested by the participant and authorized by the managed care organization, the following requirements shall be met to ensure the delivery method does not lead to isolating or regimenting the participant from the greater community.
 - o The virtual delivery of the service shall be provided in the participant's preferred setting.
 - The participant's choice for virtual delivery of a service shall be documented and included in their service plan.
 - o The participant shall be able to rescind their choice of virtual delivery of a service at any time. When this occurs, the MCO shall ensure service continuity via a non-virtual delivery method and confirm that the participant's service plan reflects the participant's choice change.
 - o The managed care organization shall be responsible for ensuring that the provider is educating and informing the participant on the scope of the virtual delivery of the service prior to documenting the choice of the individual.
 - o The physical location where virtual services are provided, as well as the activities rendered as part of the service are monitored through KDADS licensing as well as the MCO. Training Requirement
 - Where virtual delivery of a service is requested by the participant and authorized by the managed care organization, the provider shall train the participant to use the solution or application and device (where a new device is provided).
 - Training for the participant and staff must demonstrate trainees understands how the virtual services will ensure the participant's health, welfare, and independence.
 - Training must demonstrate that staff and participant have the competency after training to successfully utilize the technology.
 - o The training should assist the participant in attaining the knowledge required to operate technologies that facilitate successful virtual delivery of the service.
 - o Staff training on the technology that will be utilized for the person in service. must be person-specific, mode of technology utilized for the participant. Training for both participant and staff must be documented with a plan for

continuing education on the technology for participant and staff. Units and delivery for virtual delivery is found below.

Further information on virtual delivery of services available in Main 8 B.

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

Occupational therapy is an agency directed service.

- Occupational Therapy is available through the BI waiver no sooner than six months after the BI occurs. (Prior to this, OT is available as a Medicaid State Plan service.)
- A maximum of 3,120 units per calendar year (1 unit=15 minutes), either alone or in combination with any other BI Waiver rehabilitation therapy services, may be allocated.
- Occupational Therapy Waiver funding requires prior authorization from the MCO via the participant's Person-Centered Service Plan. This waiver service is only provided to individuals aged 21 and over. All medically necessary Occupational Therapy services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. Participants under the age of 21 who are Medicaid eligible will continue to receive Medicaid services available to them participant under EPSDT in addition to the extended State Plan service unless the extended state plan service is not available under EPSDT.

Occupational Therapy waiver services are provided when the limits of the approved Occupational Therapy State Plan service (i.e., up to six months post injury) are exhausted. Therapeutic treatments provided over and above the amount allowed in the State Plan are provided according to the participants needs as identified by the licensed provider and in keeping with the rehabilitative intent of the waiver, i.e., that the participant continues to make progress in their habilitation/rehabilitation.

Occupational Therapy waiver services are provided when the limits of the approved Occupational Therapy State Plan service (i.e., up to six months post injury) are exhausted. Therapeutic treatments provided over and above the amount allowed in the State Plan are provided according to the participants needs as identified by the participant, the licensed provider and in keeping with the rehabilitative intent of the waiver, i.e., that the participant continues to make progress in their habilitation/rehabilitation.

BI providers or provider assistants are not permitted to be dual providers for the same participant on the following services: Personal Care Services (PCS) and Transitional Living Specialist (TLS).

Transitional Living Specialist (TLS) and Therapeutic Services (including behavioral, cognitive, speech-language, physical, and occupational).

Virtual Units and Delivery:

- One unit of a service delivered virtually, shall be equivalent to one unit of in person service delivery (the same) when provided through virtual delivery of a service and shall be reimbursed equivalently.
- The managed care organization shall require providers delivering virtual services to have backup plans in the event of failure of the virtual delivery of service solution.
- In the event there is a problem with virtual supports that includes but is not limited to: equipment failure, device failure or staff are not adequately trained in the usage of the device; the agency will implement the person-specific backup plan.
- All Therapy Providers and Agency directed Personal Care Service must adhere to the following:
 - o An outcome monitoring plan must be developed and approved by the team and the MCO.
 - o The state may require the managed care organizations to present a sample of their provider backup plans for virtual delivery of a service.
 - o The outcome plan must include the person-specific back up plan, the impact the virtual support plan will have on the participant's privacy including whether devices/equipment used facilitates each participant's right to privacy of person and possessions.
 - o This information must be provided to the participant in a form of communication understood by the consumer.
 - o The Therapy Provider and Agency that provides personal care must obtain either the participant's consent in writing or the written consent of parent/guardian of the participant.
 - o This process must be completed prior to the utilization of virtual supports and any change that impacts the consumer's privacy and mode of service delivery.
 - o Virtual supports may only be permitted in bedrooms and bathrooms when an evaluation of multiple factors show that the technology increases independence and facilitates each participant's right to privacy of person and possession.
 - o Virtual Services in bedrooms and bathrooms can only be provided with signed consent of the consumer/guardian, the person's support team and the MCO.

- o Virtual delivery of service in bedrooms and bathrooms must be approved in the Person-Centered Service Plan with a plan to fade the service as appropriate.
 - o If a technology or device is provided to the participant for the primary purpose of virtual delivery of a service, placement of such devices/equipment/technology shall be solely determined by the participant.
 - o The Therapy Provider and Agency that provides personal care is required to actively provide each participant the necessary support to make choice and understand their rights, including the right to choose or decline usage of remote supports
 - o The participant shall have total control of the device, including turning it off or on.
 - o It shall be documented in the service plan what happens if and when a participant decides to turn off the equipment.
 - o The participant's MCO Care Coordinator will monitor and ensure that each participant's health, safety, and wellness are also monitored.
- The MCO Care Coordinator is responsible for verifying that all services (including virtual supports) are appropriate to meet the participant's needs and ensures that the participant exercises free choice of provider, including choice of service delivery method. This includes if the participant continues to choose virtual supports or would like to change to in-person supports.

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Occupational Therapist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service

Service Name: Occupational Therapy

Provider Category:

Individual

Provider Type:

Occupational Therapist

Provider Qualifications

License (*specify*):

Licensed by the Kansas Board of Healing Arts (K.S.A. 65-5401 et seq). All services must be provided in accordance with applicable licensing statutes and regulations.

Certificate (*specify*):

Other Standard (*specify*):

Complete KDADS approved training curriculum.

40 hours of training in BI or one year of experience working with individuals with BI.

In compliance with State statutes and regulations (KSA 65-5419, KAR 100-54-10) occupational therapy may be provided by an occupational aide, occupational therapy tech, or occupational therapy paraprofessional (K.S.A. 65-5419) under the supervision of an enrolled licensed occupational therapist.

The occupational therapy provider will comply with the statutes and regulations deemed necessary by the certification/licensing board.

The licensed occupational therapist is responsible for providing, upon request from the State, the following:

- a. Comprehensive list of the selected tasks that will be performed by the aide/tech/paraprofessional
- b. Documentation of training completed by the aide/tech/paraprofessional
- c. Documentation of evidence to support the aide/tech/paraprofessional's competence at completing the selected tasks

Requirements for occupational aide/occupational therapy tech/occupational therapy paraprofessional:

- a. Must have the appropriate level of education and certification (KAR 100-54-2 & 100-54-3)
- b. Must be at least eighteen years of age or older
- c. Must reside outside of the waiver recipient's home
- d. Must be a Medicaid enrolled provider or be an employee of a Medicaid enrolled 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 a

prohibited offense, as listed in K.S.A. 39-2009, is not eligible for reimbursement of services under Medicaid funding.

Verification of Provider Qualifications

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.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Physical Therapy

HCBS Taxonomy:

Category 1:**Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Physical Therapy is a treatment approach that assists individuals with reaching their highest level of motor functioning and mobility. Through Physical Therapy, people with BI receive treatment to move and perform functional activities in their daily lives and to help prevent conditions associated with loss of mobility through fitness and wellness programs that achieve healthy and active lifestyles. Treatment may involve intensive work in a variety of areas including standing, sitting, walking, balance, muscle tone, endurance, strength, and coordination. Physical Therapy also identifies and instructs the individual in the use of special equipment, when necessary, that can help the individual adapt to limited physical functioning and move more freely and independently in their environment.

Physical Therapy waiver services are provided when the limits of the approved Physical Therapy State Plan service (i.e., up to six months post injury) are exhausted. Therapeutic treatments provided over and above the amount allowed in the State Plan are provided according to the participant needs as identified by the licensed provider and in keeping with the rehabilitative intent of the waiver, i.e., that the participant continues to make progress in their habilitation/rehabilitation.

Physical Therapy is an agency directed service.

Virtual delivery of a service is an electronic method of service delivery. The purpose of virtual delivery of a service is to maintain or improve a participant's functional abilities, enhance interactions, support meaningful relationships, and meaningfully participate in their community. The participant should have other opportunities for integration in the community via other services the participant receives.

Virtual Delivery of a service shall mean the provision of services through equipment with the capability for live real-time audio-visual connection that allows the staff member to both see and hear the participant. (e.g., Skype, Zoom, Facetime, telephonic, or another device that facilitates live two-way communication). Text messaging and e-mailing do not constitute virtual services and, therefore, will not be considered provision of direct services under specified HCBS Services.

Direct service can be provided through the virtual delivery of the service when all of the following requirements are met:

- a. The virtual delivery of the service ensures the participant's rights of privacy, dignity and respect, and freedom from coercion and restraint.
- b. The virtual delivery of the service does not isolate the participant from the community or interacting with people without disabilities.
- c. The virtual delivery of the service has been agreed to by the participant and their team and outlined in the Person-Centered Plan;
 - i. Participants must have an informed choice between in person or the virtual delivery of the service;
 - ii. The virtual delivery of a service cannot be the only service delivery provision for a participant seeking the given service; and
 - iii. Participants must affirmatively choose virtual delivery of the service over in-person services.
- d. Virtual delivery of a service is not, and will not be, used for the provider's convenience. The virtual delivery of the service must be used to support a participant to reach identified outcomes in the participant's Person-Centered Plan;
- e. Virtual delivery of a service must be documented appropriately as any other service being delivered, including start and end times.
- f. The virtual delivery of a service must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations to protect the privacy and security of the participant's protected health information.
- g. Virtual delivery of a service, including using phones, cannot be used to assess a participant for a medical emergency. The provider must develop and maintain written policies, train direct support staff on those policies, and advise participants and their person-centered planning team regarding those policies that address:
 - i. Identifying individuals to intervene (such as uncompensated caregivers present in the participant's home);
 - ii. Ensuring they are present during provision of virtual delivery of the service in case the participant experiences an emergency; and
 - iii. Processes for requesting such intervention if the participant experiences an emergency during provision of virtual services, including contacting 911 if necessary.
- h. The virtual services meets all federal and State requirements, policies, guidance, and complies with 42 CFR

442.301 (c)(4)(vi)(A) through (D) related to privacy, control of schedule, activities, and access to visitors.

- i. Providers furnishing a HCBS waiver service via virtual delivery of service must include virtual delivery of a service in their provider Program Service Plan prior to implementing outside of the Appendix K authority.
- j. The provider must develop, maintain, and enforce written policies, approved by the MCO, which address:
 - i. Identifying whether the participant's needs, including health and safety, can be addressed safely via virtual delivery of the service.
 - ii. How the provider will ensure the participant's rights of privacy, dignity and respect, and freedom from coercion and restraint during virtual delivery of the service.
 - iii. How the provider will ensure the virtual delivery of the service meets applicable information security standards; and
 - iv. iv. How the provider will ensure the provision of virtual delivery of the service complies with applicable laws governing individuals' right to privacy.

Instances

Virtual Delivery of a service will only be authorized when a waiver participant requests the service to be delivered virtually and the technology or device appropriate to support the virtual delivery of the service is available.

Instructions and Limitations

- The program participant's person-centered service plan must indicate the use of the virtual delivery of the service.
- The managed care organization must document the frequency of the virtual delivery of the service.
- The provider must also document and track how the service is delivered. Documentation must be done in the same manner as if it was delivered in person.
- Virtual delivery of a service shall be provided in real-time, not via a recording.
- When virtual delivery of the service is provided, the provider shall only render the service on a one-on-one/individualized basis.
- The service provider shall be responsible for providing the device or technology required to support the virtual delivery of the service. The Waiver program will not fund any costs associated with the provider's virtual delivery of the service such as obtaining, installing, and implementing equipment, internet, software applications, and other related expenses. These costs, in the virtual delivery of the service are part of the provider's operating costs.

Technology and Devices

- Virtual delivery of a service may leverage the existing technologies or devices belonging to the waiver participant.
- HCBS waiver funding shall NOT be used to purchase technologies or devices or internet connectivity for the primary purpose of virtual delivery of a service.
- The provider shall be responsible for the maintenance, upkeep and assurance the device is in working order.

Community Integration and Participant's Choice

- Where virtual delivery of a service is requested by the participant and authorized by the managed care organization, the following requirements shall be met to ensure the delivery method does not lead to isolating or regimenting the participant from the greater community.
- The virtual delivery of the service shall be provided in the participant's preferred setting.
- The participant's choice for virtual delivery of a service shall be documented and included in their service plan.
- The participant shall be able to rescind their choice of virtual delivery of a service at any time.
- When this occurs, the MCO shall ensure service continuity via a non-virtual delivery method and confirm that the participant's service plan reflects the participant's choice change.
- The managed care organization shall be responsible for ensuring that the provider is educating and informing the participant on the scope of the virtual delivery of the service prior to documenting the choice of the individual.
- The physical location where virtual services are provided, as well as the activities rendered as part of the service are monitored through KDADS licensing as well as the MCO.

Training Requirement

- Where virtual delivery of a service is requested by the participant and authorized by the managed care organization, the provider shall train the participant to use the solution or application and device (where a new device is provided).
- Training for the participant and staff must demonstrate trainees understands how the virtual services will ensure the participant's health, welfare, and independence.
- Training must demonstrate that staff and participant have the competency after training to successfully utilize the technology.
- The training should assist the participant in attaining the knowledge required to operate technologies that facilitate successful virtual delivery of the service.
- Staff training on the technology that will be utilized for the person in service. must be person-specific, mode of technology utilized for the participant. Training for both participant and staff must be documented with a plan for continuing education on the technology for participant and staff.

Units and delivery for virtual delivery is found below. Further information on virtual delivery of services available in Main 8 B.

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

Physical Therapy is an agency directed service.

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

A maximum of 3,120 units per year (1 unit=15 minutes) either alone or in combination with any other BI Waiver rehabilitation therapy services may be allocated.

Participants under the age of 21 who are Medicaid eligible will continue to receive Medicaid services available to them under EPSDT in addition to the extended State Plan service. EPSDT eligible children receive services solely through EPSDT unless the extended state plan service is not available under EPSDT.

Physical Therapy is offered through the BI waiver no sooner than six months after the BI occurs. (Prior to this, it is available as a Medicaid State Plan service.)

BI providers or provider assistants are not permitted to be dual providers for the same participant on the following services:

- o Personal Care Attendant (PCA) and Transitional Living Specialist (TLS)
 - o Transitional Living Specialist (TLS) and Therapeutic Services (including behavioral, cognitive, speech-language, physical, and occupational)
 - o Multiple therapeutic services (including behavioral, cognitive, speech-language, physical, and occupational)
- One unit of a service delivered virtually, shall be equivalent to one unit of in person service delivery (the same) when provided through virtual delivery of a service and shall be reimbursed equivalently.
 - The managed care organization shall require providers delivering virtual services to have backup plans in the event of failure of the virtual delivery of service solution.
 - In the event there is a problem with virtual supports that includes but is not limited to: equipment failure, device failure or staff are not adequately trained in the usage of the device; the agency will implement the person-specific backup plan.
 - All Therapy Providers and Agency directed Personal Care Service must adhere to the following.
 - An outcome monitoring plan must be developed and approved by the team and the MCO.
 - o The state may require the managed care organizations to present a sample of their provider backup plans for virtual delivery of a service.
 - o The outcome plan must include the person-specific back up plan, the impact the virtual support plan will have on the participant's privacy including whether devices/equipment used facilitates each participant's right to privacy of person and possessions.
 - o This information must be provided to the participant in a form of communication understood by the consumer.
 - o The Therapy Provider and Agency that provides personal care must obtain either the participant's consent in writing or the written consent of parent/guardian of the participant.
 - o This process must be completed prior to the utilization of virtual supports and any change that impacts the consumer's privacy and mode of service delivery.
 - o Virtual supports may only be permitted in bedrooms and bathrooms when an evaluation of multiple factors show that the technology increases independence and facilitates each participant's right to privacy of person and possession.
 - o Virtual Services in bedrooms and bathrooms can only be provided with signed consent of the consumer/guardian, the person's support team and the MCO.
 - o Virtual delivery of service in bedrooms and bathrooms must be approved in the Person-Centered Service Plan with a plan to fade the service as appropriate.
 - If a technology or device is provided to the participant for the primary purpose of virtual delivery of a service, placement of such devices/equipment/technology shall be solely determined by the participant.
 - The Therapy Provider and Agency that provides personal care is required to actively provide each participant the necessary support to make choice and understand their rights, including the right to choose or decline usage of remote supports
 - The participant shall have total control of the device, including turning it off or on.
 - It shall be documented in the service plan what happens if and when a participant decides to turn off the equipment.

- The participant’s MCO Care Coordinator will monitor and ensure that each participant’s health, safety and wellness are also monitored.
 - The MCO Care Coordinator is responsible for verifying that all services (including virtual supports) are appropriate to meet the participant’s needs and ensures that the participant exercises free choice of provider, including choice of service delivery method. This includes if the participant continues to choose virtual supports or would like to change to in-person supports.

Service Delivery Method *(check each that applies):*

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by *(check each that applies):*

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Physical Therapist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service

Service Name: Physical Therapy

Provider Category:

Individual

Provider Type:

Physical Therapist

Provider Qualifications

License *(specify):*

Licensed by the Kansas Board of Healing Arts (K.S.A. 65-2901 et seq). All services must be provided in accordance with applicable licensing statutes and regulations.

Certificate *(specify):*

(K.A.R 100-29-16, K.S.A. 65-2901, 65-2906).

Other Standard *(specify):*

Complete KDADS approved training curriculum.

40 hours of training in BI or one-year experience working with individuals with BI.

In accordance with statutes and regulations (KAR 100-29-16 & KSA 65-2909, 65-2010, 65-2918), physical therapy may be provided by a physical therapist assistant under the supervision of an enrolled licensed physical therapist provider in accordance with applicable statutes and regulations.

The physical therapy provider will comply with the statutes and regulations deemed necessary by the certification/licensing board.

The licensed physical therapist is responsible for providing, upon request from the State, the following:

- o Comprehensive list of the selected tasks performed by the physical therapy assistant
- o Documentation of education, training, experience, and skill level of the physical therapist assistant
- o Documentation of the setting in which the care is being delivered to the participant
- o Documentation of the complexity and acuteness of the participant condition or health status

Requirements for physical therapy assistant:

- o Must have the appropriate level of education and certification (K.A.R. 100-29-2, 100-29-3 & KSA 65-2909, 65-2910)
- o Must be at least eighteen years of age or older
- o Must reside outside of the waiver recipient's home
- o Must be a Medicaid enrolled provider or an employee of a Medicaid enrolled 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.

Verification of Provider Qualifications

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.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Speech and Language Therapy

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (*Scope*):

Speech-Language Therapy is the treatment of speech and/or language disorders, i.e., problems with the actual production of sounds and difficulty understanding or putting words together to communicate ideas. Assessment and treatment of persons with BI may include the areas of language (listening, talking, reading, writing), cognition (attention, memory, sequencing, planning, time management, problem solving), motor speech skills and articulation, and conversational skills. Speech-language therapy can also address issues related to swallowing and respiration. Goals for the person with BI will depend on the participant's level of functioning, with the overriding focus being to regain lost skills and/or learn ways to compensate for abilities that have permanently changed so as to help the individual achieve the greatest level of independence possible.

Speech-Language Therapy waiver services are provided when the limits of the approved Speech-Language Therapy State Plan service (i.e., up to six months post injury) are exhausted. Therapeutic treatments provided over and above the amount allowed in the State Plan are provided according to the participants needs as identified by the licensed provider and in keeping with the habilitative /rehabilitative intent of the waiver, i.e., that the participant continues to make progress in their rehabilitation.

To avoid any overlap of services, Speech-Language Therapy is limited to those services not covered through regular State Plan Medicaid. BI waiver funding is used as the funding source of last resort and requires prior authorization from the MCO.

Speech Language Therapy is an agency directed service.

Virtual delivery of a service is an electronic method of service delivery. The purpose of virtual delivery of a service is to maintain or improve a participant's functional abilities, enhance interactions, support meaningful relationships, and meaningfully participate in their community. The participant should have other opportunities for integration in the community via other services the participant receives.

Virtual Delivery of a service shall mean the provision of services through equipment with the capability for live real-time audio-visual connection that allows the staff member to both see and hear the participant. (e.g., Skype, Zoom, Facetime, telephonic, or another device that facilitates live two-way communication). Text messaging and e-mailing do not constitute virtual services and, therefore, will not be considered provision of direct services under specified HCBS Services.

Direct service can be provided through the virtual delivery of the service when all of the following requirements are met:

- a. The virtual delivery of the service ensures the participant's rights of privacy, dignity and respect, and freedom from coercion and restraint.
- b. The virtual delivery of the service does not isolate the participant from the community or interacting with people without disabilities.
- c. The virtual delivery of the service has been agreed to by the participant and their team and outlined in the Person-Centered Plan;
 - i. Participants must have an informed choice between in person or the virtual delivery of the service;
 - ii. The virtual delivery of a service cannot be the only service delivery provision for a participant seeking the given service; and
 - iii. Participants must affirmatively choose virtual delivery of the service over in-person services.
- d. Virtual delivery of a service is not, and will not be, used for the provider's convenience. The virtual delivery of the service must be used to support a participant to reach identified outcomes in the participant's Person-Centered Plan;
- e. Virtual delivery of a service must be documented appropriately as any other service being delivered, including start and end times.
- f. The virtual delivery of a service must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations to protect the privacy and security of the participant's protected health information.
- g. Virtual delivery of a service, including using phones, cannot be used to assess a participant for a medical emergency. The provider must develop and maintain written policies, train direct support staff on those policies, and advise participants and their person-centered planning team regarding those policies that address:
- h. Identifying individuals to intervene (such as uncompensated caregivers present in the participant's home), and

ensuring they are present during provision of virtual delivery of the service in case the participant experiences an emergency; and processes for requesting such intervention if the participant experiences an emergency during provision of virtual services, including contacting 911 if necessary.

- i. The virtual services meets all federal and State requirements, policies, guidance, and complies with 42 CFR 442.301 (c)(4)(vi)(A) through (D) related to privacy, control of schedule, activities, and access to visitors.
- j. Providers furnishing a HCBS waiver service via virtual delivery of service must include virtual delivery of a service in their provider Program Service Plan prior to implementing outside of the Appendix K authority.
- k. The provider must develop, maintain, and enforce written policies, approved by the MCO, which address:
 - i. Identifying whether the participant's needs, including health and safety, can be addressed safely via virtual delivery of the service.
 - ii. How the provider will ensure the participant's rights of privacy, dignity and respect, and freedom from coercion and restraint during virtual delivery of the service.
 - iii. How the provider will ensure the virtual delivery of the service meets applicable information security standards; and
 - iv. How the provider will ensure the provision of virtual delivery of the service complies with applicable laws governing individuals' right to privacy.

Instances

Virtual Delivery of a service will only be authorized when a waiver participant requests the service to be delivered virtually and the technology or device appropriate to support the virtual delivery of the service is available.

Instructions and Limitations

- The program participant's person-centered service plan must indicate the use of the virtual delivery of the service.
- The managed care organization must document the frequency of the virtual delivery of the service.
- The provider must also document and track how the service is delivered. Documentation must be done in the same manner as if it was delivered in person.
- Virtual delivery of a service shall be provided in real-time, not via a recording.
- When virtual delivery of the service is provided, the provider shall only render the service on a one-on-one/individualized basis.
- The service provider shall be responsible for providing the device or technology required to support the virtual delivery of the service. The Waiver program will not fund any costs associated with the provider's virtual delivery of the service such as obtaining, installing, and implementing equipment, internet, software applications, and other related expenses. These costs, in the virtual delivery of the service are part of the provider's operating costs.

Technology and Devices

- Virtual delivery of a service may leverage the existing technologies or devices belonging to the waiver participant.
- HCBS waiver funding shall NOT be used to purchase technologies or devices or internet connectivity for the primary purpose of virtual delivery of a service.
- The provider shall be responsible for the maintenance, upkeep and assurance the device is in working order.

Community Integration and Participant's Choice

- Where virtual delivery of a service is requested by the participant and authorized by the managed care organization, the following requirements shall be met to ensure the delivery method does not lead to isolating or regimenting the participant from the greater community.
 - o The virtual delivery of the service shall be provided in the participant's preferred setting.
 - The participant's choice for virtual delivery of a service shall be documented and included in their service plan.
 - o The participant shall be able to rescind their choice of virtual delivery of a service at any time.

When this occurs, the MCO shall ensure service continuity via a non-virtual delivery method and confirm that the participant's service plan reflects the participant's choice change.

- o The managed care organization shall be responsible for ensuring that the provider is educating and informing the participant on the scope of the virtual delivery of the service prior to documenting the choice of the individual.
- o The physical location where virtual services are provided, as well as the activities rendered as part of the service are monitored through KDADS licensing as well as the MCO.

Training Requirement

- Where virtual delivery of a service is requested by the participant and authorized by the managed care organization, the provider shall train the participant to use the solution or application and device (where a new device is provided).
- Training for the participant and staff must demonstrate trainees understands how the virtual services will ensure the participant's health, welfare, and independence.

- Training must demonstrate that staff and participant have the competency after training to successfully utilize the technology.
 - o The training should assist the participant in attaining the knowledge required to operate technologies that facilitate successful virtual delivery of the service.
 - o Staff training on the technology that will be utilized for the person in service. must be person-specific, mode of technology utilized for the participant. Training for both participant and staff must be documented with a plan for continuing education on the technology for participant and staff.
- Units and delivery for virtual delivery is found below. Further information on virtual delivery of services available in Main 8 B.

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

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

A maximum of 3,120 units per year (1 unit=15 minutes) either alone or in combination with any other BI Waiver rehabilitation therapy services may be allocated.

Participants under the age of 21 who are Medicaid eligible will continue to receive Medicaid services available to them under EPSDT in addition to the extended State Plan service. EPSDT eligible children receive services solely through EPSDT unless the extended state plan service is not available under EPSDT.

Speech-Language Therapy is offered through the BI waiver no sooner than six months after the BI occurs. (Prior to this, it is available as a Medicaid State Plan service.)

BI providers or provider assistants are not permitted to be dual providers for the same participant on the following services:

Direct Support Worker (DSW) and Transitional Living Specialist (TLS)

Transitional Living Specialist (TLS) and Therapeutic Services (including behavioral, cognitive, speech-language, physical, and occupational)

Multiple therapeutic services (including behavioral, cognitive, speech-language, physical, and occupational)

- One unit of a service delivered virtually, shall be equivalent to one unit of in person service delivery (the same) when provided through virtual delivery of a service and shall be reimbursed equivalently.
- The managed care organization shall require providers delivering virtual services to have backup plans in the event of failure of the virtual delivery of service solution.
- In the event there is a problem with virtual supports that includes but is not limited to: equipment failure, device failure or staff are not adequately trained in the usage of the device; the agency will implement the person-specific backup plan.
- All Therapy Providers and Agency directed Personal Care Service must adhere to the following.
- An outcome monitoring plan must be developed and approved by the team and the MCO.
- o The state may require the managed care organizations to present a sample of their provider backup plans for virtual delivery of a service.

The outcome plan must include the person-specific back up plan, the impact the virtual support plan will have on the participant's privacy including whether devices/equipment used facilitates each participant's right to privacy of person and possessions.

This information must be provided to the participant in a form of communication understood by the consumer.

The Therapy Provider or Agency that provides personal care must obtain either the participant's consent in writing or the written consent of parent/guardian of the participant.

This process must be completed prior to the utilization of virtual supports and any change that impacts the consumer's privacy and mode of service delivery.

- o Virtual supports may only be permitted in bedrooms and bathrooms when an evaluation of multiple factors show that the technology increases independence and facilitates each participant's right to privacy of person and possession.

Virtual Services in bedrooms and bathrooms can only be provided with signed consent of the consumer/guardian, the person's support team and the MCO.

- o Virtual delivery of service in bedrooms and bathrooms must be approved in the Person-Centered Service Plan with a plan to fade the service as appropriate.

- If a technology or device is provided to the participant for the primary purpose of virtual delivery of a service, placement of such devices/equipment/technology shall be solely determined by the participant.
- The Therapy Provider and Agency that provides personal care is required to actively provide each participant the necessary support to make choice and understand their rights, including the right to choose or decline usage of remote supports
- The participant shall have total control of the device, including turning it off or on.
- It shall be documented in the service plan what happens if and when a participant decides to turn off the equipment.
- The participant's MCO Care Coordinator will monitor and ensure that each participant's health, safety and wellness are also monitored.

- The MCO Care Coordinator is responsible for verifying that all services (including virtual supports) are appropriate to meet the participant’s needs and ensures that the participant exercises free choice of provider, including choice of service delivery method. This includes if the participant continues to choose virtual supports or would like to change to in-person supports.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Speech/Language Therapist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service

Service Name: Speech and Language Therapy

Provider Category:

Individual

Provider Type:

Speech/Language Therapist

Provider Qualifications

License (specify):

Licensed by Kansas Department for Aging and Disability Services. All services must be provided in accordance with applicable licensing statutes and regulations.(K.S.A. 65-6501 et seq & K.A.R. 28-61)

Certificate (specify):

Other Standard (specify):

Complete KDADS approved training curriculum.

40 hours of training in BI or one year experience working with individuals with BI.

In compliance with statutes and regulations (KSA 65-6501 and KAR 28-61), speech/language therapy may be provided by a speech-language pathology assistant under the supervision of an enrolled licensed speech-language pathologist provider in accordance with applicable statutes and regulations.

The speech/language therapy provider will comply with the statutes and regulations deemed necessary by the certification/licensing board.

The speech-language pathologist is responsible for providing, upon request from the State, the following:

- File documentation of the assistant's qualifications and training
- Documentation of performance level of the assistant
- Comprehensive list of the tasks performed by the assistant

Requirements for speech-language pathology assistant:

- Must have the appropriate level of education and certification (KAR 28-61-8)
- Must be at least eighteen years of age or older
 - o Must reside outside of the waiver participant's home
 - o Must be a Medicaid enrolled provider or an employee of a Medicaid enrolled 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.

Verification of Provider Qualifications

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.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Financial Management Services

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

12 Services Supporting Self-Direction

Sub-Category 1:

12010 financial management services in support of self-direction

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

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.

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.

FMS Provider Responsibilities

The FMS Kansas Medical Assistance Program (KMAP) manual and State policy detail the responsibilities of the FMS provider.

FMS support is available for the participant (or the person assigned by the participant, such as a representative, family member, parent, spouse, adult child, guardian) who has chosen to self-direct some or all services, to assist the participant by performing administrative and payroll functions. FMS support will be provided within the scope of the Employer Authority model. The FMS is available to participants who reside in their own private residences or the private home of a family member and have chosen to self-direct their services. FMS assists the participant or participant's representative by providing two distinct types of tasks: (1) Administrative Tasks and (2) Information and Assistance (I & A) Tasks. The FMS provider is also responsible for informing the participant that he/she must exercise responsibility for making the choice to self-direct his/her services, understand the impact of the choices made, and assume responsibility for the results of any decisions and choices that were made. The FMS provider is responsible for clearly communicating verbally and in writing the participants responsibilities relating his/her role as an employer of a direct service worker.

The FMS provider is responsible for certain administrative functions, tasks include, but are not limited to, the following:

- Verification and processing of time worked and the provision of quality assurance;
- Preparation and disbursement of qualified direct support worker payroll in compliance with federal, state and local tax; labor; and workers' compensation insurance requirements; making tax payments to appropriate tax authorities;
- Performance of fiscal accounting and expenditure reporting to the participant or participant's representative and the state, as required.
- Assistance to ensure the basic minimum qualifications set by the State are met in order to ensure participant safety, health and welfare.

The FMS provider is responsible for Information and Assistance functions including but not limited to:

1. Explanation of all aspects of self-direction and subjects pertinent to the participant or participant's representative in managing and directing services;
2. Assistance to the participant or participant's representative in arranging for, directing and managing services;
3. Assistance in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services;
4. Offers practical skills training to enable participants or representatives to independently direct and manage waiver services such as recruiting and hiring direct service workers (DSW), managing workers, and providing effective communication and problem-solving.

Participant Responsibilities

1. Act as the employer for the Direct Support Workers (DSW), or designate a representative to manage or help manage Direct Support Workers (DSWs). See definition of representative above.
2. Negotiate a FMS Service Agreement with the chosen FMS provider that clearly identifies the roles and responsibilities of the participant and the FMS provider
3. Establish the wage of the DSW(s)
4. Select Direct Support Worker(s)
5. Refer the DSW to the FMS provider for completion of required human resources and payroll documentation. In cooperation with the FMS provider, all employment verification and payroll forms must be completed.
6. Negotiate an Employment Service Agreement with the DSW that clearly identifies the responsibilities of all parties, including work schedule.
7. Provide or arrange for appropriate orientation and training of DSW(s).
8. Determine schedules of DSW(s).
9. Determine tasks to be performed by DSW(s) and where and when they are to be performed in accordance with the services approved within the and authorized Person-Centered Service Plan or others as identified and/or are appropriate.
10. Manage and supervise the day-to-day HCBS activities of DSW(s).
11. Verify time worked by DSW(s) was delivered according to the Person-Centered Service Plan; and approve and validate time worked electronically or by exception paper timesheets.
12. Assure utilization of EVV system to record DSW time worked and all other required documents to the FMS provider for processing and payment in accordance with established FMS, State, and Federal requirements. The EVV/timesheet will be reflective of actual hours worked in accordance with an approved Person-Centered Service Plan.
13. Process for reporting Report work-related injuries incurred by the DSW(s) to the FMS provider.
14. Develop an emergency worker back-up plan in in case a substitute DSW is ever needed on short notice or as a back-up (short- term replacement worker).
15. Assure all appropriate service documentation is recorded as required by the State of Kansas HCBS Waiver program policies, procedures, or by Medicaid Provider Agreement.
16. Inform the FMS provider of any changes in the status of DSW(s), such as changes of address or telephone number, in a timely fashion.
17. Inform the FMS provider of the dismissal of a DSW within 3 working days.
18. Inform the FMS provider of any changes in the status of the participant or participant's representative, such as the participant's address, telephone number or hospitalizations within 3 working days.
19. Participate in required quality assurance visits with MCOs, and State Quality Assurance Staff, or other Federal and State authorized reviewers / auditors.

Payment for FMS

FMS providers will be reimbursed a monthly fee per member per month. The per member per month payment was is estimated based upon a formula that includes all direct and indirect costs to payroll agents and an average hourly rate for direct care workers (DSWs). Under the KanCare program, FMS providers will contract with MCOs for final payment rates, which cannot be less than the current FMS rate.

The FMS provider is responsible for Information and Assistance functions including but not limited to:

1. Explanation of all aspects of self-direction and subjects pertinent to the participant or participant's representative in managing and directing services;
2. Assistance to the participant or participant's representative in arranging for, directing and managing services;
3. Assistance in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services;
4. Offers practical skills training to enable participants or representatives to independently direct and manage waiver services such as recruiting and hiring direct service workers (DSW), managing workers, and providing effective communication and problem-solving.

Participant Responsibilities

1. Act as the employer for the Direct Support Workers (DSW), or designate a representative to manage or help manage Direct Support Workers (DSWs). See definition of representative above.
2. Negotiate a FMS Service Agreement with the chosen FMS provider that clearly identifies the roles and responsibilities of the participant and the FMS provider
3. Establish the wage of the DSW(s)
4. Select Direct Support Worker(s)
5. Refer the DSW to the FMS provider for completion of required human resources and payroll documentation. In cooperation with the FMS provider, all employment verification and payroll forms must be completed.
6. Negotiate an Employment Service Agreement with the DSW that clearly identifies the responsibilities of all parties, including work schedule.
7. Provide or arrange for appropriate orientation and training of DSW(s).
8. Determine schedules of DSW(s).
9. Determine tasks to be performed by DSW(s) and where and when they are to be performed in accordance with the services approved within the and authorized Person-Centered Service Plan or others as identified and/or are appropriate.
10. Manage and supervise the day-to-day HCBS activities of DSW(s).
11. Verify time worked by DSW(s) was delivered according to the Person-Centered Service Plan; and approve and validate time worked electronically or by exception paper timesheets.
12. Assure utilization of EVV system to record DSW time worked and all other required documents to the FMS provider for processing and payment in accordance with established FMS, State, and Federal requirements. The EVV/timesheet will be reflective of actual hours worked in accordance with an approved Person-Centered Service Plan.
13. Process for reporting Report work-related injuries incurred by the DSW(s) to the FMS provider.
14. Develop an emergency worker back-up plan in in case a substitute DSW is ever needed on short notice or as a back-up (short- term replacement worker).
15. Assure all appropriate service documentation is recorded as required by the State of Kansas HCBS Waiver program policies, procedures, or by Medicaid Provider Agreement.
16. Inform the FMS provider of any changes in the status of DSW(s), such as changes of address or telephone number, in a timely fashion.
17. Inform the FMS provider of the dismissal of a DSW within 3 working days.
18. Inform the FMS provider of any changes in the status of the participant or participant's representative, such as the participant's address, telephone number or hospitalizations within 3 working days.
19. Participate in required quality assurance visits with MCOs, and State Quality Assurance Staff, or other Federal and State authorized reviewers / auditors.

Payment for FMS

FMS providers will be reimbursed a monthly fee per member per month. The per member per month payment was is estimated based upon a formula that includes all direct and indirect costs to payroll agents and an average hourly rate for direct care workers (DSWs). Under the KanCare program, FMS providers will contract with MCOs for final payment rates, which cannot be less than the current FMS rate.

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

Access to this service is limited to participants who chose to self-direct some or all of the service(s) when self-direction is offered.

FMS service is reimbursed per member per month. FMS service may be accessed by the participant at a minimum monthly or as needed in order to meet the needs of the participant. A participant may have only one FMS provider per month.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Enrolled Medicaid Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction

Service Name: Financial Management Services

Provider Category:

Agency

Provider Type:

Enrolled Medicaid Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Enrolled FMS providers will furnish Financial Management Services according to Kansas model.

Organizations interested in providing Financial Management Services (FMS) are required to contract with KDADS, or their designee. The contract must be signed prior to enrollment in KMAP to provide the service. The agreement identifies the waiver programs under which the organization is requesting to provide FMS and outlines general expectations and specific provider requirements. The agreement will be renewed annually and approval is subject to satisfactory completion of the required GAAP audit. KanCare MCOs will not credential any application without a fully executed FMS Provider agreement.

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.

For new organizations seeking to be a FMS provider, the FMS provider agreement and accompanying documentation are reviewed by the State Operating Agency and/or their designee to ensure that all assurances are satisfied as part of a readiness review prior to signing by the Secretary of KDADS, or designee.

FMS organizations are required to submit the following documents with the signed FMS provider agreement as a part of the readiness review:

- Community Developmental Disability Organization (CDDO) affiliate agreement (I/DD only)
- Secretary of State Certificate of Corporate Good Standing
- W-9 form
- Proof of Liability Insurance
- Proof of Workers Compensation insurance
- Copy of the most recent quarterly operations report or estimate for first quarter operations
- Financial statements (last 3 months bank statements or documentation of line of credit)
- Copy of the organization's Policies and Procedures manual, to include information that covers requirements listed in the FMS Medicaid Provider Manual.
- Including process for conducting background checks
- Process for establishing and tracking workers wage with the participant

Verification of Provider Qualifications

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

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Behavior Therapy

HCBS Taxonomy:**Category 1:**

11 Other Health and Therapeutic Services

Sub-Category 1:

11130 other therapies

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

In general, Behavior Therapy applies to the application of findings from behavioral science research to help individuals change in ways that they would like to change. These research-based strategies are used to help increase the quality of life of the individual with BI and decrease problem, self-destructive behavior, such as aggression, property destruction, self-injury, poor anger management, and other behaviors that can interfere with a participant's ability to adapt to and live successfully in the community. Behavior Therapy can involve looking at the participant's early life experiences, long-time internal psychological or emotional conflicts, and/or the participant's personality structure. Generally, however, Behavior Therapy emphasizes the participant's current environment and making positive changes to that environment while improving the participant's self-control using procedures to expand the participant's skills, abilities, and level of independence.

Behavior therapy is an agency directed service.

Virtual delivery of a service is an electronic method of service delivery. The purpose of virtual delivery of a service is to maintain or improve a participant's functional abilities, enhance interactions, support meaningful relationships, and meaningfully participate in their community. The participant should have other opportunities for integration in the community via other services the participant receives.

Virtual Delivery of a service shall mean the provision of services through equipment with the capability for live real-time audio-visual connection that allows the staff member to both see and hear the participant. (e.g., Skype, Zoom, Facetime, telephonic, or another device that facilitates live two-way communication). Text messaging and e-mailing do not constitute virtual services and, therefore, will not be considered provision of direct services under specified HCBS Services.

Direct service can be provided through the virtual delivery of the service when all of the following requirements are met:

- a. The virtual delivery of the service ensures the participant's rights of privacy, dignity and respect, and freedom from coercion and restraint.
- b. The virtual delivery of the service does not isolate the participant from the community or interacting with people without disabilities.
- c. The virtual delivery of the service has been agreed to by the participant and their team and outlined in the Person-Centered Plan;
 - i. Participants must have an informed choice between in person or the virtual delivery of the service;
 - ii. The virtual delivery of a service cannot be the only service delivery provision for a participant seeking the given service; and
 - iii. Participants must affirmatively choose virtual delivery of the service over in-person services.
- d. Virtual delivery of a service is not, and will not be, used for the provider's convenience. The virtual delivery of the service must be used to support a participant to reach identified outcomes in the participant's Person-Centered Plan;
- e. Virtual delivery of a service must be documented appropriately as any other service being delivered, including start and end times.
- f. The virtual delivery of a service must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations to protect the privacy and security of the participant's protected health information.
- g. Virtual delivery of a service, including using phones, cannot be used to assess a participant for a medical emergency. The provider must develop and maintain written policies, train direct support staff on those policies, and advise participants and their person-centered planning team regarding those policies that address:
- h. Identifying individuals to intervene (such as uncompensated caregivers present in the participant's home), and ensuring they are present during provision of virtual delivery of the service in case the participant experiences an emergency; and processes for requesting such intervention if the participant experiences an emergency during provision of virtual services, including contacting 911 if necessary.
- i. The virtual services meets all federal and State requirements, policies, guidance, and complies with 42 CFR 442.301 (c)(4)(vi)(A) through (D) related to privacy, control of schedule, activities, and access to visitors.
- j. Providers furnishing a HCBS waiver service via virtual delivery of service must include virtual delivery of a service in their provider Program Service Plan prior to implementing outside of the Appendix K authority.
- k. The provider must develop, maintain, and enforce written policies, approved by the MCO, which address:
 - i. Identifying whether the participant's needs, including health and safety, can be addressed safely via virtual delivery of the service.
 - ii. How the provider will ensure the participant's rights of privacy, dignity and respect, and freedom from coercion

and restraint during virtual delivery of the service.

iii. How the provider will ensure the virtual delivery of the service meets applicable information security standards; and

iv. iv. How the provider will ensure the provision of virtual delivery of the service complies with applicable laws governing individuals' right to privacy.

Instances

Virtual Delivery of a service will only be authorized when a waiver participant requests the service to be delivered virtually and the technology or device appropriate to support the virtual delivery of the service is available.

Instructions and Limitations

- The program participant's person-centered service plan must indicate the use of the virtual delivery of the service.
- The managed care organization must document the frequency of the virtual delivery of the service.
- The provider must also document and track how the service is delivered. Documentation must be done in the same manner as if it was delivered in person.
- Virtual delivery of a service shall be provided in real-time, not via a recording.
- When virtual delivery of the service is provided, the provider shall only render the service on a one-on-one/individualized basis.
- The service provider shall be responsible for providing the device or technology required to support the virtual delivery of the service. The Waiver program will not fund any costs associated with the provider's virtual delivery of the service such as obtaining, installing, and implementing equipment, internet, software applications, and other related expenses. These costs, in the virtual delivery of the service are part of the provider's operating costs.

Technology and Devices

- Virtual delivery of a service may leverage the existing technologies or devices belonging to the waiver participant.
- HCBS waiver funding shall NOT be used to purchase technologies or devices or internet connectivity for the primary purpose of virtual delivery of a service.
- The provider shall be responsible for the maintenance, upkeep and assurance the device is in working order.

Community Integration and Participant's Choice

- Where virtual delivery of a service is requested by the participant and authorized by the managed care organization, the following requirements shall be met to ensure the delivery method does not lead to isolating or regimenting the participant from the greater community.
 - o The virtual delivery of the service shall be provided in the participant's preferred setting.
- The participant's choice for virtual delivery of a service shall be documented and included in their service plan.
- o The participant shall be able to rescind their choice of virtual delivery of a service at any time.

When this occurs, the MCO shall ensure service continuity via a non-virtual delivery method and confirm that the participant's service plan reflects the participant's choice change.

- o The managed care organization shall be responsible for ensuring that the provider is educating and informing the participant on the scope of the virtual delivery of the service prior to documenting the choice of the individual.
- o The physical location where virtual services are provided, as well as the activities rendered as part of the service are monitored through KDADS licensing as well as the MCO.

Training Requirement

- Where virtual delivery of a service is requested by the participant and authorized by the managed care organization, the provider shall train the participant to use the solution or application and device (where a new device is provided).
- Training for the participant and staff must demonstrate trainees understands how the virtual services will ensure the participant's health, welfare, and independence.
- Training must demonstrate that staff and participant have the competency after training to successfully utilize the technology.
 - o The training should assist the participant in attaining the knowledge required to operate technologies that facilitate successful virtual delivery of the service.
 - o Staff training on the technology that will be utilized for the person in service. must be person-specific, mode of technology utilized for the participant. Training for both participant and staff must be documented with a plan for continuing education on the technology for participant and staff.

Units and delivery for virtual delivery is found below. Further information on virtual delivery of services available in Main 8 B.

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

A maximum of 3,120 units per year (1 unit=15 minutes) either alone or in combination with any other BI Waiver rehabilitation therapy services.

Participants under the age of 21 who are Medicaid eligible will continue to receive Medicaid services available to them under EPSDT in addition to the extended State Plan service.

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

BI providers or provider assistants are not permitted to be dual providers for the same participant on the following services:

- Personal Care Attendant (PCA) and Transitional Living Specialist (TLS)
- Transitional Living Specialist (TLS) and Therapeutic Services (including behavioral, cognitive, speech-language, physical, and occupational)
- Multiple therapeutic services (including behavioral, cognitive, speech-language, physical, and occupational)

One unit of a service delivered virtually, shall be equivalent to one unit of in person service delivery (the same) when provided through virtual delivery of a service and shall be reimbursed equivalently.

- The managed care organization shall require providers delivering virtual services to have backup plans in the event of failure of the virtual delivery of service solution.
- In the event there is a problem with virtual supports that includes but is not limited to: equipment failure, device failure or staff are not adequately trained in the usage of the device; the agency will implement the person-specific backup plan.
- All Therapy Providers and Agency directed Personal Care Service must adhere to the following:
 - o An outcome monitoring plan must be developed and approved by the team and the MCO.
 - o The state may require the managed care organizations to present a sample of their provider backup plans for virtual delivery of a service.
 - o The outcome plan must include the person-specific back up plan, the impact the virtual support plan will have on the participant's privacy including whether devices/equipment used facilitates each participant's right to privacy of person and possessions.
 - o This information must be provided to the participant in a form of communication understood by the consumer.
 - o The Therapy Provider and Agency that provides personal care must obtain either the participant's consent in writing or the written consent of parent/guardian of the participant.
 - o This process must be completed prior to the utilization of virtual supports and any change that impacts the consumer's privacy and mode of service delivery.
 - o Virtual supports may only be permitted in bedrooms and bathrooms when an evaluation of multiple factors show that the technology increases independence and facilitates each participant's right to privacy of person and possession.
 - o Virtual Services in bedrooms and bathrooms can only be provided with signed consent of the consumer/guardian, the person's support team and the MCO.
 - o Virtual delivery of service in bedrooms and bathrooms must be approved in the Person-Centered Service Plan with a plan to fade the service as appropriate.
 - o If a technology or device is provided to the participant for the primary purpose of virtual delivery of a service, placement of such devices/equipment/technology shall be solely determined by the participant.
 - o The Therapy Provider and Agency that provides personal care is required to actively provide each participant the necessary support to make choice and understand their rights, including the right to choose or decline usage of remote supports
 - o The participant shall have total control of the device, including turning it off or on.
 - o It shall be documented in the service plan what happens if and when a participant decides to turn off the equipment.
 - o The participant's MCO Care Coordinator will monitor and ensure that each participant's health, safety, and wellness are also monitored.
- The MCO Care Coordinator is responsible for verifying that all services (including virtual supports) are

appropriate to meet the participant’s needs and ensures that the participant exercises free choice of provider, including choice of service delivery method. This includes if the participant continues to choose virtual supports or would like to change to in-person supports.

Service Delivery Method *(check each that applies):*

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by *(check each that applies):*

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Behavior Therapist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavior Therapy

Provider Category:

Individual

Provider Type:

Behavior Therapist

Provider Qualifications

License *(specify):*

Licensed by the Kansas Behavioral Sciences Regulatory Board
(K.S.A. 74-5301 et seq. and K.S.A. 65-6301 et seq.)

Certificate *(specify):*

Providers serving in a school environment can provide these services if the provider has a certification in Special Education by the Kansas State Department of Education. For this circumstance, the provider must have a Master’s degree in Special Education, complete KDADS approved training curriculum, 40 hours of training of one year of experience working with individuals with BI, and comply with State statutes, rules, and regulations. Consistent with the certification/licensing board requirement, a provider meeting these qualifications can only provide services in a school environment.

Other Standard *(specify):*

Master's degree in a behavioral science field (e.g., psychology, neuropsychology, social work)
 Complete KDADS approved training curriculum.
 40 hours of training in BI or one year experience working with individuals with BI.

In accordance with State statutes and regulations (KAR 102-2-8 and 102-1-11), behavioral therapy may be provided by an unlicensed assistant under the supervision of an enrolled licensed provider.

The behavior therapy provider will comply with the statutes and regulations deemed necessary by the certification/licensing board.

The behavior therapy provider is responsible for providing, upon request from the State, the following:

- a. File documentation of the assistant's qualifications and training
- b. Documentation of performance level of the assistant
- c. Comprehensive list of the tasks performed by the assistant

Requirements for unlicensed behavior therapy assistant:

- Must have the appropriate level of education and certification (KAR 102-1-11 & 102-2-8)
- Must be at least eighteen years of age or older
- Must reside outside of the waiver recipient's home
- Must be a Medicaid enrolled provider or an employee of a Medicaid enrolled 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.

Verification of Provider Qualifications

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.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Cognitive Rehabilitation

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Cognitive Rehabilitation is a treatment process in which a person works to alleviate deficits in thinking. In cases of persons with BI, these deficits can include poor attention and concentration, memory loss, difficulty with problem solving, and dysfunctional thoughts and beliefs that can contribute to maladaptive behavior and emotional responses. Through Cognitive Rehabilitation, the individual utilizes methods that aim to help make the most of existing cognitive functioning despite the difficulties they are experiencing through various methods, including guided practice on tasks that reflect cognitive functions, development of skills to help identify distorted beliefs and thought patterns, and strategies for taking in new information, such as the use of memory aids and other assistive devices. The goal for the individual receiving Cognitive Rehabilitation is to achieve an awareness of their cognitive limitations, strengths, and needs and acquire the awareness and skills in the use of functional compensations necessary to increase the quality of life and enhance their ability to live successfully in the community.

Cognitive Rehabilitative Therapy is an agency directed service.

Virtual delivery of a service is an electronic method of service delivery. The purpose of virtual delivery of a service is to maintain or improve a participant's functional abilities, enhance interactions, support meaningful relationships, and meaningfully participate in their community. The participant should have other opportunities for integration in the community via other services the participant receives.

Virtual Delivery of a service shall mean the provision of services through equipment with the capability for live real-time audio-visual connection that allows the staff member to both see and hear the participant. (e.g., Skype, Zoom, Facetime, telephonic, or another device that facilitates live two-way communication). Text messaging and e-mailing do not constitute virtual services and, therefore, will not be considered provision of direct services under specified HCBS Services.

Direct service can be provided through the virtual delivery of the service when all of the following requirements are met:

- a. The virtual delivery of the service ensures the participant's rights of privacy, dignity and respect, and freedom from coercion and restraint.
- b. The virtual delivery of the service does not isolate the participant from the community or interacting with people without disabilities.
- c. The virtual delivery of the service has been agreed to by the participant and their team and outlined in the Person-Centered Plan;
 - i. Participants must have an informed choice between in person or the virtual delivery of the service;
 - ii. The virtual delivery of a service cannot be the only service delivery provision for a participant seeking the given service; and
 - iii. Participants must affirmatively choose virtual delivery of the service over in-person services.
- d. Virtual delivery of a service is not, and will not be, used for the provider's convenience. The virtual delivery of the service must be used to support a participant to reach identified outcomes in the participant's Person-Centered Plan;
- e. Virtual delivery of a service must be documented appropriately as any other service being delivered, including start and end times.
- f. The virtual delivery of a service must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations to protect the privacy and security of the participant's protected health information.
- g. Virtual delivery of a service, including using phones, cannot be used to assess a participant for a medical emergency. The provider must develop and maintain written policies, train direct support staff on those policies, and advise participants and their person-centered planning team regarding those policies that address:
- h. Identifying individuals to intervene (such as uncompensated caregivers present in the participant's home), and ensuring they are present during provision of virtual delivery of the service in case the participant experiences an emergency; and processes for requesting such intervention if the participant experiences an emergency during provision of virtual services, including contacting 911 if necessary.
- i. The virtual services meets all federal and State requirements, policies, guidance, and complies with 42 CFR 442.301 (c)(4)(vi)(A) through (D) related to privacy, control of schedule, activities, and access to visitors.
- j. Providers furnishing a HCBS waiver service via virtual delivery of service must include virtual delivery of a service in their provider Program Service Plan prior to implementing outside of the Appendix K authority.
- k. The provider must develop, maintain, and enforce written policies, approved by the MCO, which address:
 - i. Identifying whether the participant's needs, including health and safety, can be addressed safely via virtual

delivery of the service.

- ii. How the provider will ensure the participant's rights of privacy, dignity and respect, and freedom from coercion and restraint during virtual delivery of the service.
- iii. How the provider will ensure the virtual delivery of the service meets applicable information security standards; and
- iv. iv. How the provider will ensure the provision of virtual delivery of the service complies with applicable laws governing individuals' right to privacy.

Instances

Virtual Delivery of a service will only be authorized when a waiver participant requests the service to be delivered virtually and the technology or device appropriate to support the virtual delivery of the service is available.

Instructions and Limitations

- The program participant's person-centered service plan must indicate the use of the virtual delivery of the service.
- The managed care organization must document the frequency of the virtual delivery of the service.
- The provider must also document and track how the service is delivered. Documentation must be done in the same manner as if it was delivered in person.
- Virtual delivery of a service shall be provided in real-time, not via a recording.
- When virtual delivery of the service is provided, the provider shall only render the service on a one-on-one/individualized basis.
- The service provider shall be responsible for providing the device or technology required to support the virtual delivery of the service. The Waiver program will not fund any costs associated with the provider's virtual delivery of the service such as obtaining, installing, and implementing equipment, internet, software applications, and other related expenses. These costs, in the virtual delivery of the service are part of the provider's operating costs.

Technology and Devices

- Virtual delivery of a service may leverage the existing technologies or devices belonging to the waiver participant.
- HCBS waiver funding shall NOT be used to purchase technologies or devices or internet connectivity for the primary purpose of virtual delivery of a service.
- The provider shall be responsible for the maintenance, upkeep and assurance the device is in working order.

Community Integration and Participant's Choice

- Where virtual delivery of a service is requested by the participant and authorized by the managed care organization, the following requirements shall be met to ensure the delivery method does not lead to isolating or regimenting the participant from the greater community.
 - o The virtual delivery of the service shall be provided in the participant's preferred setting.
 - The participant's choice for virtual delivery of a service shall be documented and included in their service plan.
 - o The participant shall be able to rescind their choice of virtual delivery of a service at any time.

When this occurs, the MCO shall ensure service continuity via a non-virtual delivery method and confirm that the participant's service plan reflects the participant's choice change.

- o The managed care organization shall be responsible for ensuring that the provider is educating and informing the participant on the scope of the virtual delivery of the service prior to documenting the choice of the individual.
- o The physical location where virtual services are provided, as well as the activities rendered as part of the service are monitored through KDADS licensing as well as the MCO.

Training Requirement

- Where virtual delivery of a service is requested by the participant and authorized by the managed care organization, the provider shall train the participant to use the solution or application and device (where a new device is provided).
- Training for the participant and staff must demonstrate trainees understands how the virtual services will ensure the participant's health, welfare, and independence.
- Training must demonstrate that staff and participant have the competency after training to successfully utilize the technology.
 - o The training should assist the participant in attaining the knowledge required to operate technologies that facilitate successful virtual delivery of the service.
 - o Staff training on the technology that will be utilized for the person in service. must be person-specific, mode of technology utilized for the participant. Training for both participant and staff must be documented with a plan for continuing education on the technology for participant and staff.

Units and delivery for virtual delivery is found below. Further information on virtual delivery of services available in Main 8 B.

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

his waiver service is only provided to individuals aged 21 and over. All medically necessary Cognitive Rehabilitation services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. Waiver funding requires prior authorization from the MCO via the participant's Person-Centered Service Plan.

A maximum of 3,120 units per year (1 unit=15 minutes) either alone or in combination with any other BI Waiver rehabilitation therapy.

Participants under the age of 21 who are Medicaid eligible will continue to receive Medicaid services available to them under EPSDT in addition to the extended State Plan service. EPSDT eligible children receive services solely through EPSDT unless the extended state plan service is not available under EPSDT.

BI providers or provider assistants are not permitted to be dual providers for the same participant on the following services:

- o Personal Care Attendant (PCA) and Transitional Living Specialist (TLS)
- o Transitional Living Specialist (TLS) and Therapeutic Services (including behavioral, cognitive, speech-language, physical, and occupational)
- o Multiple therapeutic services (including behavioral, cognitive, speech-language, physical, and occupational)

One unit of a service delivered virtually, shall be equivalent to one unit of in person service delivery (the same) when provided through virtual delivery of a service and shall be reimbursed equivalently.

- The managed care organization shall require providers delivering virtual services to have backup plans in the event of failure of the virtual delivery of service solution.
- In the event there is a problem with virtual supports that includes but is not limited to: equipment failure, device failure or staff are not adequately trained in the usage of the device; the agency will implement the person-specific backup plan.
- All Therapy Providers and Agency directed Personal Care Service must adhere to the following:
 - o An outcome monitoring plan must be developed and approved by the team and the MCO.
 - o The state may require the managed care organizations to present a sample of their provider backup plans for virtual delivery of a service.
 - o The outcome plan must include the person-specific back up plan, the impact the virtual support plan will have on the participant's privacy including whether devices/equipment used facilitates each participant's right to privacy of person and possessions.
 - o This information must be provided to the participant in a form of communication understood by the consumer.
 - o The Therapy Provider and Agency that provides personal care must obtain either the participant's consent in writing or the written consent of parent/guardian of the participant.
 - o This process must be completed prior to the utilization of virtual supports and any change that impacts the consumer's privacy and mode of service delivery.
 - o Virtual supports may only be permitted in bedrooms and bathrooms when an evaluation of multiple factors show that the technology increases independence and facilitates each participant's right to privacy of person and possession.
 - o Virtual Services in bedrooms and bathrooms can only be provided with signed consent of the consumer/guardian, the person's support team and the MCO.
 - o Virtual delivery of service in bedrooms and bathrooms must be approved in the Person-Centered Service Plan with a plan to fade the service as appropriate.
 - o If a technology or device is provided to the participant for the primary purpose of virtual delivery of a service, placement of such devices/equipment/technology shall be solely determined by the participant.
 - o The Therapy Provider and Agency that provides personal care is required to actively provide each participant the necessary support to make choice and understand their rights, including the right to choose or decline usage of remote supports
 - o The participant shall have total control of the device, including turning it off or on.
 - o It shall be documented in the service plan what happens if and when a participant decides to turn off the equipment.
 - o The participant's MCO Care Coordinator will monitor and ensure that each participant's health, safety, and wellness are also monitored.
- The MCO Care Coordinator is responsible for verifying that all services (including virtual supports) are appropriate to meet the participant's needs and ensures that the participant exercises free choice of provider,

including choice of service delivery method. This includes if the participant continues to choose virtual supports or would like to change to in-person supports.

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Cognitive Therapist/Rehabilitation Specialist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Cognitive Rehabilitation

Provider Category:

Individual

Provider Type:

Cognitive Therapist/Rehabilitation Specialist

Provider Qualifications

License (*specify*):

Licensed by the Kansas Behavioral Sciences Regulatory Board (K.S.A. 74-5301 et seq. and K.S.A. 65-6301 et seq.)

Certificate (*specify*):

Providers serving in a school environment can provide these services if the provider has a certification in Special Education by the Kansas State Department of Education. For this circumstance, the provider must have a Master's degree in Special Education, complete KDADS approved training curriculum, 40 hours of training of one year of experience working with individuals with TBI, and comply with State statutes, rules, and regulations. Consistent with the certification/licensing board requirement, a provider meeting these qualifications can only provide services in a school environment.

Other Standard (*specify*):

Master's degree in a behavioral science field (e.g., psychology, neuropsychology, social work) and Complete KDADS approved training curriculum.

40 hours of training in BI or one year experience working with individuals with BI.

In accordance with statutes and regulations (KAR 102-2-8 and 102-1-11), cognitive therapy may be provided by an unlicensed assistant under the supervision of an enrolled licensed provider.

The cognitive therapy provider will comply with the statutes and regulations deemed necessary by the certification/licensing board.

The cognitive therapy provider is responsible for providing, upon request from the State, the following:

- a. File documentation of the assistant's qualifications and training
- b. Documentation of performance level of the assistant
- c. Comprehensive list of the tasks performed by the assistant

Requirements for unlicensed cognitive therapy assistant:

- Must have the appropriate level of education and certification (KAR 102-2-8 & 102-1-11)
- Must be at least eighteen years of age or older
- Must reside outside of the waiver recipient's home
- Must be a Medicaid enrolled provider or an employee of a Medicaid enrolled 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.

Verification of Provider Qualifications

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.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Enhanced Care Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

08 Home-Based Services

08030 personal care

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Enhanced Care Services provides non-nursing physical assistance and/or supervision during the consumer's normal sleeping hours in the participant's place of residence. This assistance includes, the following: physical assistance or supervision with toileting, transferring, turning, intake of liquids, mobility issues, and prompting to take medication.

Providers will sleep and awaken as identified on the participant's person-centered service plan and must provide the consumer with a mechanism to gain their attention or awaken them at any time (e.g., a bell or buzzer). Providers must be ready to call a physician, hospital, any identified contact individuals, or other medical personnel should an emergency arise. The scope of and intent behind Enhanced Care Services is entirely different from and therefore not duplicative of services defined as and provided under Personal Services.

The Person-Centered Service Plan must indicate a need for this service that is beyond the need for a Personal Emergency Response System.

Enhanced Care Services can be either an agency directed service or self-directed service.

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

To avoid overlap of services, ECS 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.

The length of service (i.e., one unit) during any 24-hour time period must be at least 6 hours, but hours but cannot exceed twelve hours.

1 unit of service is equal to 6-12 hours within a 24-hour period.

The ECS provider cannot be an individual residing in the home with the participant unless the provider is a legally responsible person and an exception has been granted by the MCO as described below.

ECS cannot be provided by a participant's legally responsible person (spouse or parent of a minor child). The MCO may grant an exception to allow a legally responsible person to provide ECS when one of the following three circumstances are present:

- 1) The participant lives in a rural area, in which access to a provider is beyond a 50-mile radius from the participant's residence and the relative or family member is the only provider available to meet the needs of the participant.
- 2) The participant lives alone and has a severe cognitive impairment, physical disability or intellectual disability
- 3) The participant has exhausted other support options offered by the MCO and absent ECS would be at significant risk of institutionalization.

ECS cannot be provided by a guardian or activated durable power of attorney unless conflict of interest is mitigated as ordered by the probate court or a designated representative is appointed to direct the care of the participant as detailed in Appendix C.2.E.

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Enhanced Care Services provider
Agency	Enhanced Care Services provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Enhanced Care Services

Provider Category:

Individual

Provider Type:

Enhanced Care Services provider

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

- must be at least 18 years of age
- must sign an agreement with a Medicaid-enrolled Financial Management Services (FMS) provider
- must have the ability to call appropriate individual/organization in case of an emergency and provide the intermittent care the individual may need.
- ECS cannot be provided by a guardian or activated durable power of attorney unless conflict of interest is mitigated as ordered by the probate court or a designated representative is appointed to direct the care of the participant.

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.

Verification of Provider Qualifications

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.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Enhanced Care Services

Provider Category:

Agency

Provider Type:

Enhanced Care Services provider

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

- must be at least 18 years old
 - Agency must be an enrolled Medicaid provider
 - must have the ability to call appropriate individual/organization in case of an emergency and provide the intermittent care the individual may need

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.

Verification of Provider Qualifications

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.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home and Environmental Modification Services (HEMS)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (*Scope*):

Home and Environmental Modification Services (HEMS) are physical modifications to the participant's home based on an assessment designed to support the participant's efforts to function with greater independence and to create a safer, healthier environment. The need for HEMS adaptations shall be determined through the person-centered service plan and based on need related to the participant's disability. This service may only be substituted for Personal Care Services when they have been identified as a cost-effective alternative to Personal Care Services on the participant's Person-Centered Service Plan. Participants will have the opportunity to choose from any qualified provider with consideration given to the most economical option available that meets the participant's assessed needs as documented on their PCSP by the participant's chosen KanCare MCO.

This service is limited to those services not covered through the Medicaid State Plan, Early and Periodic Screening, Diagnostic and Treatment (EPSDT), and which cannot be procured by or provided by 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 MCO.

Instance

HEMS adaptations may include, but shall not be limited to, the following:

Modifications to the environment

Installation of grab bars;

Construction of access ramps and railings;

Installation of detectable warnings on walking surfaces;

Alerting devices for participant who has a hearing or sight impairment;

Adaptations to the electrical, telephone, and lighting systems;

Generator to support medical and health devices that require electricity;

Widening of doorways and halls;

Door openers;

Installation of lifts and stair glides (with the exception of elevators), such as overhead lift systems and vertical lifts;

Bathroom modifications for accessibility and independence with self-care;

Kitchen modifications for accessibility and independence;

Alarms or locks on windows, doors, and fences; protective padding on walls, floors, or pipes; Plexiglas, safety glass, a protected glass coating on windows; outside gates and fences; brackets for appliances; raised/lowered electrical switches and sockets; and safety screen doors which are necessary for the health, welfare, and safety of the participant;

Any home modifications not listed here but determined to be of remedial benefit to the participant by a qualified healthcare provider.

Training on use of HEMS;

Service and maintenance of the modification.

To determine an economically viable option available to meet a participant's assessed needs, the Managed Care Organization (MCO) shall evaluate the most cost-effective HEMS solution by completing a process that includes, but is not limited, to the following:

-Prior to authorizing HEMS, the MCO shall coordinate with other benefits the participant may have.

--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.

-The MCO shall request an in-home or remote assessment, as appropriate, of the participant's needs and recommendations from a therapist or a person qualified to complete home usability/accessibility assessments.

--This helps determine the options available for meeting the participant's need; and which option may be the most cost-effective.

-The MCO will request bids for HEM services.

--This process will not be completed where the MCO cannot find more than one provider/contractor to provide a bid.

-The MCOs will review both the participant's assessed needs and the received bids to ensure that items, materials, or services are within the scope of what is needed and covered and are not of extraordinary cost.

-Certain conditions besides cost will determine if a bid is to be accepted.

-The MCO will not accept bids solely based on the proposed cost.

--Bids that do not meet the participant's needs or submitted by contractors with a history of low work quality will not be considered.

-A participant that is a Tribe member may opt to be served through a federally recognized Tribal entity that does not wish to contract with the MCO or FMS provider. In that case, the state shall provide a separate provider agreement which will allow the tribal vendor to receive direct payment from Medicaid.

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

Instructions and Limitations

-Payment for Home and Environmental Modification Services (HEMS) alone, or in combination with Vehicle Modification Services (VMS), and Specialized Medical Equipment and Supplies (SMES), shall not exceed \$10,000 per program participant and across all waiver programs.

-In the event that a program participant has exceeded the \$10,000 limit, and still has needs that may be furnished through HEMS, the MCO shall furnish such needed using and 'in lieu of other services' approach, or using other value-added services provided by the managed care organization.

-Upon delivery to the participant (including installation), the HEMS adaptation must be in good operating condition and repair in accordance with applicable specifications.

HEMS adaptations do not include:

-Improvements to the residence that:

--Are of general utility;

--Are not of direct medical or remedial benefit to the participant or otherwise meets the needs of the participant as defined in instances above;

--Add to the home's total square footage, unless the construction is necessary, reasonable, and directly related to the participant's access to the participant's primary residence; or

--Are required by local, county, or State law when purchasing or licensing a residence;

-A generator for use other than to support the participant's medical and health devices that require electricity for safe operation; or

-Traditional shafted elevator.

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Center for Independent Living

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Home and Environmental Modification Services (HEMS)

Provider Category:

Provider Type:**Provider Qualifications****License** (*specify*):**Certificate** (*specify*):**Other Standard** (*specify*):

- a. Enrolled in KanCare.
- b. Certificate of Worker's Compensation and General Liability Insurance
- c. Passing Background Checks consistent with the KDADS' Background Check policy
- d. Compliance with all regulations related to Abuse, Neglect, and Exploitation.

Verification of Provider Qualifications**Entity Responsible for Verification:****Frequency of Verification:**

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:**HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:**

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Category 3:**Sub-Category 3:**

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Category 4:**Sub-Category 4:**

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Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (*Scope*):

Home-Delivered Meals Service provides a participant with one (1) or two (2) meals per calendar date. Each meal will contain at least one-third (1/3) of the recommended daily nutritional requirements. The meals are prepared elsewhere and delivered to the participant's home. Participants eligible for this service have been determined functionally in need of the Home-Delivered Meals service as indicated by the Functional/Needs Assessment. Meal preparation provided by a BI waiver Personal Care Services provider may be authorized in the participant's Person-Centered Service Plan for those meals not provided under the Home-Delivered Meals Service.

Home Delivered Meal Service is an agency directed service.

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

This service is limited to participants who require extensive routine physical support for meal preparation as supported by the participant's Functional/Needs Assessment for meal preparation. This service may not be maintained when a participant is admitted to a nursing facility or acute care facility for a planned brief stay time period not to exceed two months following the admission month in accordance with Medicaid policy.

This service is not duplicative of home-delivered meal service provided through the Older Americans Act, subject to the participant meeting related age and other eligibility requirements, nor is it duplicative of meal preparation provided by attendants through Personal Services.

- This service is available in the participant's home.
- No more than two (2) home-delivered meals will be authorized per participant for any given calendar date.
- This service must be authorized in the participant's Person-Centered Service Plan.

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Approved and Medicaid-enrolled nutrition provider agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Home-Delivered Meals Service

Provider Category:

Agency

Provider Type:

Approved and Medicaid-enrolled nutrition provider agency

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Provider must have on staff or contract with a certified dietician to assure compliance with KDADS nutrition requirements for programs under the Older Americans Act.

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.

Verification of Provider Qualifications

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

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Medication Reminder Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
<div>14 Equipment, Technology, and Modifications</div>	<div>14031 equipment and technology</div>
Category 2:	Sub-Category 2:
<div></div>	<div></div>
Category 3:	Sub-Category 3:
<div></div>	<div></div>
Category 4:	Sub-Category 4:
<div></div>	<div></div>

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☐ Service is included in approved waiver. There is no change in service specifications.
- ☐ Service is included in approved waiver. The service specifications have been modified.
- ☐ Service is not included in the approved waiver.

Service Definition (Scope):

Medication Reminder Services provides a scheduled reminder to a participant when it is time for the participant to take medications. The reminder may be a phone call, automated recording, or automated alarm depending on the providers system.

Medication Reminder/Dispenser is a device that houses a participant’s medication and dispenses the medication with an alarm at programmed times.

Medication Reminder/Dispenser Installation is the placement of the Medication Dispenser in a participant’s home.

Education and assistance with all Medication Reminder Services is made available to participants during implementation and on an ongoing basis by the provider of this service.

Medication Reminder Service is an agency directed service.

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

-Routine maintenance of rental equipment is the provider’s responsibility.
-Repair/replacement of rental equipment is not covered.
-Rental of equipment is covered.
-Purchase of equipment is not covered.

This service is limited to participants who live alone or who are alone a significant portion of the day, and have no regular informal and/or formal support for extended periods of time, and who otherwise require extensive routine non-physical support including medication reminder services offered through an attendant of Personal Services.

This service is not duplicative of services offered free of charge through any other agency or service. These systems may be maintained on a monthly rental basis even if a participant is admitted to a nursing facility or acute care facility for a planned brief stay time period not to exceed two months following the admission month in accordance with Medicaid policy.

This service is available in the participant’s home. Medication Reminder service is not provided face-to-face with the exception of the Installation of Medication Reminder/Dispenser.

Installation of Medication Reminder/Dispenser is limited to one installation per participant per calendar year.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medication Reminder Services Provider/Dispenser Provider/ Dispenser Installation Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medication Reminder Services

Provider Category:

Agency

Provider Type:

Medication Reminder Services Provider/Dispenser Provider/ Dispenser Installation Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (*specify*):

Any company providing medication reminder services per industry standards is eligible to contract with KanCare as a Medication Reminder Services.

Medication Reminder Service providers must provide appropriate training to their staff on medication administration and dispensing of medication.

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.

Verification of Provider Qualifications**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.

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Emergency Response System and Installation

HCBS Taxonomy:**Category 1:**

14 Equipment, Technology, and Modifications

Sub-Category 1:

14010 personal emergency response system (PERS)

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

☐

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Personal Emergency Response Systems (PERS) involve the use of electronic devices which enable participants at high risk of institutionalization to secure help in an emergency. The system is connected to the participant's telephone and programmed to signal a response center once the help button is activated. the participant may wear a portable help button to allow for mobility. PERS is limited to those participants who:

1. live alone, or
2. who are alone for significant parts of the day, and
3. have no regular attendant (formal or informal) for extended periods of time, and
4. who would otherwise require extensive routine supervision.

Personal Emergency Response System and Installation is an agency directed service.

The PERS system has a back-up battery that is activated if an emergency situation develops. The back-up battery will activate if there is interference with the landline and connection through the cell phone will remain as long as the cell phone towers are intact. If the system is not functioning properly, the provider will attempt to contact the participant through the PERS system. If unable to communicate with the participant, the provider contacts the participant-selected responders to contact with the participant in a 15-20 minute window. If the PERS provider is unable to reach the responders, then the provider will contact 911/EMS to check on the unresponsive participant. In addition, the PERS system should be checked once a month to ensure that it is functioning properly and the back-up battery is functional. Participants have the ability to turn off/unplug the PERS system; however, turning off the system will trigger an alert to the PERS provider. The provider will follow up with the participant to ensure his/her health and welfare. The PERS provider must receive permission from the participant for the use of the device in the home.

PERS Installation is the placement of electronic PERS devices in a participant's residence. Participants must have an assessed need for a Personal Emergency Response System.

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

To avoid any overlap of services, PERS is limited to those services not covered through regular State Plan Medicaid and which cannot be procured from other formal or informal resources. BI waiver funding is used as the funding source of last resort and requires prior authorization from the MCO.

Maintenance of rental equipment is the responsibility of the provider.

Repair/replacement of equipment is not covered.

Rental is covered; purchase is not.

Call lights do not meet this definition.

There is a maximum of two PERS Installations per calendar year.

PERS requires prior authorization based on the assessed need.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian**Provider Specifications:**

Provider Category	Provider Type Title
Agency	PERS provider

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Personal Emergency Response System and Installation****Provider Category:**

Agency

Provider Type:

PERS provider

Provider Qualifications**License** (*specify*):**Certificate** (*specify*):**Other Standard** (*specify*):

Must be contracted with the MCO.
 Must conform to industry standards and any federal, state, and local laws and regulations that govern this service.
 The emergency response center must be staffed on 24 hour/7 days a week basis by trained personnel.

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.

Verification of Provider Qualifications**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.

Appendix C: Participant Services**C-1/C-3: Service Specification**

the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Specialized Medical Equipment and Supplies (SMES)

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14031 equipment and technology

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

In HCBS waivers operated in the State of Kansas, Specialized medical equipment and supplies include: (a) devices, controls, software, or appliances, specified in the person-centered service plan, that enable participants to increase their ability to perform activities of daily living; (b) devices, controls, software, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment not available under the State plan that is necessary to address participant's needs.

Instances

Some instances where SMES may be used include, but are not limited to the following:

- A program participant may use SMES service to supplement a durable medical equipment (DME) furnished through the State plan, such as wheelchairs or walkers.
- A program participant may use SMES to purchase disposable non-durable equipment or supplies such as wipes or testing strips.
- A program participant may also access augmentative communication devices and services through SMES.

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

Instructions and Limitations

- The program participant's person-centered planning team shall assess them for their need for Specialized Medical Equipment and Supplies (SMES). This service supports the achievement of the outcomes as specified in the program participant's Person-Centered Service Plan.
- The Managed-Care Organization (MCO) will access the State plan to cover medical supplies and equipment that the state of Kansas has made available under the State plan under Durable Medical Equipment
- To avoid overlap of services, this service is limited to those services not covered through the Medicaid State Plan, Early and Periodic Screening, Diagnostic and Treatment (EPSDT), or other HCBS services and which cannot be procured from other formal or informal resources.
- Payment for Specialized Medical Equipment and Supplies (SMES) alone, or in combination with Home Modification Services and Vehicle Modification Services, shall not exceed \$10,000 per program participant and across all waiver programs with the exception of the I/DD waiver as there is no limit on these services.
- In the event that a program participant has exceeded the \$10,000 limit, and still has needs that may be furnished through SMES, the MCO shall furnish such needed using and 'in lieu of other services' approach, or using other value-added services provided by the managed care organization.
- The coverage/provision of SMES furnished through this service shall include the costs of maintenance and upkeep of devices, and training on the utilization of the devices. This includes normal wear and tear. Intentional destruction or damage to device will not be a covered cost.
- A participant that is a Tribe member may opt to be served through a federally recognized Tribal entity that does not wish to contract with the MCO or Financial Management Service (FMS) provider. In this case, the state shall provide a separate provider agreement which will allow the tribal vendor to receive direct payment from Medicaid.
- HCBS 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.

Service Delivery Method (*check each that applies*):**Participant-directed as specified in Appendix E****Provider managed****Specify whether the service may be provided by** (*check each that applies*):**Legally Responsible Person****Relative****Legal Guardian****Provider Specifications:**

Provider Category	Provider Type Title
Individual	Center for Independent Living
Individual	Individual Contractor (Direct Contractor)
Individual	Individual Contractor (Non-KanCare Enrolled/Indirect Contractor): This entity will subcontract with a Center for Independent Living (CIL), with the CIL to perform the Background Check.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Specialized Medical Equipment and Supplies (SMES)****Provider Category:**☐ Individual**Provider Type:**

Provider Qualifications**License** (*specify*):**Certificate** (*specify*):**Other Standard** (*specify*):

- a. Enrolled in KanCare.
- b. Certificate of Worker's Compensation and General Liability Insurance
- c. Passing Background Checks consistent with the KDADS' Background Check policy
- d. Compliance with all laws, policies, and regulations related to Abuse, Neglect, and Exploitation.

Verification of Provider Qualifications**Entity Responsible for Verification:****Frequency of Verification:****Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type:** Other Service**Service Name:** Specialized Medical Equipment and Supplies (SMES)**Provider Category:****Provider Type:****Provider Qualifications****License** (*specify*):**Certificate** (*specify*):**Other Standard** (*specify*):

- a. Enrolled in KanCare
- b. Appropriately Licensed in Service
- c. Certificate of Worker's Compensation and General Liability Insurance
- d. Proof of business establishment for a minimum of two (2) consecutive years
- e. Passing Background Checks consistent with the KDADS' Background Check policy
- f. Compliance with all regulations related to Abuse, Neglect, and Exploitation

Verification of Provider Qualifications**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

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Specialized Medical Equipment and Supplies (SMES)****Provider Category:**

Individual

Provider Type:

Individual Contractor (Non-KanCare Enrolled/Indirect Contractor): This entity will subcontract with a Center for Independent Living (CIL), with the CIL to perform the Background Check.

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

- a. Affiliation with a CIL.
- b. Certificate of Worker's Compensation and General Liability Insurance
- c. Proof of business establishment for a minimum of two (2) consecutive years
- d. Passing Background Checks consistent with the KDADS' Background Check policy
- e. Compliance with all regulations related to Abuse, Neglect, and Exploitation.

Verification of Provider Qualifications**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

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transitional Living Skills

HCBS Taxonomy:**Category 1:**

08 Home-Based Services

Sub-Category 1:

08010 home-based habilitation

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

The purpose of Transitional Living Skills (TLS) service is to provide opportunities for waiver participants to develop and/or re-learn targeted skills identified as necessary to optimize independence and autonomy. Transitional Living Skills (TLS) provides structured community and in-home training services designed to reduce the long-term impact of a brain injury that can result in chronic disabilities and isolation due to the brain.

Transitional Living Skills are comprehensive in nature. They address multiple aspects of a participant's needs by establishing goals and milestones to reach utilizing the brain injury waiver TLS service, and to provide a guide for the participant and their support network when they transition into their life beyond the brain injury waiver.

The TLS training in real-life/time situations in their home and community. TLS services are designed to teach and support the participant through application of skills learned or acquired through habilitation/rehabilitation therapy. This allows them to become more self-sufficient in different settings and activities with the reassurance of having a resource familiar to them to guide and support them through the activity. This includes: household management, disability and social adjustment, problem-solving, functional communication, self-management, and community living and integration. The intent of the TLS services is to fade back and gradually eliminate supports as the participant's abilities and confidence improve. The participant will outline their specific TLS goals related to increasing their independence and autonomy in relation to their transition goals. The individual goals will be documented in the person-centered service plan.

Transitional Living Skills is an agency directed service.

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

To avoid any overlap of services, TLS services are limited to those services not covered through the Medicaid State Plan and which cannot be procured from other formal or informal resources. BI waiver funding is used as the funding source of last resort and requires prior authorization from the KanCare MCO's.

TLS can be authorized for 260 units/65 hours per month with an annual limit of 3,120 units per year. Hours not utilized may be utilized in other months within the same annual time frame.

BI providers are not permitted to be dual providers for the same participant for the following services:

- o Personal Care Services (PCS) and Transitional Living Specialist (TLS)
- 0 Transitional Living Specialist (TLS) and Therapeutic Services (including behavioral, cognitive, speech-language, physical, and occupational)

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Transitional Living Skills Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Transitional Living Skills

Provider Category:

Agency

Provider Type:

Transitional Living Skills Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Individual TLS Specialists must have:

a. Must have a High School Diploma/GED

b. Must be at least eighteen years of age or older

c. Complete KDADS Approved Skill Training requirements.

d. Must reside outside of waiver participant's home;

e. Complete any additional skill training needed in order care for the waiver participant as recommended either by the participant or legal representative, qualified medical provider, or KanCare MCO;

f. 28 hours of training in BI

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.
Providers must enroll in KMAP.

Verification of Provider Qualifications

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.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Vehicle Modification Services (VMS)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
<div>14 Equipment, Technology, and Modifications</div>	<div>14020 home and/or vehicle accessibility adaptations</div>
Category 2:	Sub-Category 2:
<div></div>	<div></div>
Category 3:	Sub-Category 3:
<div></div>	<div></div>

Category 4:**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

In HCBS waivers operated in Kansas, Vehicle Modification Services (VMS) are adaptations or alterations to a vehicle that is the participant's primary means of transportation. Vehicle modifications are specified by the person-centered service plan and are designed to accommodate the needs of the participant and enable the participant to integrate more fully into the community and to ensure the health, welfare and safety by removing barriers to transportation.

Reimbursement for this service is limited to the participant's assessed needs related to the participant's disability and based on the person-centered service plan. Participants will have the choice to choose any qualified provider with consideration given to the most economical option available to meet the participant's assessed needs.

This service is limited to those services not covered through the Medicaid State Plan, Early and Periodic Screening, Diagnostic and Treatment (EPSDT), 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 last resort's funding source and requires prior authorization from the participant's chosen KanCare MCO.

Instance

To determine an economical viable option available to meet a participant's assessed needs based on need related to disability, the Managed Care Organization (MCO) shall evaluate the most cost-effective VMS solution by completing a process that includes, but is not limited to the following:

- Prior to authorizing VMS, the MCO shall coordinate with other benefits the participant may have.
- Waiver funding shall be the last resort's funding source and requires prior authorization from the MCO via the participant's Person-Centered Service Plan.
- The MCO shall request an in-home or remote assessment, as appropriate, of the participant's needs and recommendations from a therapist or a person qualified to complete home usability/accessibility assessments.
- This helps determine the options available for meeting the participant's need; and which option may be the most cost-effective.
- The MCO will request bids for vehicle modification services.
- This process will not be completed where the MCO cannot find more than one provider/contractor to provide a bid.
- The MCOs will review both the participant's assessed needs and the receive bids to ensure that items, materials, or services are within the scope of what is needed and covered and are not of extraordinary cost.
- Certain conditions besides cost will determine if a bid is to be accepted.
- The MCO will not accept bids solely based on the cost proposed
- Bids that do not meet the participant's needs or submitted by contractors with a low work quality history will not be considered.
- The following are specifically excluded: 1. Adaptations or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the individual; 2. Purchase or lease of a vehicle; and 3. Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications
- A participant that is a Tribe member may opt to be served through a federally recognized Tribal entity that does not wish to contract with the MCO or FMS provider. In the case, the state shall provide a separate provider agreement which will allow the tribal vendor to receive direct payment from Medicaid.

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

Instructions and Limitations

-Payment for Vehicle Modification Services (VMS) alone, or in combination with Home Modification Services, and Specialized Medical Equipment and Supplies (SMES), shall not exceed \$10,000 per program participant and across all waiver programs with the exclusion of the I/DD Waiver participants as there is no cap on this service.

-In the event that a program participant has exceeded the \$10,000 limit, and still has needs that may be furnished through VMS, the MCO shall furnish such needed using and ‘in lieu of other services’ approach, or using other value-added services provided by the MCO.

-Upon delivery to the participant (including installation), the Vehicle Modification must be in good operating condition and repair in accordance with applicable specifications.

--The State cannot provide assistance with modifications on vehicles that are not registered under the participant or legally responsible parent of a minor or other primary caretaker.

Vehicle Modification Services (VMS) shall include:

-Assessment services to

--help determine specific needs of the participant as a driver or passenger,

--review modification options, and

--development of a prescription for required modifications of a vehicle;

-Assistance with modifications to be purchased and installed in a vehicle owned by or a new vehicle purchased by the participant, or legally responsible parent/guardian or other caregiver.

-Non-warranty vehicle modification repairs; and

-Training on use of the modification.

The following as specifically excluded from VMS:

-Purchase or lease of new or used vehicles,

-General vehicle maintenance or repair, except upkeep and maintenance of the modifications.

-State inspections, insurance, gasoline, fines, tickets, or the purchase of warranties.

-Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual;

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Contractor (Direct Contractor)
Individual	Individual Contractor (Non-KanCare Enrolled/Indirect Contractor): This entity will subcontract with a Center for Independent Living, which shall perform the background checks.
Agency	Center for Independent Living

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Vehicle Modification Services (VMS)

Provider Category:**Provider Type:****Provider Qualifications****License (specify):****Certificate (specify):****Other Standard (specify):**

- a. Enrolled in KanCare
- b. Appropriately Licensed in Service
- c. Certificate of Worker's Compensation and General Liability Insurance
- d. Proof of business establishment for a minimum of two (2) consecutive years
- e. Passing Background Checks consistent with the KDADS' Background Check policy
- f. Compliance with all laws, policies, and regulations related to Abuse, Neglect, and Exploitation.

Verification of Provider Qualifications**Entity Responsible for Verification:****Frequency of Verification:**

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service**Service Name: Vehicle Modification Services (VMS)**

Provider Category:**Provider Type:****Provider Qualifications****License (specify):****Certificate (specify):**

Other Standard (*specify*):

- a. Affiliation with a Center for Independent Living
- b. Certificate of Worker's Compensation and General Liability Insurance
- c. Proof of business establishment for a minimum of two (2) consecutive years
- d. Passing Background Checks consistent with the KDADS' Background Check policy
- e. Compliance with all laws, policies, and regulations related to Abuse, Neglect, and Exploitation.

Verification of Provider Qualifications

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.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Vehicle Modification Services (VMS)

Provider Category:

Agency

Provider Type:

Center for Independent Living

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

- a. Enrolled in KanCare.
- b. Certificate of Worker's Compensation and General Liability Insurance
- c. Passing Background Checks consistent with the KDADS' Background Check policy
- d. Compliance with all regulations related to Abuse, Neglect, and Exploitation.

Verification of Provider Qualifications

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.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

Not applicable - Case management is not furnished as a distinct activity to waiver participants.

Applicable - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

As a waiver service defined in Appendix C-3. *Do not complete item C-1-c.*

As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option). *Complete item C-1-c.*

As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c.*

As an administrative activity. *Complete item C-1-c.*

As a primary care case management system service under a concurrent managed care authority. *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (*select one*):

No. Criminal history and/or background investigations are not required.

Yes. Criminal history and/or background investigations are required.

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

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 offence as listed in K.S.A. 39-2009 is not eligible for reimbursement of services under Medicaid funding.

The contractor / sub contractor and /or provider agency must provide evidence that required standards have been met or maintained at the renewal of their professional license as required by the KDADS Background Check policy.

The employer shall submit a request for the following checks

1. a criminal record check through KDADS Health Occupation Credentialing (HOC)
2. a check for ANE through the Nurse Aid Registry
3. a driver's license record check through the Kansas Department of Revenue (KDOR)
4. an adult and child ANE check through Department of Children and Families (DCF)
5. a license, certification or registration verification through the applicable credentialing entity
6. an excluded entities and individuals check through the Office of the Inspector General (OIG)
7. All employees of HCBS provider agencies must undergo background checks.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

No. The state does not conduct abuse registry screening.

Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

All HCBS providers are required to pass DCF abuse registry checks and the Nurse Aide Registry consistent with the KDADS' Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation.

HCBS providers are responsible for ensuring background checks, which include abuse registry checks, are completed on their employees and employees of persons or families for whom they perform administrative duties. HCBS providers may require additional or follow-up background checks as they deem appropriate. Results of background checks must be available for review by authorized KDADS, CDDO, KDHE and KanCare MCO staff. KDADS regional Quality Enhancement staff review staff files as a part of their on-going provider review process. As a part of the file review, Quality Management staff confirm that documentation is present that the person has passed the required abuse registry screenings.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.

Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

A court appointed guardian or individual authorized as an A-DPOA may be paid to provide supports if the potential conflict of interest are mitigated. Natural guardians or spouses of waiver participants are not required to mitigate the conflict of interest. Participants should be educated by the MCO that they are not required to use their spouse as their paid caregiver and will be offered choice.

Services that may be furnished by a relative or legal guardian are limited to the scope, duration and amount determined by the MCO needs assessment and authorized in the participant's person-centered service plan.

Foster Care parents will be not be paid for providing waiver funded services.

Personal Care Services provided by a Court Appointed Legal Guardian:

- A court appointed legal guardian is not permitted to be a paid provider for the participant unless the probate court determines that all potential conflict of interest concerns have been mitigated in accordance with KSA 59-3068.
- a. It is the responsibility of the appointed guardian to report any potential conflicts to the court in the annual or special report as required by guardianship law and to maintain documentation regarding the determination of the court.
- b. A copy of the special or annual report in which the conflict of interest is disclosed will be provided to the MCO and FMS provider if along with the judge's order approving the annual or special report and determining that there is no conflict of interest for the guardian to be paid to provide supports for the participant under the HCBS program.
- 2. If the court determines that all potential conflict of interest concerns have not been mitigated, the legal guardian can:
 - a. Select someone (family member or friend) to provide the HCBS services to the participant. If a family member or friend is not available, the participant's selected MCO or FMS provider can assist the legal guardian in finding a direct support worker or seeking alternative HCBS service providers in the community; OR
 - b. Select someone (family member, friend) to appoint as a Designated Representative to develop the integrated service plan and direct the participant's services under HCBS.
- 3. An activated durable power of attorney (A DPOA who is currently authorized to make financial, medical or other decisions on behalf of the participant) is not permitted to be a paid provider for participant unless a Designated Representative is appointed to direct the individual's care (hire, fire, manage, training, and monitor direct support workers).

Personal Care Waiver Services provided for minors by Parents and/or Spouses.

Personal Care Services may be used to pay parents of minor enrollees under age (18) or spouses of enrollees. Parents of minors and spouses must meet the provider qualifications for this service.

For an enrollee's spouse or parent of a minor enrollee to be paid under the waiver, the service or support must meet all of the following authorization criteria and monitoring provisions. The service must:

- Meet the definition of a personal care services as outlined in the federal waiver plan.
- be specified in the individual's Person-Centered Service Plan
- be provided by a parent or spouse who meets the qualifications and training standards identified as necessary in the enrollees Person-Centered Service Plan;

The MCO needs assessment will be used to provide a means to identify activities in which the enrollee is dependent, to distinguish between activities that a parent or family member would ordinarily perform and those activities that go beyond what is normally expected to be performed, and to identify areas in which the level of assistance or supervision required exceeds what is typically required of a person of the same age. The needs assessment will be used to determine whether extraordinary care is required and may be provided by a spouse. To determine if extraordinary care is required and may be provided by a parent, the needs assessment for age appropriateness is completed.

- Completes training from the waiver participant or their representative utilizing the Personal Care Services checklist developed by the waiver participant and/or their representative and aided by their Care Coordinator as necessary. This document will be in kept in the person's home and be part of the Person-Centered Service Plan record and reviewed at least annually and updated as needed to indicate change in the participant's service needs.

In addition to the above:

- All employers must act in accordance with the Fair Labor Standards Act.
- All direct service workers including parents and spouses must utilize the EVV system for hours paid.
- Married enrollees must be offered a choice of providers. If they choose a spouse as their care provider, it must be documented in the Person-Centered Service Plan

Additional payment cannot be supplemented by the member or natural supports.

The Person-Centered Service Plan must state that the relative is the best available appropriate direct service worker

for the person using services.

Self-directed

Agency-operated

- e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

The state does not make payment to relatives/legal guardians for furnishing waiver services.

The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

The State of Kansas does not prevent non-legally responsible relatives from providing PCS and ECS services. The non-legally responsible relatives are subject to the same requirements as detailed in the service definitions and provider qualifications in Appendix C.

The State of Kansas defines legally responsible individuals as: 1) the parent of a minor child; 2) a spouse of a waiver participant; 3) the court appointed guardian or activated DPOA of a waiver participant; 4) a foster parent.

KDADS allows legally responsible individuals to provide ECS under the following circumstances:

1. A court appointed legal guardian is not permitted to be a paid provider for the participant unless the probate court determines that all potential conflicts of interest have been mitigated in accordance with K.S.A. 59-3068.

a. It is the responsibility of the appointed guardian to report any potential conflicts to the court in the annual or special report as required by guardianship law and to maintain documentation regarding the determination of the court.

b. It shall be the responsibility for the legal guardian to provide to the MCO and FMS provider a copy of the special or annual report in which the conflict of interest is disclosed and a copy of the judge's order or approval determining that there is no conflict of interest for the guardian to be paid to provide HCBS supports for the participant.

2. If the court determines that all potential conflicts of interest have not been mitigated; or the legal guardian otherwise chooses to provide personal care services, the legal guardian shall select a designated representative, who is not a legally responsible individual for the participant, to develop the Person-Centered Service Plan and direct the participant's HCBS services.

3. An A-DPOA, who is currently authorized to make financial, medical or other decisions on behalf of the participant, is not permitted to be a paid provider unless a designated representative is appointed to direct the individual's care.

4. The MCO may grant an exception to the above listed criteria when one of the three circumstances is present:

1) The participant lives in a rural area, in which access to a provider is beyond a 50 mile radius from the participant's residence and the relative or family member is the only provider available to meet the needs of the participant.

2) The participant lives alone and has a severe cognitive impairment, physical disability or intellectual disability

3) The participant has exhausted other support options offered by the MCO and absent services would be at significant risk of institutionalization.

The controls that are employed to ensure that payments are made only for services rendered include: MCO quarterly Quality Reviews to monitor that services that are provided are approved in the Person-Centered Service plan, monitoring of services provided via the Electronic Visit Verification system, and other controls as described in Appendix I.

Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is

qualified to provide services as specified in Appendix C-1/C-3.

Specify the controls that are employed to ensure that payments are made only for services rendered.

Other policy.

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Kansas provides for continuous, open enrollment of waiver service provider by way of an online provider enrollment portal (see <https://www.kmap-state-ks.us/Public/provider.asp>). The online portal also contains training materials and other useful information that prospective providers may access at their convenience, including a tip sheet and provider enrollment training video. The adequacy of MCO provider networks is monitored quarterly via standardized reports submitted through the KanCare Reporting System. HCBS waiver program management staff are maintained on a report distribution list and notified when a new report submission is received. Whenever the number of providers falls below the established network adequacy threshold, the HCBS program manager works with the MCO and KDHE to develop an action plan for achieving the required threshold.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

- a. Sub-Assurance:** *The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of newly enrolled licensed/certified waiver provider

organizations that met all license and certification requirements and other standards.

N=Number of newly enrolled licensed/certified waiver providers that met licensure/certification requirements and other standards D=Number of newly enrolled licensed/certified waiver provider organizations reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record Review

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95%; +/- 5% margin of error (The state conducts a representative sample against a pool of providers that includes both newly enrolled licensed/certified as well as non-licensed/certified providers)</div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div>Proportionate by MCO</div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other	

	Specify: <div></div>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

Performance Measure:

and % of enrolled licensed/certified waiver provider organizations that met all license and certification requirements and other standards. N=# of enrolled licensed/certified waiver provider organizations that continue to meet all licensure/certification requirements, and other standards D=# of enrolled licensed/certified waiver provider organizations reviewed

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Record Review

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100%

		Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> 95%; +/- 5% margin of error (The state conducts a representative sample against a pool of providers that includes both newly enrolled licensed/certified as well as non-licensed/certified providers) </div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

b. Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of newly enrolled non-licensed/non-certified waiver provider organizations that met all waiver requirements and other standards. N=# of newly enrolled non-licensed/non-certified waiver provider organizations that met waiver requirements and other standards D=# of all newly enrolled non-licensed/non-certified waiver provider organizations reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record Review

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative

		Sample Confidence Interval = <div> 95%; +/- 5% margin of error (The state conducts a representative sample against a pool of providers that includes both newly enrolled licensed/certified as well as non-licensed/certified providers) </div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="text"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Number and percent of enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements and other standards. N=Number enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements
D=Number of enrolled non-licensed/non-certified providers

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Managed Care Organization (MCO) reports and record reviews

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="95%"/>
Other Specify: <input type="text" value="KanCare Managed Care Organizations (MCOs)"/>	Annually	Stratified Describe Group: <input type="text" value="Proportionate by MCO"/>
	Continuously and Ongoing	Other Specify:

		<div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div>KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency</div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

- c. Sub-Assurance:** *The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.*

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of active providers that meet training requirements.

Numerator: Number and percent of active providers that meet training requirements

Denominator: Number of providers reviewed
Workplan: KDADS will use FMAP funds to review and develop training standards for training for every service. PM start date 7/1/2025.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record Review

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px;"> 95%; +/- 5% margin of error; Stratified: Proportionate by MCO </div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through a state interagency monitoring team, which includes program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

State staff request, approve, and assure implementation of contractor corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through on-site monitoring, MCO compliance monitoring, survey results and other performance monitoring. These processes are monitored by both contract managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other	Annually

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Specify: <div>KanCare Managed Care Organizations (MCOs)</div>	
	Continuously and Ongoing
	Other Specify: <div></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. **Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services *(select one)*.

Not applicable- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Applicable - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. *(check each that applies)*

Limit(s) on Set(s) of Services. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

Budget Limits by Level of Support. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

Other Type of Limit. The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Person-Centered Service Plan

- a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

Registered nurse, licensed to practice in the state

Licensed practical or vocational nurse, acting within the scope of practice under state law

Licensed physician (M.D. or D.O)**Case Manager** (qualifications specified in Appendix C-1/C-3)**Case Manager** (qualifications not specified in Appendix C-1/C-3).*Specify qualifications:*

Kansas has contracted with Managed Care Organizations (MCOs), to provide overall management of Home and Community-Based Services (HCBS) services as one part of the comprehensive KanCare program. The MCOs are responsible for development of the Person-Centered Service Plan (Service Plan) in accordance with KDADS' Person-Centered Service Plan policy. The MCO or their designee will use their staff to provide that service.

Social Worker*Specify qualifications:***Other***Specify the individuals and their qualifications:*

Kansas has contracted with Managed Care Organizations (MCOs) to provide overall management of Home and Community Based Services (HCBS) services as part of the comprehensive KanCare program. Outcomes sought are that the participants will be supported in achieving health, wellness, and independence through integrated whole-person health care including: 1) Physical Health Services 2) Behavioral Health Services 3) and the Long-Term Services and Supports offered through the HCSB BI Waiver, and if needed and chosen, other non-HCBS Long-Term Services offered.

The MCO representative is responsible for leading the development, monitoring, follow-up, and revisions of the Person-Centered Service Plan (Service Plan) in accordance with KDADS' HCBS Person-centered Service Plan policy.

Regarding Aetna: (Clinical) Service Coordinator positions require a registered nurse (RN) or a licensed, master's level behavioral health professional (e.g. LMSW, LCSW, LPC). They are generally assigned the most complex members and may assist with clinical needs of less complex members.

Service Coordination Coordinator positions require at a minimum a bachelor's degree, but a master's degree in a health care or related field is preferred. They are generally assigned to manage members whose care coordination needs may be complex, but who do not require a licensed CM or complex clinical judgment to manage (e.g., members in long term services and supports who may have multiple home and community based non-clinical service needs.

Regarding Sunflower: Care managers are Registered Nurses and Master's level Behavioral Health clinicians with care management experience and, as applicable to the position, expertise including adult and pediatric medical, maternity and behavioral health/psychiatric care.

Regarding United: Service plans are developed by licensed nurses or licensed social workers.

Appendix D: Participant-Centered Planning and Service Delivery**D-1: Service Plan Development (2 of 8)****b. Service Plan Development Safeguards. Select one:**

Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility for service plan development may provide other

direct waiver services to the participant.

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

- c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

According to K.A.R. 30-5-305 qualified staff and assessment providers shall conduct an assessment prior to the implementation of any HCBS services.

Each participant, parent (minor), activated DPOA or court appointed guardian, may choose whether or not they will accept, enroll, and participate in the BI Waiver services at any point in time. The MCO representative is responsible for providing written information about the waiver therapy services offered, as well as the other BI waiver and KanCare services offered while they are actively participating in therapy services.

The MCO representative is responsible for notifying

Each participant, parents (if a minor), activated DPOA, or court appointed guardian identifies any other natural supports, the MCO, community resources, and HCBS providers they wish to utilize while enrolled in the BI waiver. Working together, this team will support the participant not only with their brain injury habilitation (youth)/rehabilitation (youth and adults) but also with their overall health and wellbeing and addressing social determinants of health (SDOH).

KDADS' Person-Centered Service Plan policy ensures the individual directs or has the opportunity to be actively engaged in the person-centered planning process at the maximum level possible. The MCO representative completes the Health Screens, Health Risk Assessment, and the Needs Assessment with the participant, parent (minors), activated DPOA, or court appointed guardian. The participant will be provided the Personal Interest Inventory Form to complete as the foundation of the person-centered service plan. If needed, they will be provided assistance in completing the form prior to the development of their person-centered service plan. This form captures the participants strengths, needs, lifestyle and other preferences. The Health Screens, Health Risk Assessment and the Needs Assessment will help identify the needed services and supports (scope and duration) to help the participant live in the community and achieve their goals.

Participants are given choice of all agency and self-directed, qualified providers for each applicable service included in the Person-Centered Service Plan (Service Plan). Based on their selection the MCO representative assists the participant with accessing information and supports from the chosen providers and community resources.

The participant has the authority to determine the parties that he/she chooses to be involved in the development of their Service Plan. The MCO representative must hold the meeting, at a minimum of annually in person, at a time that the participant, parent(s) (minors), activated DPOA and or Court Appointed Guardian can meet in person, and extend an invitation to all natural and paid supports they wish to be involved. This invitation shall include the date, time, location, and purpose of the meeting.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

- d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing

information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The Person-Centered Service Plan process and expectations are outlined in the KDADS' Person-Centered Service Plan policy.

a) MCOs may use contracted entities to assist in the development and monitoring of the person-centered service plan (service plan) but holds the primary responsibility and accountability for the development of the service plan and delivery of all Medicaid covered services included in a participant's Service Plan. The initial and annual plans are developed during a face-to-face meeting with the participant, parents (minors) activated DPOA, or court appointed guardian (if applicable), any selected providers or natural support representatives that the participant chooses to involve, and the MCO or their designee.

The Date and time of the Service Plan meeting is coordinated based on the convenience of the participant and the participant's representative, if applicable. The MCO, or their designee, is responsible for notifying all parties authorized by the participant of the date, time, and location of the Service Plan meeting. If the participant is a 1) minor or 2) has a court appointed guardian/conservator 3) an activated durable power of attorney, they must be included. The service plan must be complete, containing all of the agreed upon information and care data before the participant, parent (minor), court appointed guardian, or activate DPOA and Care Coordinator sign the service plan. The MCO representative is required to obtain the signature of all providers also. Electronic signatures may be utilized.

b) All applicants for program services must undergo a Medicaid Functional Eligibility Instrument (MFEI) assessment to determine Level of Care eligibility for the BI waiver. The state's functional eligibility contractor conducts an in-person assessment with the individual, their legal representative, and those the individual wishes to provide input within the timeframe specified in the contract, unless a different timeframe is requested by the applicant or their legal representative, if appropriate.

KDHE holds the sole authority over the KanCare Long Term Care HCBS waiver enrollments. The participant may choose to not enroll or continue their BI waiver services at any point in time. When initial eligibility has been confirmed by KDHE the waiver authorization is forwarded to the MCO selected by the applicant. If the applicant did not select or have an MCO preference, KDHE will designate the MCO.

Upon receipt of the waiver authorization the MCO, or their designee will initiate completing the Health Screens, Health Risk Assessment if not already completed, and the Needs Assessment with the new participant. This assessment will 1) identify the habilitation (youth)/rehabilitation therapies needs and 2) other services the participant needs in order to allow them to safely remain in the community and to help them achieve their preferred lifestyle while actively engaged in therapies or TLS services. The participant will also be asked to complete a Participant Interest Inventory (PII). The PII allows the participant to identify what is important to them in regard to their preferred lifestyle, as well as their strengths, their passions and values, their goals, areas in which they feel they need support and how they would like that support to be provided to them.

The person-centered service planning process assists the participant in bringing all those who support the participant together to focus on assisting the participant in identifying their preferred lifestyle and goals, and using the information from the various assessments building on their strengths and identifying both short term and long term goals utilizing the BI waiver therapies and other services to 1) improve their health, increase their safety and self-sufficiency through accomplishing their goals and/or use of adaptations 2) improve their opportunities for full membership within their families, school, work, and community 3) Identifying risks involved as well as emergency needs and identifying back up supports that may be implemented if needed. The Service Plan includes the scope, duration and amount of the authorized services for the participant based on the agreements made in the service plan meeting, and as signed off on by the participant, Parent (minor), activated DPOA, or Court Appointed Guardian, the MCO representative, and the service providers.

c) Each participant, parent(minor), activated DPOA, or court appointed guardian, determined eligible for the BI waiver is responsible for making the decision on the therapy, other waiver services, and any Medicaid services they wish to engage in or obtain while enrolled in the BI waiver. The MCO representative is responsible to inform the participant of the benefits and consequences of each choice. The MCO, or their designee, is responsible for providing information about all of the BI waiver service available to the participant. The participant, MCO, or their designee, and authorized legal representative work together to determine the services that best fit the needs of the participant.

Participants are given free choice of all agency and self-directed qualified providers for each applicable service, as well as

service delivery method and these choices will be documented in the Person-Centered Service Plan (Service Plan). Participants will select the first choice of providers as well as a second-choice provider. To avoid a delay in implementing the service plan, if the first choice Therapy provider is not able to initiate active therapy services within the requested time frame, the participant and MCO will initiate services through the alternative provider. These choices will be documented in the Person-Centered Service Plan, as well as the timeline that services are to be initiated.

The MCO, or their designee, assists the participant with accessing information and supports from the participant's chosen provider. If during this process the participant chooses to not enroll in the therapies offered thru the BI Waiver, their enrollment in the BI waiver will be closed and they will be referred back to the MFEI assessing contractor to determine if other waivers offer the services they are seeking.

d) Through the various assessments and Service Plan related documents described in b) above, the participant's rehabilitation goals, or habilitation/rehabilitation goals for youth, needs and preferences are at the forefront when developing their Service Plan.

e) The Person-Centered Service Plan (Service Plan) is coordinated according to the process outlined in the KDADS' Person-Centered Service Plan policy. Additional coordination requirements are specified in the KanCare contract between the State and the MCOs. The MCO, or their designee, coordinates other federal and state program resources in the development of the Service Plan.

f) The responsibilities for implementing and monitoring delivery of services as authorized in the Service Plan are detailed in the Person-Centered Service Plan policy and the HCBS Quality Review Policy. At a minimum the service plan must be signed by the participant, parent (minor), and activated DPOA or court appointed guardian and MCO representative to be implemented. Any providers and others present at the meeting must also sign.

The Service Plan is valid for 365 days from the date of the participant's and/or legal representative's signature unless there is a change in condition that requires an update to the Service Plan as detailed in the Person-Centered Service Plan policy.

g) The Person-Centered Service Plan is subject to update as needed during the face-to-face meetings between the MCOs and the waiver participants. While the MCO representative is responsible for drafting the service plan or updates, it is the participant, or their chosen or legal representative holds the responsibility to direct the process to the extent they wish. Service Plan reviews will take place at a minimum of every 6 months to determine the appropriateness and adequacy of the services in relation to the participants assessed needs, risks, and goals as well as ensuring that the services furnished are consistent with the nature and scope of the participant's assessed needs and that the targeted progress is being achieved.

Additional meetings may be necessary due to changes in condition or circumstances. In the event a change in need, circumstance or condition occurs, the MCO will conduct a needs assessment to re-evaluate the scope, duration and amount of HCBS services the individual needs to stay safely in the community.

During the Person-Centered Service Plan meeting the MCO Care Coordinator shall educate the participant on the following: service options that will assist the participant in progress toward established goal; identify care gaps; assess the participant's understanding of risks and consequences if the care gaps remain; verify that the participant demonstrates understanding of risks, strategies to mitigate risks, consequences, and shall make appropriate referrals to address risks; and additional community and social supports available to the participant. The MCO Care Coordinator will review 1) how to recognize abuse, neglect, and exploitation 2) when to report and how to report suspicions of abuse, neglect, and exploitation.

Once the participant has signed the Person-Centered Service Plan, the plan is sent to the applicable providers. The providers then sign the plan to agree that they are able and willing to provide the applicable service in the scope, duration and amount authorized in the Person-Centered Service Plan. The MCO monitors the delivery of the service plan, which includes a 6-month, and annual face-to-face visit with the participant to evaluate the appropriateness of the current Service Plan.

- e. Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The participant's Person-Centered Service Plan (Service Plan) takes into account information from the Functional Eligibility Instrument as well as the MCO's needs assessment which identify potential risk factors.

The Person-Centered Service Plan will document, at a minimum, the types of services to be furnished, the amount, frequency, and duration of each service, and the type of provider to furnish each service, including informal services and providers.

The Person-Centered Service Plan identifies the support and services provided to the participant that are necessary to minimize the risk of institutionalization and ensure the health and welfare needs of the participants are being met.

The Participant Interest Inventory (PII), a document that is a part of the Service Plan, describes, in the participant's own words, how the participant would like their supports to be provided. This includes any interventions that are identified as necessary to mitigate risk to the participant's health safety and welfare (PII Risk Assessment & Intervention Plans).

Reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the participant's disability. Additional meetings may be necessary due to changes in condition or circumstances. A meeting to update the Service Plan shall occur in accordance with the Person-Centered Service Plan policy.

An emergency back-up plan for each individual is established during the needs assessment and Person-Centered Service Plan development. This and other information from the assessment and annual re-assessment are incorporated into the emergency backup plan which is utilized to mitigate risk related to extraordinary circumstances. Backup plans are developed according to the unique needs such as physical limitations and circumstances, such as the availability of informal supports of each participant. Backup arrangements are added to Service Plans and identify key elements, including specific strategies and contact individuals.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

- f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

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 cohesive and current list of all of their BI Waiver service providers from which the participant can choose the service providers that they wish to use while on the BI waiver.

The MCO assists the participant with accessing information and supports from the participant's preferred providers. This includes the services offered and available to the participant, the names and contact information of qualified providers of waiver services identified in their Person-Centered Service Plan

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

Oversight of the service plans by the Medicaid Agency is completed through the following strategies. One waiver quality strategy is the following process is utilized and reported quarterly to the KDHE LTC.

A representative sample of HCBS Waiver individual's case files, to include National Core Indicators (NCI surveys), will be selected quarterly by KDADS' Financial and Information Services Commission (FISC), and assigned to the appropriate Quality Management Specialist (QMS) for review. The selected cases will include both Primary (P) and Secondary (S) listing of cases. Record cases open for 30 days or less, from MMIS eligibility date, are considered a "non-review" and will not be reviewed by QMS. A secondary case will be substituted when the case is deemed a "non-review."

Case specific documentation for Quality Reviews shall be completed by desk review or provider's on-site location. For desk reviews, file documentation should be uploaded in the systems of record, to include but not limited to the Quality Review Tracker (QRT) by the MCO's and KAMIS by the Assessor's. QMS will review documentation by using the established protocols. For on-site reviews, file documentation uploaded by the MCO's and/or Assessor's, will be reviewed by QMS using the established protocols at the designated provider locations. Findings for desk and on-site reviews will be recorded in Quality Review Tracking system (QRT) for the MCO/Assessor's remediation.

Data analysis is completed and remediated for any assurance or sub-assurance less than 86%. KDADS staff will notify the provider of areas below 86% with details of each finding. The provider will be required to respond to the notification for remediation within 15 business days detailing their plan for correction. The plan will be reviewed by KDADS staff for approval of the plan. Should the plan not be approved, the provider will be notified and asked to resubmit an acceptable plan of correction. Once the remediation plan is approved, with a timeline for compliance, KDADS staff will continue to monitor through Quality Reviews to ensure compliance.

Any abuse, neglect or exploitation issue will be immediately reported to the designated state reporting agency. Any substantiated case of ANE will require remediation. The remediation plan must address how health and safety needs have been addressed including immediate corrective action and ongoing plan to prevent ANE.

Findings or concerns on a specific case identified through the review by QMS will be entered in QRT. Once entered, the QRT system will send an alert to the Assessor and/or MCO, and copy to the applicable Program Manager.

KDADS estimates the statistical range of values within which the true target population is likely to fall, and how certain we can be that the true population value is within the range of values. The sample sizes prepared for the quality review team use a probability sample method, using a multi-stage, stratified sample.

- The sample size is determined by total waiver population, or with some measures, the total population of those waiver members with whom the measure is applicable (example, some measures are only applicable to new waiver eligible only).
- In respect to the degree of accuracy, the random samples are prepared with a 95% confidence level that the confidence interval of each measure (the measure metric) meets the standard denoted in each measure, with a +/-5% margin of error.
- KDADS oversample by 30%, to insure the output the quality review team submits for reporting meets the 95% confidence level requirements of each waiver population and measure.

KDHE also contracts for EQRO to review a sample of service plans annually for each waiver. The PPOC is reviewed for new waiver participants by KDHE.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

Every three months or more frequently when necessary

Every six months or more frequently when necessary

Every twelve months or more frequently when necessary

Other schedule

Specify the other schedule:

- i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

Medicaid agency

Operating agency

Case manager

Other

Specify:

Service plans and related documentation will be maintained by the participant's chosen KanCare MCO, and will be retained at least as long as this requirement specifies

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

- a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The MCOs are responsible for monitoring the implementation of the Person-Centered Service Plan and for ensuring the health and welfare of the participant with input from the BI Program Manager and KDADS Regional Field Staff. Service Plan implementation is assessed through the comprehensive statewide KanCare Quality Improvement Strategy (which includes all of the HCBS waiver performance measures). Kansas also monitors the Adverse Incident Reporting system and implements corrective action plans for remediation with the MCOs.

On an ongoing basis, the MCOs monitor the Person-Centered Service Plan and participant needs to ensure:

- Services are delivered according to the Person-Centered Service Plan;
- Participants have access to the waiver services indicated on the Person-Centered Service Plan;
- Participants have free choice of providers and whether or not to self-direct their services;
- Services meet participant's needs;
- Liabilities with self-direction/agency-direction are discussed, and back-up plans are effective;
- Participant's health and safety are assured, to the extent possible; and
- Participants have access to Medicaid State Plan services when the participant's need for services has been assessed and determined medically necessary.

The KanCare contracting managed care organizations are responsible for monitoring the implementation of the Person-Centered Service Plan that was developed as a partnership between the participant and the MCO and for ensuring the health and welfare of the participant with input from the IDD Program Manager, involvement of KDADS Regional Field Staff, and assessed with the comprehensive statewide KanCare quality improvement strategy (which includes all of the HCBS waiver performance measures).

The three KanCare contracting managed care organizations are responsible for monitoring the implementation of the Service Plan that was developed as a partnership between the participant, participant's responsible party (if participant has responsible party), TCM, participant's team, and the MCO.

On an ongoing basis, the MCOs monitor the Person-Centered Service Plan and participant needs to ensure:

- Services are delivered according to the Person-Centered Service Plan;
- Participants have access to the waiver services indicated on the Person-Centered Service Plan;
- Participants have free choice of providers and whether or not to self-direct their services;
- Services meet participant's needs;
- Liabilities with self-direction/agency-direction are discussed, and back-up plans are effective;
- Participant's health and safety are assured, to the extent possible; and
- Participants have access to non-waiver services that include health services."

The Person-Centered Service Plan is the fundamental tool by which the State will ensure the health and welfare of participants served under this waiver. The KanCare MCOs, who deliver no direct waiver services to waiver participants, are responsible for both the initial and updated plans of care.

In-person monitoring by the MCOs is ongoing:

- Choice and monitoring are offered at least annually, regardless of current provider or self-direction, or at other life choice decision points, or any time at the request of the participant.
- Choice is documented.
- The Person-Centered Service Plan is modified to meet change in needs, eligibility, or preferences, or at least annually."

In addition, the Person-Centered Service Plan and choice are monitored by state quality review and/or performance improvement staff as a component of waiver assurance and minimum standards. Issues found needful of resolution are reported to the MCO and waiver provider for prompt follow-up and remediation. Related information is reported to the IDD Program Manager.

Service plan implementation and monitoring performance measures and related collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through the KanCare QI Strategy, which includes HCBS waiver program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

State staff request, approve, and assure implementation of contractor/provider corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through on-site monitoring, MCO compliance monitoring, survey results and other performance monitoring. These processes are monitored by both contract managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent

with the statewide quality improvement strategy.

b. **Monitoring Safeguards.** *Select one:*

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. **Methods for Discovery: Service Plan Assurance/Sub-assurances**

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

i. **Sub-Assurances:**

a. *Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of waiver participants whose person-centered service plans address participants' goals. N=Number of waiver participants whose service plans address participants' goals. D=Number of waiver participants whose service plans were reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record review

Responsible Party for data collection/generation	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
--	---	---

<i>(check each that applies):</i>		
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px;">95%; confidence level +/-5% margin of error</div>
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; padding: 2px;">Proportionate by MCO</div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="text"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Number and percent of waiver participants whose person-centered service plans address health and safety risk factors N=Number of waiver participants whose service plans address health and safety risk factors D=Number of waiver participants whose service plans were reviewed

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Record review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and	Other

	Ongoing	Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

Performance Measure:

Number and percent of waiver participants whose person-centered service plans address their assessed needs and capabilities as indicated in the assessment
N=Number of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment D=Number of waiver participants whose service plans were reviewed

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Record review

Responsible Party for data	Frequency of data collection/generation	Sampling Approach (<i>check each that applies</i>):
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collection/generation (check each that applies):	(check each that applies):	
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95%; +/- 5% margin of error</div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div>Proportionate by MCO</div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div></div>	Annually

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

- b. Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

- c. Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of person-centered service plans (initial and annual updates) signed and dated within state required timeframes. Numerator: Number of person-centered service plans (initial and annual updates) signed and dated within state required timeframes Denominator: Number of waiver participants whose service plans were reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record Review

Responsible Party for data	Frequency of data collection/generation	Sampling Approach (<i>check each that applies</i>):
-----------------------------------	--	---

collection/generation (check each that applies):	(check each that applies):	
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95% confidences level; +/- 5% margin of error</div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div>Proportionate by MCO</div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="text"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Number and percent of waiver participants whose service plan was revised, as needed, to address a change in need. Numerator: Number of waiver participants whose service plan was revised, as needed, to address a change in need. Denominator: Number of waiver participants whose service plans were reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record Review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and	Other

	Ongoing	Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

- d. Sub-assurance:** *Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

and % of waiver participants who received services and supports as authorized in their serv. plans including type, scope, amount, duration, and frequency. N=Number of waiver participants who received services and supports as authorized in their SPs including type, scope, amount, duration, and frequency D=Number of waiver participants whose service plans were reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record Review

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95%; confidence level; +/- 5% margin of error.</div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div>Proportionate by MCO</div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

e. Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care
N=Number of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care
D=Number of waiver participants whose service plans were reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record review

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
---	--	--

State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95%; confidence level; +/- 5% margin of error</div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div>Proportionate by MCO</div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div></div>	Annually

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

Number and percent of waiver participants whose record contains documentation indicating a choice of waiver services. N=Number of waiver participants whose record contains documentation indicating a choice of waiver services. D=Number of waiver participants whose files are reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record review

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; margin-top: 5px;">95%; confidence level; +/- 5% margin of error.</div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; padding: 5px; margin-top: 5px;">Proportionate by MCO</div>
	Continuously and Ongoing	Other Specify:

		<input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Number and percent of waiver participants whose record contains documentation indicating a choice of waiver service providers. N=Number of waiver participants whose record contains documentation indicating a choice of waiver service providers
D=Number of waiver participants whose plans are reviewed.

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Record review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
---	--	--

State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95%; confidence level; +/- 5% margin of error.</div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div>Proportionate by MCO</div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div></div>	Annually

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Kansas Department of Health and Environment, Division of Health Care Finance (KDHE), the single state Medicaid agency, and Kansas Department for Aging and Disability Services (KDADS) work together to develop state operating agency priority identification regarding all waiver assurances and minimum standards/basic assurances. The state agencies work in partnership with participants, advocacy organizations, provider groups and other interested stakeholders to monitor the state quality strategy and performance standards and discuss priorities for remediation and improvement. The state quality improvement strategy includes protocols to review cross-service system data to identify trends and opportunities for improvement related to all Kansas waivers, policy and procedure development and systems change initiatives.

Data gathered by KDADS Regional Staff during the Quality Survey Process, and data provided by the KanCare MCOs, is compiled quarterly for evaluation and trending to identify areas for improvement. Upon completion of identified areas of improvement this information is compiled into reports and shared both internally and externally, including with KDHE. As the KanCare program is operationalized, staff of the three managed care health plans will engage with state staff to ensure strong understanding of Kansas' HCBS waiver programs and the quality measures associated with each waiver program. Over time, the role of the MCOs in collecting and reporting data regarding the waiver performance measures will evolve, with increasing responsibility once the MCOs fully understand the Kansas programs. These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through a state interagency monitoring team, which includes program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

State staff and/or KanCare MCO staff request, approve, and assure implementation of provider corrective action planning and/or technical assistance to address non-compliance with waiver and performance standards as detected through on-site monitoring, survey results and other performance monitoring. These processes are monitored by both program managers and other relevant state and MCO staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy and the operating protocols of the interagency monitoring team.

Monitoring and survey results are compiled, trended, reviewed, and disseminated consistent with protocols identified in the statewide quality improvement strategy. Each provider receives annual data trending which identifies Provider specific performance levels related to statewide performance standards and statewide averages. Corrective Action Plan requests, technical assistance and/or follow-up to remediate negative trending are included in annual provider reports where negative trending is evidenced.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div>KanCare Managed Care Organizations (MCOs)</div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability (from Application Section 3, Components of the Waiver Request):

Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.

No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested (select one):

Yes. The state requests that this waiver be considered for Independence Plus designation.

No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

a) All participants of BI waiver services have the opportunity to choose the KanCare managed care organization that will support them in overall service access and care management. The opportunity for participant direction (self-direction) of Personal Services and Enhanced Care Services is made known to the participant by the MCO, which is available to all waiver participants (Kansas Statute 39-7,100).

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 Person-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.

b) Participants are provided with information about self direction of services and the associated responsibilities by the MCO during the service planning process. Once the participant is deemed eligible for waiver services, the option to self-direct is offered and, if accepted, the choice is indicated on a Participant Choice form and included in the participant's Person-Centered Service Plan.

The MCO assists the participant with identifying an FMS provider and related information is included in the participant's Person-Centered Service Plan. The MCO supports the participant who selects self direction of services by monitoring services to ensure that they are provided by Personal Care Service workers and Enhanced Care Service workers in accordance with the Person-Centered Service Plan and the Attendant Care Worksheet, which are developed by the participant with assistance from the MCO. The MCO also provides the same supports given to all waiver participants, including Person-Centered Service Plan updates, referral to needed supports and services, and monitoring and follow-up activities.

c) FMS Provider Responsibilities

The FMS Kansas Medical Assistance Program (KMAP) manual and State policy detail the responsibilities of the FMS provider.

FMS support is available for the participant (or the person assigned by the participant, such as a representative, family member, parent, spouse, adult child, guardian) who has chosen to self-direct some or all services, to assist the participant by performing administrative and payroll functions. FMS support will be provided within the scope of the Employer Authority model. The FMS is available to participants who reside in their own private residences or the private home of a family member and have chosen to self-direct their services. FMS assists the participant or participant's representative by providing two distinct types of tasks: (1) Administrative Tasks and (2) Information and Assistance (I & A) Tasks. The FMS provider is also responsible for informing the participant that he/she must exercise responsibility for making the choice to self-direct his/her services, understand the impact of the choices made, and assume responsibility for the results of any decisions and choices that were made. The FMS provider is responsible for clearly communicating verbally and in writing the participants responsibilities relating his/her role as an employer of a direct service worker.

The FMS provider is responsible for certain administrative functions, tasks include, but are not limited to, the following:

- Verification and processing of time worked and the provision of quality assurance;
- Preparation and disbursement of qualified direct support worker payroll in compliance with federal, state and local tax; labor; and workers' compensation insurance requirements; making tax payments to appropriate tax authorities;
- Performance of fiscal accounting and expenditure reporting to the participant or participant's representative and the state, as required.
- Assistance to ensure the basic minimum qualifications set by the State are met in order to ensure participant safety, health and welfare.

The FMS provider is responsible for Information and Assistance functions including but not limited to:

1. Explanation of all aspects of self-direction and subjects pertinent to the participant or participant's representative in managing and directing services;
 2. Assistance to the participant or participant's representative in arranging for, directing and managing services;
 3. Assistance in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services;
 4. Offers practical skills training to enable participants or representatives to independently direct and manage waiver services such as recruiting and hiring direct service workers (DSW), managing workers, and providing effective communication and problem-solving.
- d) For all health maintenance activities, the participant shall obtain a completed Physician/RN Statement to be signed by an attending physician or registered professional nurse. The statement must identify the specific activities that have been authorized by the physician or registered professional nurse. The MCO is responsible to ensure that the Physician/RN Statement is completed in its entirety.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

- b. Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the waiver.
Select one:

Participant: Employer Authority. As specified in *Appendix E-2, Item a*, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.

Participant: Budget Authority. As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

Both Authorities. The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.

- c. Availability of Participant Direction by Type of Living Arrangement.** *Check each that applies:*

Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.

Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.

The participant direction opportunities are available to persons in the following other living arrangements

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

- d. Election of Participant Direction.** Election of participant direction is subject to the following policy (*select one*):

Waiver is designed to support only individuals who want to direct their services.

The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.

The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria

Participants on this waiver or legal guardian on the participant's behalf may direct some or all of the services offered under participant-direction. Participant-direction option is available for Personal Care Services and Enhanced Care Services. Participant-direction is not offered for the following services:

- Occupational Therapy
- Physical Therapy
- Cognitive Rehabilitation/Therapy
- Behavior Therapy
- Speech/Language Therapy
- Home-Delivered Meals Service
- Transition Living Skills
- Financial Management Services
- Assistive Services
- Medication Reminder Services
- Personal Emergency Response System

Self-direction is not an option when the participant/legal guardian has been determined to have been documented as demonstrating the inability to participant-direct the direct service workers, resulting in fraudulent activities; confirmation of abuse, exploitation or medical neglect. Any decision to restrict or remove a participant's direction opportunity will be referred by the MCO to KDADS for concurrence of action and is subject to the grievance and appeal protections detailed in Appendix F.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

- 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.
- 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 chosen 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.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative (*select one*):

The state does not provide for the direction of waiver services by a representative.

The state provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: (*check each that applies*):

Waiver services may be directed by a legal representative of the participant.

Waiver services may be directed by a non-legal representative freely chosen by an adult participant.

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Waiver services may be directed by a non-legal representative of an adult waiver-eligible participant. An individual acting on behalf of the participant must be freely chosen by the participant. This includes situations when the representative has an activated durable power of attorney (DPOA). The DPOA process involves a written document in which participants authorize another individual to make decisions for them in the event that they cannot speak for themselves. A DPOA is usually activated for health care decisions. The extent of the non-legal representative's decision-making authority can include any or all of the responsibilities outlined in E-1-a that would fall to the participant if he/she chose to self-direct services. Typically, a durable power of attorney for health care decisions, if activated, cannot be the participant's paid attendant for Personal Services and/or Enhanced Care Services.

In the event that non-legal representatives' has been chosen by an adult participant, the support team, along with the participant will identify the roles and responsibilities of the non-legal representative and these roles and responsibilities will be documented in the Person-Centered Service Plan. The designation of a representative must comport with state policy and procedures for mitigation of conflict of interest.

To ensure that non-legal representatives function in the best interests of the participant, additional safeguards are in place. Quality of care is continuously monitored by the MCO. The MCO may discontinue the self direct option and offer agency-directed services when, in the judgment of the MCO, as observed and documented in the participant's case file, certain situations arise, particularly when the participant's health and welfare needs are not being met. In addition, post-pay reviews completed by the fiscal agent and quality assurance reviews completed by the KDADS Regional Field Staff and/or MCO staff serve to monitor participant services and serve as safeguards to ensure the participant's best interests are followed. Any decision to restrict or remove a participant's opportunity to self-direct care, made by a KanCare MCO, is subject to the grievance and appeal protections detailed in Appendix F.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Enhanced Care Services		
Personal Care		

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

Yes. Financial Management Services are furnished through a third party entity. *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

Governmental entities

Private entities

No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

FMS are covered as the waiver service specified in Appendix C-1/C-3

The waiver service entitled:

Financial Management Services

FMS are provided as an administrative activity.

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Enrolled FMS providers will furnish Financial Management Services using the Employer Authority model. The provider requirements will be published and placed on the Kansas Medical Assistance Program (KMAP) website and/or in the KanCare MCO provider manuals and websites.

Organizations interested in providing Financial Management Services (FMS) are required to submit a signed Provider Agreement to the State Operating Agency, KDADS, prior to enrollment to provide the service. The agreement identifies the waiver programs under which the organization is requesting to provide FMS and outlines general expectations and specific provider requirements. In addition, organizations are required to submit the following documents with the signed agreement:

- Secretary of State Certificate of Corporate Good Standing
- W-9 form
- Proof of Liability Insurance
- Proof of Workers Compensation insurance
- Copy of the most recent quarterly operations report or estimate for first quarter operations
- Financial statements (last 3 months bank statements or documentation of line of credit)
- Copy of the organization's Policies and Procedures manual, to include information that covers requirements listed in the FMS Medicaid Provider Manual.

The FMS provider agreement and accompanying documentation are reviewed by the State Operating Agency and all assurances are satisfied prior to signing by the Secretary of KDADS (or designee). KanCare MCOs should not credential any application without evidence of a fully executed FMS Provider agreement.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

FMS providers will be reimbursed a monthly fee per participant through the electronic MMIS system (MMIS). The per member per month payment was estimated based upon a formula that included all direct and indirect costs to payroll agents and an average hourly rate for direct care workers. Information was gathered as part of a Systems Transformation Grant study conducted by Myers & Stauffer. Under the KanCare program, FMS providers will contract with MCOs for final payment rates, which cannot be less than the current FMS rate.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide (*check each that applies*):

Supports furnished when the participant is the employer of direct support workers:

Assist participant in verifying support worker citizenship status

Collect and process timesheets of support workers

Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance

Other

Specify:

Supports furnished when the participant exercises budget authority:

Maintain a separate account for each participant's participant-directed budget

Track and report participant funds, disbursements and the balance of participant funds

Process and pay invoices for goods and services approved in the service plan

Provide participant with periodic reports of expenditures and the status of the participant-directed budget

Other services and supports

Specify:

Additional functions/activities:

Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency

Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency

Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget

Other

Specify:

- iv. Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

(a) The state verifies FMS providers meet waiver standards and state requirements to provide financial management services through a biennial review process. A standardized tool is utilized during the review process and the process includes assurance of provider requirements, developed with stakeholders and the State Medicaid Agency (Kansas Department of Health and Environment [KDHE]). Requirements include agreements between the FMS provider and the participant, Direct Support Worker and the State Medicaid Agency and verification of processes to ensure the submission of Direct Support Worker time worked and payroll distribution. Additionally, the state will assure FMS provider development and implementation of procedures including, but not limited to, procedures to maintain background checks; maintain internal quality assurance programs to monitor participant and Direct Support Worker satisfaction; maintain a grievance process for Direct Support Workers; and offer choice of Information and Assistance services.

The Division of Legislative Post Audit contracts with an independent accounting firm to complete Kansas' state wide single audit each year. The accounting firm must comply with all requirements contained in the single audit act. The Medicaid program, including all home and community based services waivers, is a required component of every single state audit. Independent audits of the waiver will look at cost-effectiveness, the quality of services, service access, and the substantiation of claims for HCBS payments. Each HCBS provider is to permit KDHE or KDADS, its designee, or any other governmental agency acting in its official capacity to examine any records and documents that are necessary to ascertain information pertinent to the determination of the proper amount of a payment due from the Medicaid program. The Surveillance and Utilization Review Unit of the fiscal agent completes the audits of both participants and providers (K.A.R. 30-5-59).

(b) The Operating Agency is responsible for performing and monitoring the FMS review process. State staff will conduct the review and the results will be monitored by KDADS. A system for data collection, trending and remediation will be implemented to address individual provider issues and identify opportunities for systems change. KDHE through the fiscal agent maintains financial integrity by way of provider agreements signed by prospective providers during the enrollment process and contract monitoring activities.

(c) All FMS providers are assessed on a biennial basis through the FMS review process and as deemed necessary by the State Medicaid Agency.

(d) State staff will share the results of state monitoring and auditing requirements, with the KanCare MCOs, and state/MCO staff will work together to address/remediate any issue identified. FMS providers also must contract with KanCare MCOs to support KanCare members, and will be included in monitoring and reporting requirements in the comprehensive KanCare quality improvement strategy.

In general, contracted managed care entities are responsible for ensuring the FMS entity is in compliance with federal/ state policies and procedures. KDHE through its operating agency KDADS, establish a provider agreement with the FMS provider and conduct monitoring activities of the FMS entity in accordance with the terms of the agreement and policies and procedures. In accordance with established agreements, KDADS requires GAP audits initially and every 3 years. In addition, KDADS reviews the FMS financial report and determine financial integrity annually.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

Case Management Activity. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Waiver Service Coverage.

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Physical Therapy	
Home and Environmental Modification Services (HEMS)	
Transitional Living Skills	
Cognitive Rehabilitation	
Medication Reminder Services	
Enhanced Care Services	
Financial Management Services	
Specialized Medical Equipment and Supplies (SMES)	
Home-Delivered Meals Service	
Personal Care	
Occupational Therapy	
Vehicle Modification Services (VMS)	
Behavior Therapy	
Speech and Language Therapy	
Personal Emergency Response System and Installation	

Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

No. Arrangements have not been made for independent advocacy.

Yes. Independent advocacy is available to participants who direct their services.

Describe the nature of this independent advocacy and how participants may access this advocacy:

Independent advocacy is available to participants who direct their services through the Disability Rights Center of Kansas (DRC), the state's Protection and Advocacy organization. DRC is a public interest legal advocacy agency empowered by federal law to advocate for the civil and legal rights of Kansans with disabilities. DRC operates eight federally authorized and funded protection and advocacy programs in Kansas, including a program specifically for persons with BI. Participants are referred directly to DRC from various sources, including KDADS. These organizations do not provide direct services either through the waiver or through the Medicaid State Plan.

Independent advocacy is also available through the Brain Injury Association of Kansas and Greater Kansas City (BIAKS). The mission of BIAKS, an affiliate of the national Brain Injury Association of America, is to be the voice of brain injury in the state in a way that contributes to the improvement of the quality of life for survivors and family members. BIAKS provides timely information, resources, and training to survivors and family members through various means including support groups, seminars, and individual contact. BIAKS acts as a source of disinterested assistance to participants and family members in that it provides no direct waiver or State plan services to participants or assessment, monitoring, fiscal, or service oversight functions that have a direct impact on the participant. Participants access support through direct contact with BIAKS. A link to the BIAKS web site is available on the KDADS web site.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

I. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

One of the participant's opportunities, as well as responsibilities, is the ability to discontinue the self-direct option. At any time, if the participant chooses to discontinue the self-direct option, he/she is to:

- Notify all providers as well as the Financial Management Services (FMS) provider.
- Maintain continuous coverage for authorized Personal Care Services and/or ECS
- Give ten (10) day notice of his/her decision to the KanCare MCO chosen by the participant, to allow for the coordination of service provision.

The duties of the participant's KanCare MCO are to:

- Explore other service options and complete a new Participant Choice form with the participant; and
- Advocate for participants by arranging for services with individuals, businesses, and agencies for the best available service within limited resources
- Work with the participant to maintain continuous coverage as outlined and authorized in the participant's Service Plan.
- The MCO, through their care management and monitoring activities, works with the participant's self-directed provider to assure participant health and welfare during the transition period.
- Ensure open communication with both the participant and the self-directed provider, monitor the services provided, and gather continual input from the participant as to satisfaction with their services.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

The MCO may, if appropriate discontinue the participants choice to direct their services when, in the MCOs professional judgment through observation and documentation, it is not in the best interest of the participant to participant-direct their services. The MCO will make the recommendation based on the determination that the following conditions will be compromised if participant-direction continues:

- The health and welfare needs of the participant are not being met based on documented observations of the MCO and KDADS Quality Assurance staff, or confirmation by APS, and all training methods have been exhausted;
- The PCS is not providing the services as outlined on the PCS Skilled worksheet, and the situation cannot be remedied;
- The participant is at risk for fraud, abuse, neglect and exploitation
- The participant is falsifying records resulting in claims for services not rendered.
- The participant chooses to employ a provider or maintain employment of a provider whose background check does not clear the list of Kansas prohibited offenses.

When an involuntary termination occurs, the MCO will apply safeguards to assure the participant's health and welfare remains intact and ensures continuity of care by offering the participant or family a choice of qualified agency-directed services as an alternative. If the participant chooses the alternative agency-directed services, the MCO will assess the participant's needs and coordinate services according to the individual's health and safety needs.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n					
	Employer Authority Only			Budget Authority Only or Budget Authority in Combination with Employer Authority	
Waiver Year	Number of Participants			Number of Participants	
Year 1		267			
Year 2		267			
Year 3		267			
Year 4		267			
Year 5		267			

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

- i. Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both:*
- Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

Participant/Common Law Employer. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

Recruit staff

Refer staff to agency for hiring (co-employer)

Select staff from worker registry

Hire staff common law employer

Verify staff qualifications

Obtain criminal history and/or background investigation of staff

Specify how the costs of such investigations are compensated:

The direct service worker (provider) will assume the cost of criminal history and/or background investigations conducted by the financial management service provider as an administrative function.

Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

It does not vary from Appendix C-2-a.

Determine staff duties consistent with the service specifications in Appendix C-1/C-3.

Determine staff wages and benefits subject to state limits

Schedule staff

Orient and instruct staff in duties

Supervise staff

Evaluate staff performance

Verify time worked by staff and approve time sheets

Discharge staff (common law employer)

Discharge staff from providing services (co-employer)

Other

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

Reallocate funds among services included in the budget

Determine the amount paid for services within the state's established limits

Substitute service providers

Schedule the provision of services

Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3

Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3

Identify service providers and refer for provider enrollment

Authorize payment for waiver goods and services

Review and approve provider invoices for services rendered

Other

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- iii. **Informing Participant of Budget Amount.** Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- iv. **Participant Exercise of Budget Flexibility.** *Select one:*

Modifications to the participant directed budget must be preceded by a change in the service plan.

The participant has the authority to modify the services included in the participant directed budget without prior approval.

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to

offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

ELIGIBILITY DECISIONS:

Kansas has contracted with independent assessors to conduct level of care assessments (functional eligibility).

Decisions made by the independent assessors are subject to state fair hearing review and notice of that right and related process will be provided by the independent assessors with their decision on the LOC assessment/reassessment.

The Independent contractor conducts participant waiver assessments for current and potential participants. KDADS Program Manager reviews each initial eligibility packet for LOC evaluation and determines program eligibility before KDHE determines financial eligibility. Level of care appeals are limited to initial assessments that result in a "not eligible" determination. In addition, any reassessment that results in a change from eligible to not eligible is subject to appeal.

Notices of Action for Eligibility Decisions:

The State determines, including through contracting entities, eligibility for HCBS waivers and is responsible for notifying an individual of an adverse action in the event that their application (choice of HCBS vs. institutional services, is denied. The contracting entities issue a notice of action following a functional assessment that notes whether the participant met or did not meet eligibility criteria for an HCBS waiver. The State issues a notice of adverse action for all adverse eligibility actions.

Eligibility Grievances:

KanCare participants have the right to file a grievance. A grievance is any expression of dissatisfaction about any matter other than an Action. Grievances can be filed in writing or verbally. The State will send a written response to the grievance to the participant within 30 calendar days.

Fair Hearings:

A Fair Hearing is a formal process where an impartial person, assigned by the Office of Administrative Hearings or the agency Secretary pursuant to K.S.A. 77-514, listens to all of the facts and then hears motions, conducts hearings and makes a decision based on the relevant facts and law within the authority granted to an administrative law judge. If the participant is not satisfied with the decision made about eligibility, the participant or participant's representative may ask for a fair hearing. It may be requested verbally by calling 1-800-888-8888 or in writing. Written requests should be mailed or faxed to:

Office of Administrative Hearings

1020 S. Kansas Ave. Topeka, KS 66612-1327

Fax: 785-296-4848

For eligibility decisions made by the State, the letter or fax must be received within 33 days of the date of the notice of action.

Continuation of Eligibility:

Participants have the right to continuation of eligibility while a hearing is pending. Eligibility for participants will be continued if the participant asks for a hearing either before the effective date of the eligibility decision or within 15 calendar days from the date of the notice of action, whichever is later.

SERVICE DECISIONS:

Kansas has contracted with three KanCare managed care organizations (MCOs) who are required to have grievance and appeal processes that meet all relevant federal and state standards, including state fair hearings, expedited appeals, and expedited state fair hearings. Each MCO has established operational processes regarding these issues, about which they must inform every member.

Each participant is provided information about grievances, appeals and fair hearings in their KanCare member enrollment packet. Participant grievance process and Fair Hearing process can also be found at the KanCare website.

MCO Grievances:

KanCare participants have the right to file a grievance. A grievance is any expression of dissatisfaction about any matter other than an Action. Grievances can be filed in writing or verbally. Grievances will be acknowledged by MCOs in writing within 10 calendar days of receipt, and a written response to the grievance will be given to the participant within 30 calendar days (except in cases where it is in the best interest of the member that the resolution timeframe be extended).

If the MCO fails to send a grievance notice within the required timeframe, the participant is deemed to have exhausted the MCO's appeal process, and the participant may initiate a State Fair Hearing.

MCO Appeals:

An appeal can only occur under the following circumstances:

If an Action has occurred. An Action is the denial of services or a limitation of services, including the type of service; the reduction, suspension, or termination of a service you have been receiving; the denial, in whole or part, of payment for a service; or the failure of the health plan to act within established time requirements for service accessibility.

An Appeal is a request for a review of any of the above actions.

Members will receive a Notice of Action in the mail if an adverse action has occurred.

To file an MCO Appeal:

Members or (a friend, an attorney, or anyone else on the member's behalf can file an appeal).

An MCO appeal can be filed verbally, or in writing. The Customer Service Center for your health plan can also help you with an appeal.

An MCO appeal must be filed within 63 days calendar days of the date on the MCO's Notice of Action.

The MCO appeal will be resolved within 30 calendar days unless more time is needed. The participant will be notified of the delay, but the participant's appeal will be resolved in 44 calendar days.

If the participant is on the BI waiver, previously authorized BI waiver services must continue during the MCO appeal period timeframe in order to ensure that continuity of care is provided while the appeal period is in effect and to provide the participant time to appeal.

Fair Hearings

A Fair Hearing is a formal process where an impartial person, assigned by the Office of Administrative Hearings or the agency Secretary pursuant to K.S.A. 77-514, listens to all the facts and then hears motions, conducts hearings and makes a decision based on the relevant facts and law within the authority granted to an administrative law judge. If the participant is not satisfied with the decision made on his or her appeal, the participant or participant's representative may ask for a fair hearing. It must be done in writing and mailed or faxed to: Office of Administrative Hearings

1020 S. Kansas Ave. Topeka, KS 66612-1327

Fax: 785-296-4848

For service decisions made by an MCO, the letter or fax must be received within 123 days of the date of the notice of appeal decision.

Continuation of Benefits:

Participants have the right to benefits continuation of previously authorized BI waiver services while a hearing is pending. If the participant is on the BI waiver, previously authorized BI waiver services will be continued. The participant's MCO will inform the participant of their right to benefit continuation during the fair hearing process. All three MCOs will advise participants of their right to a State Fair Hearing. Participants have to finish their appeal with the MCO before requesting a State Fair Hearing.

For all KanCare MCOs:

In addition to the education provided by the State, participants receive information about the Fair Hearing process in the participant handbook they receive at the time of enrollment. The participant handbook is included in the welcome packet provided to each person. It will also be posted online at the MCOs' participant web site. In addition, every notice of action includes detailed information about the Fair Hearing process, including timeframes, instructions on how to file, and who to contact for assistance. And, at any time, a participant can call the MCO to get information and assistance with the Fair Hearing process.

Definition of MCO Action:

The state requires that all MCOs define an "action" pursuant to KanCare RFP Attachment C and 42 CFR §438.400. MCOs issue a notice of adverse action under the following circumstances:

The denial or limited authorization of a requested service, including the type or level of service;

The reduction, suspension, or termination of a previously authorized service;

The denial, in whole or in part, of payment for a service;

The failure to provide services in a timely manner;

The failure of an MCO to act within the timeframes provided in 42 CFR §438.408(b); and

For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network.

MCOs retain all Notices of Action in the participant's file.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

No. This Appendix does not apply

Yes. The state operates an additional dispute resolution process

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

No. This Appendix does not apply

Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

Under the KanCare program, nearly all Medicaid services - including nearly all HCBS waiver services - will be provided through one of the three contracting managed care organizations. Participants have the right to submit grievances or appeals to their assigned managed care organization. The Single State Medicaid Agency, Kansas Department of Health and Environment (KDHE), requires the managed care organizations to operate a member grievance and appeal system consistent with federal regulations and Attachment D of the State's contract with CMS. (A description as to how KanCare members are informed that filing a grievance is not a prerequisite for a Fair Hearing is included at Appendix F.1. KanCare members are informed that filing an appeal with the MCO is a prerequisite for a Fair Hearing.

The MCOs acknowledge, process and issue responses to all grievances and appeals submitted by a member to their assigned MCO. The MCO staff logs and tracks all grievances and appeals. If a provider has three complaints lodged against him or her, an investigation is initiated. KDHE and KDADS have access to this information at any time. Participants who are not part of the KanCare program are part of the State's fee-for-service Medicaid program. Fee-for-service participants have the right to submit grievances to the State's fiscal agent, DXC. KDHE requires the fiscal agent to operate the consumer fee-for-service grievance system consistent with federal regulations. The fiscal agent staff logs and tracks all fee-for-service grievances and fee-for-service state fair hearings. KDHE and KDADS have access to this information at any time. The fiscal agent educates fee-for-service participants that lodging a complaint and/or grievance is not a pre-requisite or substitute for a Fair Hearing and is a separate activity from a Fair Hearing.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The fiscal agent is open to any complaint, concern, or grievance a participant has against a Medicaid provider. The Consumer Assistance Unit staff logs and tracks all complaints, concerns, or grievances. If a provider has three complaints lodged against them, an investigation is initiated. The fiscal agent team escalates any grievance prior to the 3-occurrence timeframe based on the severity of the grievance. Through the escalation processes the fiscal agent team contacts KDADS, KDHE or the appropriate local authority who have access to this information at any time to ensure the member's safety and wellbeing.

The MCOs acknowledge, process and issue responses to all grievances and appeals submitted by a member to their assigned MCO. The MCO staff logs and tracks all grievances and appeals. If a provider has three complaints lodged against him or her, an investigation is initiated. KDHE and KDADS have access to this information at any time.

Participants who are not part of the KanCare program are part of the State's fee-for-service Medicaid program. Fee-for-service participants have the right to submit grievances to the State's fiscal agent, KDHE requires the fiscal agent to operate the consumer fee-for-service grievance system consistent with federal regulations. The fiscal agent staff logs and tracks all fee-for-service grievances and fee-for-service state fair hearings. KDHE and KDADS have access to this information at any time. The fiscal agent educates fee-for-service participants that lodging a complaint and/or grievance is not a pre-requisite or substitute for a Fair Hearing and is a separate activity from a Fair Hearing. This information may also be provided by the Waiver Program Manager, or by the Ombudsman's office.

Complaints are received in the state's fiscal agent Call Center and documented in call tracking. This tracking is then routed to the Grievance Unit for investigation. If the grievance situation is urgent the call center staff makes direct contact with the grievance staff immediately.

Grievance Unit must make contact related to a grievance within 3 business days. If the situation is urgent, the grievance staff make contact immediately. The grievance is required to be resolved within 30 calendar days.

- **HCBS eligibility decision:** DHCF makes decisions regarding HCBS waiver eligibility. If an HCBS member loses eligibility for HCBS waiver services, DHCF sends the notice of action. The language regarding the member's opportunity to request a fair hearing is in DHCF's notice. Those notices are generated by KEES.
- **HCBS service decision:** The MCOs make decisions regarding HCBS waiver services. If an MCO reduces or terminates HCBS services, the MCOs issue the notice of adverse benefit determination (formerly called a notice of action). The language regarding a member's opportunity to request a fair hearing is in that notice. The same information is also in each MCO's Member Handbook. The notices are generated by each MCO's notice generation system.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

- a. Critical Event or Incident Reporting and Management Process.** Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program. *Select one:*

Yes. The state operates a Critical Event or Incident Reporting and Management Process (*complete Items b through e*)

No. This Appendix does not apply (*do not complete Items b through e*)

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

- b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

KDADS defined “adverse incidents” include the following: Death, Elopement, Emergency Medical Care, Law Enforcement Involvement, Misuse of Medications, Natural Disaster, Abuse, Neglect, Exploitation, Serious Injury, Suicide, Suicide Attempt, and use of Restraints, Seclusion, and Restrictive interventions.

The reporting process is almost identical for children and adults as the Department for Children and Families is responsible for all investigations of abuse, neglect, and exploitation in the State of Kansas. Below is a summary of that process.

Identification of the individuals/entities that must report critical events and incidents:

The Kansas statutes K.S.A. 39-1431 and K.S.A. 38-2223 identify mandated reporters required to report suspected Abuse Neglect, and Exploitation or Fiduciary Abuse of an adult or minor immediately to either Kansas Department for Children and Families or Law Enforcement. According to K.S.A. 39-1431, mandated reporters include: Any person who is licensed to

practice any branch of the healing arts:

A licensed psychologist, a licensed master level psychologist, a licensed clinical psychotherapist, the chief administrative officer of a medical care facility, a teacher, a licensed social worker, a licensed professional nurse, a licensed practical nurse, a licensed dentist, a licensed marriage and family therapist, a licensed clinical marriage and family therapist, licensed professional counselor, licensed clinical professional counselor, registered alcohol and drug abuse counselor, a law enforcement officer, a case manager, a rehabilitation counselor, a bank trust officer or any other officers of financial institutions, a legal representative, a governmental assistance provider, an owner or operator of a residential care facility, an independent living counselor and the chief administrative officer of a licensed home health agency, the chief administrative

officer of an adult family home and the chief administrative officer of a provider of community services and affiliates thereof

operated or funded by the Kansas Department for Children and Families or licensed under K.S.A. 75-3307b and amendments there to

who has reasonable cause to believe that an adult or child is being or has been abused, neglected or exploited or is in need

of protective services shall report, immediately from receipt of the information, such information or cause a report of such

information to be made in any reasonable manner.

An employee of a domestic violence center shall not be required to report information or cause a report of information to be made

under this subsection.

Specifically, mandated reporters include but are not limited to: Staff working for any KDADS licensed or contacted organization, including Community Developmental Disability Organization (CDDO)s, the Aging and Disability Resource

Center (ADRC), Financial Management Services Providers (FMS), Community Mental Health Centers (CMHC), Psychiatric Residential Treatment Facilities (PRTF) and Substance Abuse Treatment Facilities.

All other individuals who may witness a reportable event may voluntarily report it.

The timeframes within which critical incidents must be reported: KSA 39-1431 requires other state agencies receiving reports that are to be referred to the Kansas DCF and the appropriate law enforcement agency, shall submit the report to the department and agency within six hours, during normal workdays, of receiving the information. Outside of working hours, the reports shall be submitted to DCF on the first working day that the Kansas Department for Children and Families is in operation after the receipt of such information.

AIR is used to report adverse/critical incidents involving individuals receiving services by providers who are licensed by or contracted with KDADS including all HCBS waivers. AIR reports are required to be submitted to KDADS w/in 24 hours of the individual becoming aware of the adverse incident. MCOs and their providers are all required to submit AIR reports. MCOs are required to follow-up with KDADS on all substantiated ANE reports. All AIR reports are required to be submitted by direct entry into the KDADS web-based AIR system.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

MCO's review abuse, neglect, and exploitation with the Participant and their support team as a part of the Person-Centered Service Plan meetings. If there are concerns that indicate there is a risk/vulnerability that may make the participant vulnerable to abuse, neglect, or exploitation a safety plan may be included in the Person-Centered Service Plan.

The information given to the participants and their caregivers directs them to make reports directly to the Department of Children and Family Services if they suspect or are experiencing Abuse, Neglect, or Exploitation. The Department of Children and Family Services (KDCF) at its discretion may follow up directly with Law Enforcement, KDADS, KDHE, and/or MCOs if KDCF believe the situation and resolution requires their involvement.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

KDADS is the entity responsible for evaluating all adverse incident reports in accordance with KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110 and KDADS HCBS Adverse Incident Monitoring SOP. All events reported to AIRS are reviewed by KDADS staff to determine whether or not they meet the SOP definition of an adverse incident. Those that do not are screened out from further investigation by KDADS. Those that meet the definition are investigated by KDADS and contracted MCOs. Any event reported through AIRS that involves the possible abuse, neglect, exploitation or fiduciary abuse of children that was not reported first to DCF is immediately reported to DCF by KDADS for further investigation.

In accordance with the KDADS HCBS Adverse Incidents Monitoring Standard Operating Procedure (SOP), KDADS Program Integrity and Compliance Specialists (PICS) or their designated back-up(s) are responsible for checking AIRS for any newly reported adverse incident. AIRS will automatically distribute adverse incident reports for review based on the issue, KDADS provider/program type (e.g., Behavioral Health, Older Americans Act, Senior Care Act, HCBS Waiver), and county location of the incident. If data was entered incorrectly, the KDADS PICS must correct any errors, and re-route the review to the appropriate KDADS party. This process will occur within one business day of receipt of an adverse incident report.

If AIRS does not auto assign the adverse incident, the KDADS PICS will review the adverse incident report and assign it appropriately within AIR. If the member requires protective services intervention or review, the PICS will immediately notify and forward the adverse incident report to (DCF) for further investigation.

If an Adverse Incident was reported directly to DCF, DCF must adhere to the timeframes for incident review as defined in each of the HCBS waivers. DCF must notify KDADS outlining DCF's determination for the incident within five business days of the date of DCF determination, in accordance with the DCF Policy and Procedure Manual (Chapter 10320) and as defined in KSA 39-1433/38-2226.

For all submitted AIR reports, PICS first review AIRS adverse incident report information to determine if there is any indication of criminal activity and report any instances to law enforcement. If it is determined that there is suspected for Abuse, Neglect, Exploitation or Fiduciary Abuse, the KDADS PICS report immediately to DCF. Any areas of vulnerability would be identified for Additional training and assurance of education. PICS determine if the adverse incident report is screened in, screened out, or requires additional follow-up. Even for those incidents referred to DCF, PICS document the incident and notify the participant's MCO of the incident.

Within one business day of receiving an AIR report, KDADS PICS will determine the level of severity for each screened in adverse incident reported in AIRS and will assign a level of severity. Within one business day of a determination of the severity level PICS will notify the participant's MCO and discuss further required investigation, follow-up, and corrective action planning as applicable. In the event the incident requires further discussion within KDADS or with MCOs, the PICS will notify the appropriate Program Manager and then notify the MCO to schedule a meeting and discuss. All use of restraint, seclusion or restrictive interventions shall be reviewed by the MCO to ensure adherence to policy and appropriate follow-up in accordance with the KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110. MCOs will review the report, investigate the incident (as appropriate), and identify the actions taken by the MCO to conclude the investigation. MCO actions are documented within AIRS.

KDADS Program Integrity and Compliance Specialists will review all MCO summary findings for all incidents involving restraints, seclusion and/or restrictive intervention to determine appropriate use in accordance with the Member's Person-centered Service Plan. Corrective action plan (CAP) development, implementation and monitoring will comply with the KDADS HCBS Adverse Incidents Monitoring SOP. All use of restraint, seclusion or restrictive interventions shall be reviewed by the MCO to ensure adherence to policy and appropriate follow-up.

- The timeframes for investigating and completing an investigation:

Following the DCF Prevention and Protective Services (PPS) Policy and Procedure Manual (<http://content.dcf.ks.gov/PPS/robohelp/PPMGenerate/>) the Kansas Protection Report Center (KPRC) completes an initial assessment on all reports received to determine whether criteria is met to assign the report for further assessment. DCF assigns the response time, ranging from same day to 7 days, depending on whether abuse is suspected and other characteristics. PPS is required to make a case finding in 30 working days from case assignment, unless allowable reasons exist to delay the case finding decision.

All adverse incidents must be reported in AIRS no later than 24 hours of a mandated reported becoming aware of the incident as described in the KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110.

KDADS assigns the report to the participant's managed care organization within one business day of receiving the report. The managed care organization has 30 days to complete all necessary follow-up measures and return to KDADS for confirmation and final resolution.

- The entity that is responsible for conducting investigations and how investigations are conducted: DCF is responsible for contacting the involved child or adult, alleged perpetrator and all other collaterals to obtain relevant information for investigation purposes.

Review and Follow-up for Abuse, Neglect, Exploitation, and Fiduciary Abuse investigation and follow-up in accordance with

K.S.A. 39-1433 for adults, K.S.A. 38-2226 for children:

1. DCF is statutorily responsible for all Abuse, Neglect, Exploitation, and Fiduciary Abuse investigation and follow-up in accordance with K.S.A. 39-1433 for adults, K.S.A. 38-2226 for children, and DCF Prevention and Protection Services (PPS) Policy and Procedure Manual. DCF reportable event reports that come through AIRS will be reviewed by KDADS and referred to DCF, if the report indicates possible Abuse, Neglect, Exploitation, or Fiduciary Abuse of adults or children and requires protective services.
2. DCF will determine if the reportable event will be handled by Adult Protective Services (APS) or Child Protective Services (CPS). The investigation will conclude with an investigation status report that is sent to KDADS.
3. The report will not be assigned for further assessment or may be screened out after acceptance if the following apply:
 - a. The report does not meet the criteria for further assessment per DCF PPS Policy and Procedure Manual;
 - b. The event has previously been investigated;
 - c. DCF does not have the statutory authority to investigate;
 - d. Unable to locate family.
4. Not all reportable events require remediation; DCF shall determine which reportable events will result in remediation.

The process and timeframes for informing the participant (or the participant's family or legal representative as appropriate) and other relevant parties (e.g., the waiver providers, licensing and regulatory authorities, the waiver operating agency) of the investigation results includes:

1. Notice of Department Finding per DCF PPS Policy Number 2540:
 2. The Notice of Department Finding for reports is PPS 2012. The Notice of Department Finding informs pertinent persons who have a need to know of the outcome of an investigation of child Abuse/Neglect. The Notice of Department Finding also provides information regarding the appeal process.
 3. All case decisions/findings shall be staffed with the CPS Supervisor/designee and a finding shall be made within thirty (30) working days of receiving the report. DCF sends the Notice of Department Finding to relevant persons who have a need to know of the outcome of an investigation of child abuse/neglect on the same day, or the next business day, of the case finding decision.
 4. KDADS has primary responsibility for ensuring that all adverse incidents are reviewed and addressed in accordance with KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110 and KDADS Adverse Incident Monitoring SOP. Review and follow-up for all other adverse incidents shall be completed by KDADS or the MCO, depending on assigned level of severity.
 5. KDADS first reviews the adverse incident report information to determine if there is any indication of criminal activity or ANE that has not been reported to appropriate agencies. If the incident has not already been reported to DCF, KDADS reports it to DCF. KDADS next determines if the incident is screened in, screened out, or requires follow-up.
 6. For all screened in adverse incidents, KDADS staff assign a severity level. MCOs take steps for follow-up with providers/members and resolve the incident or implement remediation steps.
 7. KDADS tracks and approves MCO investigation and resolution steps. KDADS staff review MCO follow-up and resolution details.
- KDADS also determines if the incident should require a corrective action plan (CAP) outlining the deficiencies and necessary steps to resolve.
- KDADS monitors MCO CAP remediation efforts and required completion dates to ensure timely resolution.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

- The state entity or entities responsible for overseeing the operation of the incident management system.

KDADS is the entity responsible for overseeing the operation of the incidence management system called Adverse Incidence Reporting (AIR) system. Kansas Department for Children and Families, Division of Adult Protective Services is responsible for overseeing the reporting of and response to all critical incidents and events related to abuse, neglect and exploitation. Adult Protective Services maintains a data base of all critical incidents/events and makes available the contents of the data base to the Kansas Department for Aging and Disability Services and the Kansas Department of Health and Environment, single state Medicaid agency, on an on-going basis.

The methods for overseeing the operation of the (AIR) system, including how data are collected, compiled, and used to prevent re-occurrence.

The KDADS Quality Program Manager is responsible for reviewing the incidences reported to AIR and assigning incident to appropriate KDADS field staff for discovery, follow up and remediation. The Quality Program Manager and the DCF Adult Protective Services Program Manager gather, trend and evaluate data from both sources and report the data to KDADS CSP Director and the State Medicaid Agency.

The KDADS quality team is responsible for reviewing reported critical incidents and events. The data is collected and compiled, trended by waiver population so that it can be analyzed to enable the identification of trends/patterns and the development of quality improvement/ remediation strategies to reduce future occurrence of critical incidents or events. This information will also be a monitoring, reporting and follow up element of the comprehensive KanCare quality improvement strategy, managed the KanCare QI Strategy process to support overall quality improvement activities for the KanCare program.

KDADS conducts reviews on a quarterly basis to educate and assess the consumer's knowledge and ability and freedom to prevent or report information about Abuse, Neglect, and Exploitation. If it is determined that there is suspected for Abuse, Neglect or Exploitation, the KDADS Field Staff report immediately. Any areas of vulnerability would be identified for additional training and assurance of education.

MCOs are granted access to the Adverse Incident Reporting (AIR) system. Critical events or incidents submitted to the AIR systems are available to MCOs as part of KDADS notification to the MCOs a critical event had occurred. KDADS quality team has primary responsibility for ensuring the incidents are reviewed and addressed. KDADS quality team will reach out to the MCOs when collaboration and joint effort in follow up is necessary in order to effectively remediate an event or incident. Currently, DCF shares all APS determinations (Screened Out, Unsubstantiated and Substantiated) and Child Protective Services (CPS) provides intakes and screen-outs via the Community Support Services Protection Report Center (CSSPRC) mailbox. The reports received from DCF to the CSSPRC mailbox will be manually entered into the AIR system until the auto feed between DCF and AIR goes live. KDADS Program Integrity Staff monitor assigned counties and forward Substantiated reports to the corresponding waiver program manager, MCO Program

Integrity/Quality

Staff. Once the auto feed is complete all DCF reports will automatically be entered into AIR and Abuse, Neglect and Exploitation will only need to be reported to DCF. All DCF reports entered into AIR either manually or by auto feed will go through the same process as all other adverse incidents (verify info, assign to correct MCO for follow-up/remediation, and final review/remediation is done by KDADS). The AIR system will allow for all necessary parties to be notified.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

The state does not permit or prohibits the use of restraints

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

Kansas Department for Aging and Disability Services (KDADS) is responsible for monitoring and oversight of the use of restraints.. Information and findings are reported to KDHE (Kansas Department of Health and Environment) through quarterly/annual reports during the Long-Term Care Committee meeting.

- Methods for detecting use of restraint and ensuring that all applicable state requirements are followed:

All adverse incidents (including all uses of restraint) are required to be reported into the Adverse Incident Reporting System in accordance with KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110 and KDADS Adverse Incidents Monitoring SOP. This includes DCF reportable incidents of suspected Abuse, Neglect, Exploitation or Fiduciary Abuse perpetrated on a child or adult, after a DCF determination has been made that a specific incident has been screened out, unsubstantiated or substantiated. DCF is statutorily responsible for all Abuse, Neglect, Exploitation and Fiduciary Abuse investigation in accordance with K.S.A. 39-1433 and K.S.A. 38-2226.

A finding of screened out given to reports, submitted to DCF, that do not meet the statutory requirements for a DCF investigation. A finding of screened in is given to reports that meet the statutory requirements for a DCF investigation. A DCF screened in report will result in a substantiated or unsubstantiated finding after DCF performs an investigation. All reports from DCF will flow through the AIR system to KDADS once DCF has either screened the report out or made a determination of substantiated or unsubstantiated on a screened in report.

All screened out (unsubstantiated) and screened-in (substantiated) determinations by DCF meet the definition of an adverse incident and are entered into the AIR system for remediation and follow-up. For incidents that require follow-up, KDADS staff assign a level of severity to each screened in adverse incident. Depending on the level of severity, KDADS will determine if the incident should require a corrective action plan (CAP), as appropriate, and contact the MCO. MCO CAP remediation efforts and required completion dates are monitored by the appropriate KDADS staff.

All DCF determinations received by KDADS (screened in and screened out) are considered adverse incidents by KDADS and are entered into the AIR system for remediation and follow-up. The DCF determination informs KDADS' on the appropriate investigation and remediation steps that should be taken by the MCOs. For additional clarification, KDADS utilizes "screened in" classification to indicate that the incident meets the definition of an adverse incident and requires follow-up.

An incident classified by KDADS as screened out means that the incident does not meet the definition of an adverse incident. After such a finding, KDADS determines if any follow up is required (e.g., education to provider, participant, other reporter, or if the report should be forwarded to other appropriate agencies). If no follow-up is required, then the case will be marked as screened-out by KDADS and closed in the AIR system.

- How data are analyzed to identify trends and patterns and support improvement strategies:

KDADS will monitor data within AIR to assess:

- 1) AIR performance data on each health and welfare performance measure as identified in each HCBS waiver
- 2) Trend analysis by each HCBS waiver health and welfare performance measure (i.e. by incident type, by location, etc.)
- 3) Trend analysis on each adverse incident
- 4) Remediation efforts by health and welfare performance measure as identified in each HCBS waiver
- 5) Remediation efforts by each adverse incident

- The methods for overseeing the operation of the incident management system including how data are collected, compiled, and used to prevent re-occurrence:

Upon completion of statewide and MCO level AIR system data analysis, KDADS reviews the performance measure data reports to determine if there are performance measures that do not meet the state or national benchmarks, and whether the MCO provides comprehensive analysis with details and explanation for any deficiencies.

Based on any identified negative adverse trends associated with specific providers or provider sites, KDADS staff

will conduct as needed site visits to attempt to identify deficiencies that may be a factor associated with the identified negative adverse incident trend or trends.

- The frequency of oversight:

Oversight is ongoing, as indicated in AIRS Policy and Adverse Incident Monitoring Standard Operating Procedure. In addition, the following oversight activities occur related to monitoring MCO performance on investigating and remediation related to adverse incidents:

MCO Adverse Incident Remediation Audit

KDADS will review on a quarterly basis MCO performance in investigating and remediated adverse incidents, including:

- Reviewing MCO reported adverse incidents within AIRS data to evaluate how well MCOs are taking adequate action to report, resolve, and prevent adverse incidents
- Monitoring the time it takes the MCO to refer adverse incidents to the appropriate agency after becoming aware of the incident
- Following up with MCOs to identify systemic concerns and address them through implementation of a corrective action plan or other means, as appropriate

The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

- b. Use of Restrictive Interventions.** (*Select one*):

The state does not permit or prohibits the use of restrictive interventions

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

Kansas Department for Aging and Disability Services (KDADS) is responsible for monitoring and oversight of the use of restrictive interventions. Information and findings are reported to KDHE (Kansas Department of Health and Environment) through quarterly/annual reports during the Long-Term Care Committee meeting.

- Methods for detecting use of restrictive interventions and ensuring that all applicable state requirements are followed:

All adverse incidents (including all unauthorized use of restrictive interventions) are required to be reported into the Adverse Incident Reporting System in accordance with KDADS HCBS Adverse Incident Reporting and Management Standard Policy 2017-110 and KDADS Adverse Incidents Monitoring SOP. This includes DCF reportable incidents of suspected Abuse, Neglect, Exploitation or Fiduciary Abuse perpetrated on a child or adult, after a DCF determination has been made that a specific incident has been screened out, unsubstantiated or substantiated. DCF is statutorily responsible for all Abuse, Neglect, Exploitation and Fiduciary Abuse investigation in accordance with K.S.A. 39-1433 and K.S.A. 38-2226.

A finding of screened out is given to reports that do not meet the statutory requirements for a DCF investigation. A finding of screened in is given to reports that meet the statutory requirements for a DCF investigation. A DCF screened in report will result in a substantiated or unsubstantiated finding after DCF performs an investigation. All reports from DCF will flow through the AIR system to KDADS once DCF has either screened the report out or made a determination of substantiated or unsubstantiated on a screened in report.

All screened out (unsubstantiated) and screened in (substantiated) determinations by DCF meet the definition of an adverse incident and are entered into the AIR system for remediation and follow-up. For incidents that require follow-up, KDADS staff assign a level of severity to each screened in adverse incident. Depending on the level of severity, KDADS will determine if the incident should require a corrective action plan (CAP), as appropriate, and contact the MCO. MCO CAP remediation efforts and required completion dates are monitored by the appropriate KDADS staff.

All DCF determinations (screened out, substantiated and unsubstantiated) received by KDADS are considered adverse incidents by KDADS and are entered into the AIR system for remediation and follow-up. The DCF determination informs KDADS' on the appropriate investigation and remediation steps that should be taken by the MCOs. For additional clarification, KDADS utilizes "screened in" classification to indicate that the incident meets the definition of an adverse incident and requires follow-up. KDADS staff assign a level of severity to each screened in adverse incident. Depending on the level of severity, KDADS will determine if the incident should require a corrective action plan (CAP), as appropriate, and contact the MCO. MCO CAP remediation efforts and required completion dates are monitored by the appropriate KDADS staff.

An incident classified by KDADS as screened out means that the incident does not meet the definition of an adverse incident. After such a finding, KDADS determines if any follow up is required (e.g., education to provider, participant, other reporter, or if the report should be forwarded to other appropriate agencies). If no follow-up is required, then the case will be marked as screened-out by KDADS and closed in the AIR system.

- How data are analyzed to identify trends and patterns and support improvement strategies:

KDADS will monitor data within AIR to assess:

1. AIR performance data on each health and welfare performance measure as identified in each HCBS waiver.
2. Trend analysis by each HCBS waiver health and welfare performance measure (i.e. by incident type, by location, etc.).
3. Trend analysis on each adverse incident.
4. Remediation efforts by health and welfare performance measure as identified in each HCBS waiver.
5. Remediation efforts by each adverse incident.

KDADS staff provide the Kansas Department of Health and Environment (KDHE) with a report to the LTC Committee detailing the number of screened in and screened out AIR system adverse incident reports and provide an update on all CAPs issued, progress made, and completed.

- The methods for overseeing the operation of the incident management system including how data are collected, compiled, and used to prevent re-occurrence:

Upon completion of statewide and MCO level AIR system data analysis, KDADS reviews the performance measure data reports to determine if there are performance measures that do not meet the state or national benchmarks, and whether the MCO provides comprehensive analysis with details and explanation for any deficiencies.

Based on any identified negative adverse trends associated with specific providers or provider sites, KDADS staff will conduct as needed site visits to attempt to identify deficiencies that may be a factor associated with the identified negative adverse incident trend or trends.

- The frequency of oversight:

Oversight is ongoing, as indicated in the AIR System Policy and Adverse Incident Monitoring Standard Operating Procedure. In addition, the following oversight activities occur related to monitoring MCO performance on investigating and remediation related to adverse incidents:

MCO Adverse Incident Remediation Audit

KDADS will review on a quarterly basis MCO performance in investigating and remediated adverse incidents, including:

1. Reviewing MCO reported adverse incidents within AIRS data to evaluate how well MCOs are taking adequate action to report, resolve, and prevent adverse incidents.
2. Monitoring the time it takes the MCO to refer adverse incidents to the appropriate agency after becoming aware of the incident.
3. Following up with MCOs to identify systemic concerns and address them through implementation of a corrective action plan or other means, as appropriate.

KDADS will also meet quarterly with MCOs to discuss broader, systemic concerns and identify topics for provider and member education, as appropriate

The use of restrictive interventions is permitted during the course of the delivery of waiver services Complete Items G-2-b-i and G-2-b-ii.

- i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

- c. Use of Seclusion.** (Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to

WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)

The state does not permit or prohibits the use of seclusion

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that the state's safeguards are as followed:

The Kansas Department for Aging and Disability Services (KDADS) has primary responsibility for overseeing this issue, and works with the Kansas Department of Health and Environment (KDHE), as part of the comprehensive KanCare quality improvement strategy to monitor this service issue.

- Methods for detecting unauthorized use, overuse or inappropriate, ineffective use of seclusion and ensuring that all applicable state requirements are followed:

KDADS conducts on-going, on-site, in-person reviews to educate and assess the participant's knowledge, ability and freedom from the use of seclusion. If it is determined that there is suspected un-authorized use, the KDADS Field Staff report immediately. Any areas of vulnerability would be identified for additional training and assurance of non-aversive methods.

- How data are analyzed to identify trends and patterns and support improvement strategies, and the methods for overseeing the operation of the incident management system including how data are collected, compiled, and used to prevent reoccurrence:

KDADS Field Staff conduct quarterly, on-site, in-person quality reviews with the participant and his/her informal supports and paid staff supports to ensure there is no use of seclusion. Additionally, KDADS Field staff review planning for each participant to ensure appropriate supports and services are in place to eliminate the need for seclusion. On the rare occurrence of detection, the incident is addressed immediately. Any areas of vulnerability would be identified for additional training and assurance of non-aversive methods.

- The frequency of oversight: Continuous and ongoing

The Kansas Department for Aging and Disability Services (KDADS) has primary responsibility for overseeing this issue, and works with the Kansas Department of Health and Environment (KDHE), as part of the comprehensive KanCare quality improvement strategy to monitor this service issue.

Any use of restraints on a TA waiver member is unauthorized. All Restraints and Seclusions are required to be reported to the AIR system. Upon assignment KDADS and the MCO must identify if the use followed all requirements indicated in the Waiver Manual specific to the program in which the recipient is enrolled. If restraint, seclusion or restrictive intervention is utilized for a member receiving services under the TA waiver, this will automatically result in an unauthorized use. Utilization of any restraint, seclusion, or restrictive intervention that is not approved by the waiver will result in a Corrective Action Plan

The use of seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-c-i and G-2-c-ii.

- i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. **State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

- a. **Applicability.** Select one:

No. This Appendix is not applicable *(do not complete the remaining items)*

Yes. This Appendix applies *(complete the remaining items)*

- b. **Medication Management and Follow-Up**

- i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

- ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

- c. **Medication Administration by Waiver Providers**

Answers provided in G-3-a indicate you do not need to complete this section

- i. **Provider Administration of Medications.** *Select one:*

Not applicable. *(do not complete the remaining items)*

Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*

- ii. **State Policy.** Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and

policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. *Select one of the following:*

Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).

Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record*:

(c) Specify the types of medication errors that providers must *report* to the state:

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis,

identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. Sub-Assurances:

- a. Sub-assurance:** *The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

#/% of abuse, neglect, exploitation and unexpected death for which review/investigation resulted in identification of non-preventable causes. N: # and % of abuse, neglect, exploitation and unexpected death for which review/investigation resulted in the identification of non-preventable causes D: # of Abuse, Neglect, Exploitation, or unexpected death reported to KDADS

Data Source (Select one):

Other

If 'Other' is selected, specify:

State System (Adverse Incident Reporting System)

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>

	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

Number and percent of Abuse, Neglect, Exploitation, or death reported to KDADS for which review/investigation followed the appropriate policies and procedures. N: # of Abuse, Neglect, Exploitation, or death reported to KDADS for which review/investigation followed the appropriate policies and procedures D: # of Abuse, Neglect, Exploitation, or death reported to KDADS

Data Source (Select one):

Other

If 'Other' is selected, specify:

State System (Adverse Incident Reporting System)

Responsible Party for	Frequency of data	Sampling Approach
------------------------------	--------------------------	--------------------------

data collection/generation (check each that applies):	collection/generation (check each that applies):	(check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div></div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="text"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

- b. Sub-assurance:** *The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

& % of APS screen outs substantiated or unsubstantiated adverse incidents where KDADS subsequent review followed the appropriate policies and procedures N:# of APS screen outs,substantiated or unsubstantiated adverse incidents where KDADS subsequent review followed the appropriate policies and procedures D:# of APS screen outs,substantiated or unsubstantiated adverse incidents

Data Source (Select one):

Other

If 'Other' is selected, specify:

State System (Adverse Incident Reporting System)

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample

		Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Number and percent of Adverse Incidents reported to KDADS that were initiated and reviewed within the required timeframes. N: Number of adverse incidents reported to KDADS that were initiated and reviewed within required timeframes D: Number of adverse incidents reported to KDADS.

Data Source (Select one):

Other

If 'Other' is selected, specify:

State System (Adverse Incident Reporting System)

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

c. Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

& % of unauthorized uses of restraint,seclusion,or other restrictive interventions that followed appropriate policies and procedures
N: # of unauthorized uses of restraint,seclusion,or other restrictive interventions that followed appropriate policies and procedures
D: # of unauthorized uses of restraint,seclusion,or other restrictive interventions that were reported to KDADS

Data Source (Select one):

Other

If 'Other' is selected, specify:

State System (Adverse Incident Reporting System)

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
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State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

Number and percent of unauthorized uses of restrictive interventions that were appropriately reported. Numerator: Number of unauthorized uses of restrictive interventions that were appropriately reported. Denominator: Number of unauthorized uses of restrictive interventions

Data Source (Select one):

Other

If 'Other' is selected, specify:

State System (Adverse Incident Reporting System)

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	Other	

	Specify: <div></div>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

- d. Sub-assurance:** *The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of waiver participants who have a disaster backup plan.

Numerator: Number of waiver participants who have a disaster backup plan

Denominator: Number of waiver participants whose service plans were reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record Review

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95% confidence level; +/- 5% margin of error.</div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div>Proportionate by the MCO</div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Other Specify: <div></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Collaboration between the KDADS Field Staff and DCF-APS Social Worker occurs on an on-going basis to review trends and severity of Critical Events. KDADS Field Staff identify trends and severity with TA waiver providers to ensure adequate services and supports are in place. Additionally, KDADS conducts on-going, on-site, in-person reviews to educate and assess the participant's knowledge and ability and freedom to prevent or report information about Abuse, Neglect, and Exploitation. If it is determined that there is suspected Abuse, Neglect or Exploitation, the KDADS Field Staff report immediately. Any areas of vulnerability would be identified for additional training and assurance of education.

During quality review activities, in the event KDADS staff discovers any areas of vulnerability, the staff will issue findings and request remediation or corrective action depending upon the severity of the finding. In the event that protection from harm is necessary, KDADS staff will work with the managed care coordinator and providers to identify an alternative setting and immediately remove the individual from a dangerous environment. Any provider under investigation for ANE will be required to be suspended from providing services to the participant until the allegation can be substantiated and a corrective action leading to possible termination is necessary.

KDADS and Managed Care health plans are responsible for ensuring appropriate training and policies and procedures are put in place as part of the corrective action plan in order to ensure settings are secured, to the fullest extent possible, so that future occurrences are minimized.

DCF's Division of Adult Protective Services is responsible for overseeing the reporting of and response to all critical incidents and events. Adult Protective Services maintains a data base of all critical incidents/events and makes available the contents of the data base to the KDADS and KDHE on an on-going basis. The Performance Improvement Program Manager of KDADS-Community Services and Programs, and the DCF Adult Protective Services Program Manager, and Children and Family Services gather, trend and evaluate data from multiple sources that is reported to the KDADS-Community Services and Programs Director and the State Medicaid Agency.

These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. (The QIS is reviewed at least annually, and adjusted as necessary based upon that review.) That plan is contributed to and monitored through a state interagency monitoring team, which includes program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

KDADS-Community Services & Programs is responsible for oversight of critical events/incidents, and unauthorized use of restraints/restrictive procedures, in accordance with Kansas regulatory and statutory requirements. Oversight of regulatory standards and statute is conducted by KDADS Field Staff.

DCF-Child Protective Services (CPS) and DCF-Adult Protective Services (APS) maintain data bases of all critical incidents and events. CPS and APS maintain data bases of all critical incidents and events and make available the contents of the data base to KDADS and KDHE through quarterly reporting.

KDADS and DCF-Child Protective Services (CPS) and DCF-Adult Protective Services (APS) meet on a quarterly basis to trend data, develop evidence-based decisions, and identify opportunities for provider improvement and/or training.

State staff request, approve, and assure implementation of contractor corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through on-site monitoring, MCO compliance monitoring, survey results and other performance monitoring. These processes are monitored by both contract managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy.

During quality review activities, in the event KDADS staff discovers any areas of vulnerability, the staff will issue findings and request remediation or corrective action depending upon the severity of the finding. In the event, protection from harm is necessary KDADS staff will work with the managed care coordinator and providers to identify an alternative setting and immediately remove the individual from a dangerous. Any provider under investigation for ANE will be required to be suspended from providing services to the individual until the allegation can be substantiated and a corrective action leading to possible termination is necessary.

KDADS and managed care health plan is responsible for ensuring appropriate training and policies and procedures are put in place as part of the corrective action plan in order to ensure settings are secured to the extent possible so that future occurrences are minimized.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div>KanCare Managed Care Organizations (MCOs)</div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Kansas Department of Health and Environment (KDHE), specifically the Division of Health Care Finance, operates as the single State Medicaid Agency, and the Kansas Department for Aging and Disability Services (KDADS) serve as the operating agency. The two agencies collaborate in developing operating agency priorities to meet established HCBS assurances and minimum standards of service.

The sample for the quarterly desk review is based off of waiver standards and is statistically significant. As part of one of the performance measures in this waiver, a survey is mailed to each individual on the quarterly sample. The survey includes questions regarding current services and the individuals/guardians experience with HCBS services and the waiver. Results of this survey, if returned to the State, are logged into our Quality Review Tracking system and made available to HCBS KDADS staff. If there are concerns relayed in the returned survey, HCBS Quality Management Staff, will send an alert to the Program Manager. This alert contains information documented on the survey, so the Program Manager can follow up accordingly.

KDADS has a continual quality review process for the HCBS Performance Measures. This cycle is completed on a quarterly basis, giving continuous feedback to appropriate staff and stakeholders. The KDADS HCBS Quality Management Staff are responsible for desk reviews, for the various Performance Measures located in the waiver. Participants are selected for review based off of a statistically significant sample, pulled by KDADS, according to standards in the waiver.

KDADS Quality Assurance Team reviews quarterly submissions from the contracted assessor to ensure accurate information is being obtained and the Level of Care assessments are being completed correctly within the appropriate timeframe. KDADS Quality Assurance Team reviews quarterly submissions from the Managed Care Organizations to ensure accuracy and appropriateness of the Person-Centered Service Plan, to ensure health and welfare of the waiver children, to ensure adequacy of qualified providers and to ensure financial accuracy in billing. A representative sample of HCBS Waiver individual's case files, to include National Core Indicators (NCI surveys), will be selected quarterly by KDADS Financial and Information Services Commission (FISC), and assigned to the appropriate KDADS Quality Management Specialist (QMS) for review. The selected cases will include both Primary (P) and Secondary (S) listing of cases. Record cases open for 30 days or less, from MMIS eligibility date, are considered a "non-review" and will not be reviewed by QMS. A secondary case will be substituted when the case is deemed a "non-review."

FISC will generate and provide a report regarding findings to the KDADS Program Manager to review and to remediate as necessary.

KDADS Program Evaluation staff collect data, aggregate it, analyze it and provide information regarding discrepancies and trends to Program staff, Quality Review staff, KDHE staff, MCOs and other management staff. If systemic issues are found, several different remediation strategies are utilized, depending upon the nature, scope and severity of the issues. Strategies include but are not limited to;

- assign remediation plans and/or Quality Improvement Plan(s)
- re-education of best practices
- training of the QR staff to ensure the protocols are utilized correctly
- protocol revisions to capture the appropriate data
- policy clarifications to MCOs to ensure adherence to policy
- Meet with MCO LTSS Directors
- Interagency collaboration with KDHE and DCF.

KDADS compiles a quarterly report containing data for all of the HCBS Performance Measures. Results of these reports are distributed and reviewed internally at KDADS and KDHE, in addition to being posted publicly on the KanCare website. Also submitted by KDHE in KanCare Special Terms and Conditions quarterly and annual reports. KDADS compiles a quarterly report containing data for all of the HCBS Performance Measures. Results of these reports are distributed and reviewed internally at KDADS and KDHE, in addition to being posted publicly on the KanCare website. Also submitted by KDHE in KanCare Special Terms and Conditions quarterly and annual reports.

ii. System Improvement Activities

Responsible Party (<i>check each that applies</i>):	Frequency of Monitoring and Analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Quality Improvement Committee	Annually
Other Specify: <div>KanCare Managed Care Organizations (MCOs)</div>	Other Specify: <div></div>

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The Kansas Department on Aging (KDADS) and the Division of Health Care Finance within the Kansas Department of Health and Environment monitor and analyze the effectiveness of system design changes using several methods, dependent on the system enhancement being implemented. System changes having a direct impact on HCBS participants are monitored and analyzed through KDADS's Quality Review process. Additional questions may be added to the HCBS Customer Interview Protocols to obtain participant feedback, or additional performance indicators and policy standards may be added to the HCBS Case File Quality Review Protocols. Results of these changes are collected, compiled, reviewed, and analyzed quarterly and annually.

Based on information gathered through the analysis of the Quality Review data and daily program administration, KDADS Program Managers determine if the issues are systemic or an isolated instance or issue. This information is reviewed to determine if training to a specific Managed Care Organization is sufficient, or if a system change is required.

The Kansas Assessment Management Information System (KAMIS) is the official electronic repository of data about KDADS customers and their received services. This customer-based data is used by KDADS and the MCOs to coordinate activities and manage HCBS programs. System changes are made to KAMIS to enhance the availability of information on participants and performance. Improvements to the KAMIS system are initiated through comments from stakeholders, KDADS Program Managers, and Quality Review staff, and approved and prioritized by KDADS management. Effectiveness of the system design change is monitored by KDADS's Program Managers, working in concert with KDADS's Quality Review and Program Evaluation staff.

DHCF-KDHE contracts with DXC to manage the Medicaid Management Information System (MMIS). Improvements to this system require DHCF-KDHE approval of the concept and prioritization of the change. KDADS staff work with DHCF-KDHE and DXC staff to generate recommended systems changes, which are then monitored and analyzed by the fiscal agent and KDADS to ensure the system change operates as intended and meets the desired performance outcome.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Following is the process KDADS will use to identify and implement Quality Improvements and periodically evaluate the state's Quality Improvement Strategy:

Quarterly and as needed, KDHE and KDADS will meet monthly in their LTC meeting, to evaluate trends reflected in the HCBS Quality Review Reports and identify areas for improvement.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):

No

Yes (*Complete item H.2b*)

b. Specify the type of survey tool the state uses:

HCBS CAHPS Survey :

NCI Survey :

NCI AD Survey :

Other (*Please provide a description of the survey tool used*):

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Based on signed provider agreements, each HCBS provider is required to permit the Kansas Department of Health and Environment, the Kansas Department for Aging and Disabilities (KDADS), their designee, or any other governmental agency acting in its official capacity to examine any records and documents that are necessary to ascertain information pertinent to the determination of the proper amount of a payment due from the Medicaid program. Additionally, the Division of Legislative Post Audit contracts with an independent accounting firm to complete Kansas' statewide single audit on an annual basis. The accounting firm must comply with all requirements contained in the single audit act. The Medicaid program, including all home and community-based services waivers is a required component of the single state audit. Independent audits of the waiver will look at cost-effectiveness, the quality of services, service access, and the substantiation of claims for HCBS payments. These issues are addressed in a variety of ways, including: statewide single annual audit; annual financial and other audits of the KanCare MCOs; encounter data, quality of care and other performance reviews/audits; and audits conducted on HCBS providers. There are business practices of the state that result in additional ongoing audit activities that provide infrastructure/safeguards for the HCBS programs, including:

a. Each of the following HCBS provider entities are required to obtain and submit annual financial audits, which are reviewed and used to inform their Medicaid business with Kansas: Area Agencies on Aging; Community Mental Health Centers; Community Developmental Disability Organizations; and Centers for Independent Living. KDHE and KDADS oversees the MCOs. The MCOs are responsible for claims payment and recoupment. The MCOs are responsible for the member's Person-Centered Service Plan which authorizes the HCBS services. Claims for the fully authorized services are adjudicated in accordance with the claims processing guidelines and applicable Member due process rights. The MCOs are responsible for conducting financial audit activities of claims payment. EVV is not used for post-payment review of Personal Care Services (PCS) and Home Health Care Services (HHCS).

The State undergoes a yearly Single State Audit by a private contractor hired by the Kansas Legislative Research Dept. Part of the audit contains an in-depth review of the MCOs' claims data. CMS receives from the contractor a yearly complete audit report. CMS reviews the audit, and issues findings in which the agencies develop processes and procedures to address and close audit findings.

b. As a core provider requirement, FMS

b. As a core provider requirement, FMS providers must obtain and submit annual financial audits, which are reviewed and used to monitor their Medicaid business with Kansas.

Under the KanCare program, payment for services is being made through the monthly pmpm paid by the state to the contracting MCOs. (The payments the MCOs make to individual providers, who are part of their networks and subject to contracting protections/reviews/member safeguards.) Payments to MCOs are subject to ongoing monitoring and reporting to CMS, consistent with the Special Terms and Conditions issued with approval of the related 1115 waiver. Those STCs include both monitoring of budget neutrality as well as general financial requirements, and also a robust evaluation of that demonstration project which addresses the impact of the KanCare program on access to care, the quality, efficiency, and coordination of care, and the cost of care. The loading of capitation payments in the MMIS are reviewed for accuracy every 6 months by the KDHE finance team. This is a 100% review. Monthly, the KDHE finance team reviews the payment to MCOs against 834 file.

In addition, these services - as part of the comprehensive KanCare managed care program - will be part of the corporate compliance/program integrity activities of each of the KanCare MCOs. That includes both monitoring and enforcement of their provider agreements with each provider member of their network and also a robust treatment, consistent with federal regulation and state law requirements, of prevention, detection, intervention, reporting, correction and remediation program related to fraud, waste, abuse or other impropriety in the delivery of Medicaid services under the KanCare program. The activities include comprehensive utilization management, quality data reporting and monitoring, and a compliance officer dedicated to the KanCare program, with a compliance committee that has access to MCO senior management. As those activities are implemented and outcomes achieved, the MCOs will be providing regular and ad hoc reporting of results. KDHE will have oversight of all portions of the program and the KanCare MCO contracts, and will collaborate with KDADS regarding HCBS program management, including those items that touch on financial integrity and corporate compliance/program integrity.

The MCOs can only credential providers who meet the following qualifications.

Participant-Directed

1. Be at least eighteen years of age; or

2. Must have a High School Diploma or equivalent;
3. Have the necessary training or skills in order to meet the needs of the participant.
4. Must sign an agreement with a Medicaid-enrolled Financial Management Services (FMS) provider, acting as an administrative agent on behalf of the participant.
5. Medicaid enrolled provider, contracted and credentialed with KanCare MCO.

All staff must be in compliance with the KDADS' Background Check Policy. Any provider found identified to have been substantiated for prohibited offenses as listed in KSA 39-970 & 65-5117 is not eligible for reimbursement of services under Medicaid funding.

Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs verify provider qualifications.

Agency Directed

Licensed Home Health Agency

Certified Home Health Aide in accordance with K.S.A 65-5115 and K.A.R. 28-51-113.

- a) Must have a high school diploma or equivalent;
- b) Must be at least eighteen years of age or older;
- c) Must meet the agency's qualifications;
- d) Must reside outside of waiver recipient's home;
- e) Must be employed by and under the direct supervision of a home health agency licensed by the Kansas Department of Health and Environment, enrolled as a Medicaid provider to provide HCBS TA waiver services.
- f) Must meet KDADS approved skill training requirements

All standards, certifications and licenses that are required for the specific field through which service is provided including but not limited to:

1. Professional license / certification if required; adherence to KDADS training and professional development requirements; All staff must be in compliance with the KDADS' Background Check Policy. All standards, certifications and licenses that are required for the specific field through which service is provided including but not limited to: professional license / certification if required; adherence to KDADS training and professional development requirements; Kansas Department of Health and Environment (KDHE), through the state fiscal agent, and the KanCare MCOs verify provider qualifications.
2. Such individuals only provide the services to eligible participants with the frequency, amount, and duration specified in the plan of care.

As part of the quarterly record review, quality management staff review service plans based upon the performance measures outlined in the waiver. Additionally, the MCOs are responsible for ensuring care coordinators are trained and knowledgeable in the person-centered service planning specific to the applicable waiver.

The MCOs are responsible for claims payment and recoupment. The MCOs are responsible for the member's Person-Centered Service Plan which authorizes the HCBS services. Claims for the fully authorized services will be adjudicated in accordance with the claims processing guidelines and applicable Member due process rights.

The MCOs are responsible for conducting financial audit activities of claims payment.

The loading of capitation payments in the MMIS are reviewed for accuracy monthly by the KDHE finance team.

Some of the specific contractual requirements associated with the program integrity efforts of each MCO Include:

Coordination of Program Integrity Efforts.

The CONTRACTOR shall coordinate any and all program integrity efforts with KDHE/DHCF (Division of Health Care Finance) personnel and Kansas' Medicaid Fraud Control Unit (MFCU), located within the Kansas Attorney General's Office. At a minimum, the CONTRACTOR shall:

- a. Meet monthly, and as required, with the KDHE/DHCF staff and MFCU staff to coordinate reporting of all instances of credible allegations of fraud, as well as all recoupment actions taken against providers;
- b. Provide any and all documentation or information upon request to KDHE/DHCF or MFCU related to any aspect of this contract, including but not limited to policies, procedures, subcontracts, provider agreements, claims data, encounter data,

and reports on recoupment actions and receivables;

c. Report within two (2) working days to the KDHE/DHCF, MFCU, and any appropriate legal authorities any evidence indicating the possibility of fraud and abuse by any member of the provider network; if the CONTRACTOR fails to report any suspected fraud or abuse, the State may invoke any penalties allowed under this contract including, but not limited to, suspension of payments or termination of the contract. Furthermore, the enforcement of penalties under the contract shall not be construed to bar other legal or equitable remedies which may be available to the State or MFCU for noncompliance with this section;

d. Provide KDHE/DHCF with a quarterly update of investigative activity, including corrective actions taken;

e. Hire and maintain a staff person in Kansas whose duties shall be composed at least 90% of the time in the oversight and management of the program integrity efforts required under this contract. This person shall be designated as the Program Integrity Manager. The program integrity manager shall have open and immediate access to all claims, claims processing data and any other electronic or paper information required to assure that program integrity activity of the CONTRACTOR is sufficient to meet the requirements of the KDHE/DHCF. The duties shall include, but not be limited to the following:

- (1) Oversight of the program integrity function under this contract
- (2) Liaison with the State in all matters regarding program integrity
- (3) Development and operations of a fraud control program within the CONTRACTOR claims payment system;
- (4) Liaison with Kansas' MFCU;
- (5) Assure coordination of efforts with KDHE/DHCF and other agencies concerning program integrity issues.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of clean claims that are paid by the managed care organization within the timeframes specified in the contract. N=Number of clean claims that are paid by the managed care organization within the timeframes specified in the contract.
D=Total number of provider claims paid by the MCO Performance measure start date 7/1/2024

Data Source (Select one):

Other

If 'Other' is selected, specify:

MCO Reports

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<i>State Medicaid Agency</i>	<i>Weekly</i>	<i>100% Review</i>
<i>Operating Agency</i>	<i>Monthly</i>	<i>Less than 100% Review</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>	<i>Representative Sample</i> <i>Confidence Interval =</i> <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
<i>Other Specify:</i> <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	<i>Annually</i>	<i>Stratified Describe Group:</i> <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	<i>Continuously and Ongoing</i>	<i>Other Specify:</i> <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	<i>Other Specify:</i> <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other Specify:</i>	<i>Annually</i>

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

- b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of payment rates that were certified to be actuarially sound by the State's actuary and approved by CMS throughout the five year renewal cycle. $N =$ Number of payment rates that were certified to be actuarially sound by the State's actuary and approved by CMS. $D =$ Total number of capitation (payment) rates.
Performance measure start date 7/1/2024

Data Source (Select one):

Other

If 'Other' is selected, specify:

Actuary Documentation

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =

		<input type="text"/>
Other Specify:	Annually	Stratified Describe Group:
<input type="text"/>		<input type="text"/>
	Continuously and Ongoing	Other Specify:
		<input type="text"/>
	Other Specify:	
	<input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually
<input type="text"/>	
	Continuously and Ongoing
	Other Specify:
	<input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The state established a KanCare Interagency Coordination and Contract Monitoring (KICCM) to ensure effective interagency coordination as well as overall monitoring of MCO contract compliance. This work will be governed by the comprehensive state Quality Improvement Strategy for the KanCare program, which engages program management, contract management and financial management staff of both KDHE and KDADS.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive quality assurance strategy which is regularly reviewed and adjusted.

State staff request, approve, and assure implementation of contractor corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through on-site monitoring, survey results and other performance monitoring. These processes are monitored by both contract managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy. KDADS HCBS Program Managers participate in monthly long-term care (LTC) meetings with KDHE, and work with the KDADS Quality team on quarterly monitoring developing remediation for LOC Assessors and MCOs. Program Managers send out template for LOC assessors or MCO's to complete for Performance Measures that fall below 87% compliance. The assessor agency or MCO must complete the template with their remediation plan and return to the HCBS Director. Program Manager's review and accept or deny the plan and track progress on the remediation plan meeting compliance and continuously monitor for needed adjustments to meet remediation targets.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div>KanCare Managed Care Organizations (MCOs)</div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

- a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Under the KanCare comprehensive managed care program, capitation rates are established consistent with federal regulation requirements, by actuarially sound methods, which take into account utilization, medical expenditures, program changes and other relevant environmental and financial factors. The capitated rates are developed by a State Contracted Actuary. The resulting rates are certified to and approved by CMS.

Under managed care, HCBS provider rates are determined through contracting with the MCO while the state sets actuarial sound capitation rates that are paid to the MCO for each waiver beneficiary. The state sets the floor for the minimum rates that are required to be paid by the MCO, however. For the SED Waiver, the State's floor rates are based on prior fee for service rates and are available through KMAP. Capitation rates are based on actuarial analysis of historical data for all TA program services. These rates are based on historical claims and carried forward for KanCare Managed Care. The State's Contracted Actuary does not set provider floor rates.

All waiver services are included in the capitation rates.

Rate determination methods do not differ between Self-Directed and Agency Directed based services.

The State's Fee For Service rate schedule is determined by legislative appropriation.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Claims for services are submitted to the MCOs directly from waiver provider agencies delivering SED waiver services. All claims are either submitted through the MMIS portal, the State's front end billing solution or directly to the MCO either submitted through paper claim format or through electronic format. Capitated payments in arrears are made only when the participant was eligible for the Medicaid waiver program during the month.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

- c. Certifying Public Expenditures** (select one):

No. state or local government agencies do not certify expenditures for waiver services.

Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)

Certified Public Expenditures (CPE) of Local Government Agencies.

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability***I-2: Rates, Billing and Claims (3 of 3)***

- d. Billing Validation Process.** *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

capitated payment is made to the MCOs for each month of Waiver eligibility. This is identified through KAECEs, the State's eligibility system.

The state has been using an approved Electronic Visit Verification system for Personal Care Services since 2012. The state is on track to implement the extension of its EVV system to Home Health Care Services by December 3, 2023. Services subject to EVV pre-payment review will be Health maintenance monitoring, Intermittent Intensive Medical Care, Specialized Medical Care, Medical Respite, Agency-directed Personal Care Services, Personal Care Services (Self-Directed), and Financial Management Services. Visit information is captured in the EVV system, Authenticare, and processed through the rules engine to identify exceptions. Those exceptions are then worked within Authenticare. Authenticare creates the claims for validated visits. Paid claims are matched to the Authenticare claims in Authenticare. There will be a short-term exception to this process for HHCS. Although HHCS visit information will be captured and validated by the rules engine in Authenticare, between the go-live in December 2023 and March 2024, providers will create the validated claims for HHCS and the match to paid claims will be performed outside of Authenticare.

Post payment billings are conducted by the MCOs.

The State's Quality Management Staff (QMS) conducts quarterly and annual reviews, which includes reviewing case file documentation to see if choice was provided and if the participant signed the Choice document. Additionally, participant interviews have been completed, inquiring if they were provided choice. During the interview of the participant QMS identifies if a provider choice form was presented to the family, asks how the provider choice was decided and if services were rendered according to those identified on the participant's Service Plan.

- e. Billing and Claims Record Maintenance Requirement.** *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability**I-3: Payment (1 of 7)****a. Method of payments -- MMIS (select one):**

Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, waiver services are made through an approved MMIS.

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Claims furnished on an FFS basis are processed through the claim's engine, electronic MMIS system, based on the beneficiary's benefit plan. This benefit plan will cause the system to look for a PA for the beneficiary. The PA should include the code and the dates of service submitted on the claim. Claims will deny if a PA is not found or does not pertain to the information on the claim. The provider will be paid the rate on file for the procedure code or the rate on the PA.

Only Native American populations can opt out of managed care.

FFS providers have the option to be paid via a check or through EFT. Payment is made based on the provider's preference.

All other claims paid outside of the MMIS system are paid to the MCOs through a per member per month capitated payment. The claim is received and processed through the MMIS Claims Engine. The payment is sent to Financial to determine the funding for the payment. Some payments are made via capitated payments and those claims are paid on a per member per month capitated payment.

Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability**I-3: Payment (2 of 7)**

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):

The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.

The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.

The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

Claims furnished on an FFS basis are processed through the claim's engine, electronic MMIS system, based on the beneficiary's benefit plan. This benefit plan will cause the system to look for a PA for the beneficiary. The PA should include the code and the dates of service submitted on the claim. Claims will deny if a PA is not found or does not pertain to the information on the claim. The provider will be paid the rate on file for the procedure code or the rate on the PA.

Only Native American populations can opt out of managed care.

In the event a FFS participant chose to Self-Direct their services, those services would be provided by an FMS provider that is enrolled with the Medicaid Program that would act as a limited fiscal agent between the state and the participant/employer.

Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

All of the waiver services in this program are included in the state's contract with the KanCare MCOs.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

No. The state does not make supplemental or enhanced payments for waiver services.

Yes. The state makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. Specify whether state or local government providers receive payment for the provision of waiver services.

No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.

Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

No. The monthly capitated payments to the MCOs are not reduced or returned in part to the state.

Appendix I: Financial Accountability

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:

No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. Select one:

No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver

and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

This waiver is a part of a concurrent §1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(c) waiver specifies the types of health plans that are used and how payments to these plans are made.

If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

- a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

Appropriation of State Tax Revenues to the State Medicaid agency

Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

The non-federal share of the waiver expenditures is from direct state appropriations to the Department for Aging and Disability Services (KDADS), through agreement with the Single State Medicaid Agency, Kansas Department of Health and Environment (KDHE), as of July 1, 2012. The non-federal share of the waiver expenditures is directly expended by KDADS. Medicaid payments are processed by the State's fiscal agent through the Medicaid Management Information System using the InterChange STARS Interface System (iCSIS). iCSIS contains data tables with the current federal and state funding percentages for all funding types. State agencies are able to access iCSIS's reporting module to identify payments made by each agency. KDHE – Division of Health Care Finance draws down federal Medicaid funds for all agencies based on the summary reports from iCSIS. Interfund transfers to the other state agencies are based on finalized fund summary reports. The full rate will be expended on capitation payments in the KanCare program.

Other State Level Source(s) of Funds.

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

Not Applicable. There are no local government level sources of funds utilized as the non-federal share.

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability**I-5: Exclusion of Medicaid Payment for Room and Board**

a. Services Furnished in Residential Settings. Select one:

No services under this waiver are furnished in residential settings other than the private residence of the individual.

As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:

Do not complete this item.

Appendix I: Financial Accountability**I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver**

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:

No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)**

a. Co-Payment Requirements. Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:

No. The state does not impose a co-payment or similar charge upon participants for waiver services.

Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

Nominal deductible

Coinsurance

Co-Payment

Other charge

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the

collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Hospital

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	23949.66	21484.00	45433.66	105646.00	24881.00	130527.00	85093.34
2	23949.66	21484.00	45433.66	105646.00	24881.00	130527.00	85093.34
3	23949.66	21484.00	45433.66	105646.00	24881.00	130527.00	85093.34
4	23949.66	21484.00	45433.66	105646.00	24881.00	130527.00	85093.34
5	23949.66	21484.00	45433.66	105646.00	24881.00	130527.00	85093.34

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Hospital	
Year 1	1445		1445
Year 2	1445		1445
Year 3	1445		1445
Year 4	1445		1445
Year 5	1445		1445

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay estimate is derived from the unduplicated participants and the total days of actual waiver coverage from the CMS-372 reports for Waiver Years 2 and 3 (07/01/2020-06/30/2022). Based on that analysis, the State used an estimated average of 268 for the upcoming waiver period.

Based on programmatic assumptions, the State has no trends or indicators at this point to assume an increase or decrease in ALOS over the waiver period.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

Factor D was estimated by utilizing Managed Care encounter data from the Kansas Medicaid Management Information System and analyzing trends of annual utilization from June 2021 through July 2023. This is an estimate of MCO encounters and is not reflective of the State's capitation payments made to the MCO.

For all waiver services: The State assumes an increase in these services based on waiver growth trends and utilization from July 2021 through June 2023.

The average cost/unit or unit rate for all existing waiver services was updated to reflect the State Fiscal Year 2024 waiver service payment rates.

For the waiver renewal period, there is no growth rate applied to Factor D, as the State does not currently anticipate that there will be a significant change in rates over the next five years, as rate increases are dependent upon appropriation from the Kansas Legislature each year.

ii. Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' is projected by obtaining a two-year average (SFY2022 through SFY2023) of waiver capitation costs less a two-year average (SFY2022 through SFY2023) of MCO encounter payment costs. The waiver capitation costs and MCO encounter payment costs are derived from the Kansas Medicaid Management Information System.

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G is estimated by utilizing data from the Kansas Medicaid Management Information System and reflects the MCO encounter payments to providers for the institutional alternative, using a two-year average (SFY2022 through SFY2023).

The State used MCO encounters claims data from the Kansas Medicaid Management Information System as the base data in the derivation of Factors G and G' to most accurately represent the cost associated with those served in the institutional equivalent.

iv. Factor G' Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' is estimated by utilizing data from the Kansas Medical Management Information System and reflects the MCO encounter payments to providers for all services other than those included in Factor G, using a two-year average (SFY2022 through SFY2023).

The State used MCO encounters claims data from the Kansas Medicaid Management Information System as the base data in the derivation of Factors G and G' to most accurately represent the cost associated with those served in the institutional equivalent.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “manage components” to add these components.

Waiver Services	
Personal Care	
Occupational Therapy	
Physical Therapy	
Speech and Language Therapy	
Financial Management Services	
Behavior Therapy	
Cognitive Rehabilitation	
Enhanced Care Services	
Home and Environmental Modification Services (HEMS)	
Home-Delivered Meals Service	
Medication Reminder Services	
Personal Emergency Response System and Installation	
Specialized Medical Equipment and Supplies (SMES)	
Transitional Living Skills	
Vehicle Modification Services (VMS)	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care Total:							17454891.01
Personal Services - Agency-Directed		15 minutes	309	5122.27	4.55	7201655.51	
Personal Services - Self-Directed		15 minutes	571	4933.14	3.64	10253235.50	
Occupational Therapy Total:							2364545.55
Occupational Therapy		15 minutes	455	273.66	18.99	2364545.55	
Physical Therapy Total:							2649885.49
Physical Therapy		15 minutes	510	273.61	18.99	2649885.49	
Speech and Language Therapy Total:							1015270.73
Speech and Language Therapy		15 minutes	236	226.54	18.99	1015270.73	
Financial Management Services Total:							775154.16
Financial Management Services		1 month	657	8.41	140.29	775154.16	
Behavior Therapy Total:							1234720.12
Behavior Therapy		15 minutes	313	207.73	18.99	1234720.12	
Cognitive Rehabilitation Total:							3323250.00
Cognitive Rehabilitation		15 minutes	700	250.00	18.99	3323250.00	
Enhanced Care Services Total:							2565496.80
Enhanced Care Services		6-12 hours	137	199.96	93.65	2565496.80	
Home and Environmental Modification Services (HEMS) Total:							257400.00
Home and Environmental Modification Services (HEMS)		1 purchase	80	1.00	3217.50	257400.00	
Home-Delivered Meals Service Total:							1734160.47
Home-Delivered Meals Service		1 meal	678	423.47	6.04	1734160.47	
Medication Reminder Services Total:							27985.68
GRAND TOTAL:							34607255.93
Total: Services included in capitation:							34607255.93
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							1445
Factor D (Divide total by number of participants):							23949.66
Services included in capitation:							23949.66
Services not included in capitation:							
Average Length of Stay on the Waiver:							268

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Medication Reminder/Dispenser Installation		1 installation	16	1.04	27.18	452.28	
Medication Reminder/Dispenser		1 month	117	7.26	27.18	23087.24	
Medication Reminder		1 month	33	7.08	19.03	4446.17	
Personal Emergency Response System and Installation Total:							195980.13
Personal Emergency Response System Installation		1 installation	80	1.01	54.36	4392.29	
Personal Emergency Response System		1 month	598	8.42	38.05	191587.84	
Specialized Medical Equipment and Supplies (SMES) Total:							42900.00
Specialized Medical Equipment and Supplies (SMES)		1 purchase	80	1.00	536.25	42900.00	
Transitional Living Skills Total:							836915.82
Transitional Living Skills		15 minutes	131	852.96	7.49	836915.82	
Vehicle Modification Services (VMS) Total:							128700.00
Vehicle Modification Services (VMS)		1 purchase	10	1.00	12870.00	128700.00	
GRAND TOTAL: Total: Services included in capitation: Total: Services not included in capitation: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: Average Length of Stay on the Waiver:							34607255.93 34607255.93 1445 23949.66 23949.66 268

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care Total:							17454891.01
Personal Services - Agency-Directed		15 minutes	309	5122.27	4.55	7201655.51	
Personal Services - Self-Directed		15 minutes	571	4933.14	3.64	10253235.50	
Occupational Therapy Total:							2364545.55
Occupational Therapy		15 minutes	455	273.66	18.99	2364545.55	
Physical Therapy Total:							2649885.49
Physical Therapy		15 minutes	510	273.61	18.99	2649885.49	
Speech and Language Therapy Total:							1015270.73
Speech and Language Therapy		15 minutes	236	226.54	18.99	1015270.73	
Financial Management Services Total:							775154.16
Financial Management Services		1 month	657	8.41	140.29	775154.16	
Behavior Therapy Total:							1234720.12
Behavior Therapy		15 minutes	313	207.73	18.99	1234720.12	
Cognitive Rehabilitation Total:							3323250.00
Cognitive Rehabilitation		15 minutes	700	250.00	18.99	3323250.00	
Enhanced Care Services Total:							2565496.80
Enhanced Care Services		6-12 hours	137	199.96	93.65	2565496.80	
Home and Environmental Modification Services (HEMS) Total:							257400.00
Home and Environmental Modification Services (HEMS)		1 purchase	80	1.00	3217.50	257400.00	
Home-Delivered Meals Service Total:							1734160.47
Home-Delivered Meals Service		1 meal	678	423.47	6.04	1734160.47	
Medication Reminder Services Total:							27985.68
GRAND TOTAL:							34607255.93
Total: Services included in capitation:							34607255.93
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							1445
Factor D (Divide total by number of participants):							23949.66
Services included in capitation:							23949.66
Services not included in capitation:							
Average Length of Stay on the Waiver:							268

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Medication Reminder/Dispenser Installation		1 installation	16	1.04	27.18	452.28	
Medication Reminder/Dispenser		1 month	117	7.26	27.18	23087.24	
Medication Reminder		1 month	33	7.08	19.03	4446.17	
Personal Emergency Response System and Installation Total:							195980.13
Personal Emergency Response System Installation		1 installation	80	1.01	54.36	4392.29	
Personal Emergency Response System		1 month	598	8.42	38.05	191587.84	
Specialized Medical Equipment and Supplies (SMES) Total:							42900.00
Specialized Medical Equipment and Supplies (SMES)		1 purchase	80	1.00	536.25	42900.00	
Transitional Living Skills Total:							836915.82
Transitional Living Skills		15 minutes	131	852.96	7.49	836915.82	
Vehicle Modification Services (VMS) Total:							128700.00
Vehicle Modification Services (VMS)		1 purchase	10	1.00	12870.00	128700.00	
GRAND TOTAL: Total: Services included in capitation: Total: Services not included in capitation: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: Average Length of Stay on the Waiver:							34607255.93 34607255.93 1445 23949.66 23949.66 268

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care Total:							17454891.01
Personal Services - Agency-Directed		15 minutes	309	5122.27	4.55	7201655.51	
Personal Services - Self-Directed		15 minutes	571	4933.14	3.64	10253235.50	
Occupational Therapy Total:							2364545.55
Occupational Therapy		15 minutes	455	273.66	18.99	2364545.55	
Physical Therapy Total:							2649885.49
Physical Therapy		15 minutes	510	273.61	18.99	2649885.49	
Speech and Language Therapy Total:							1015270.73
Speech and Language Therapy		15 minutes	236	226.54	18.99	1015270.73	
Financial Management Services Total:							775154.16
Financial Management Services		1 month	657	8.41	140.29	775154.16	
Behavior Therapy Total:							1234720.12
Behavior Therapy		15 minutes	313	207.73	18.99	1234720.12	
Cognitive Rehabilitation Total:							3323250.00
Cognitive Rehabilitation		15 minutes	700	250.00	18.99	3323250.00	
Enhanced Care Services Total:							2565496.80
Enhanced Care Services		6-12 hours	137	199.96	93.65	2565496.80	
Home and Environmental Modification Services (HEMS) Total:							257400.00
Home and Environmental Modification Services (HEMS)		1 purchase	80	1.00	3217.50	257400.00	
Home-Delivered Meals Service Total:							1734160.47
Home-Delivered Meals Service		1 meal	678	423.47	6.04	1734160.47	
Medication Reminder Services Total:							27985.68
GRAND TOTAL:							34607255.93
Total: Services included in capitation:							34607255.93
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							1445
Factor D (Divide total by number of participants):							23949.66
Services included in capitation:							23949.66
Services not included in capitation:							
Average Length of Stay on the Waiver:							268

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Medication Reminder/Dispenser Installation	<input type="checkbox"/>	1 installation	16	1.04	27.18	452.28	
Medication Reminder/Dispenser	<input type="checkbox"/>	1 month	117	7.26	27.18	23087.24	
Medication Reminder	<input type="checkbox"/>	1 month	33	7.08	19.03	4446.17	
Personal Emergency Response System and Installation Total:							195980.13
Personal Emergency Response System Installation	<input type="checkbox"/>	1 installation	80	1.01	54.36	4392.29	
Personal Emergency Response System	<input type="checkbox"/>	1 month	598	8.42	38.05	191587.84	
Specialized Medical Equipment and Supplies (SMES) Total:							42900.00
Specialized Medical Equipment and Supplies (SMES)	<input type="checkbox"/>	1 purchase	80	1.00	536.25	42900.00	
Transitional Living Skills Total:							836915.82
Transitional Living Skills	<input type="checkbox"/>	15 minutes	131	852.96	7.49	836915.82	
Vehicle Modification Services (VMS) Total:							128700.00
Vehicle Modification Services (VMS)	<input type="checkbox"/>	1 purchase	10	1.00	12870.00	128700.00	
GRAND TOTAL: Total: Services included in capitation: Total: Services not included in capitation: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: Average Length of Stay on the Waiver:							34607255.93 34607255.93 1445 23949.66 23949.66 268

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care Total:							17454891.01
Personal Services - Agency-Directed		15 minutes	309	5122.27	4.55	7201655.51	
Personal Services - Self-Directed		15 minutes	571	4933.14	3.64	10253235.50	
Occupational Therapy Total:							2364545.55
Occupational Therapy		15 minutes	455	273.66	18.99	2364545.55	
Physical Therapy Total:							2649885.49
Physical Therapy		15 minutes	510	273.61	18.99	2649885.49	
Speech and Language Therapy Total:							1015270.73
Speech and Language Therapy		15 minutes	236	226.54	18.99	1015270.73	
Financial Management Services Total:							775154.16
Financial Management Services		1 month	657	8.41	140.29	775154.16	
Behavior Therapy Total:							1234720.12
Behavior Therapy		15 minutes	313	207.73	18.99	1234720.12	
Cognitive Rehabilitation Total:							3323250.00
Cognitive Rehabilitation		15 minutes	700	250.00	18.99	3323250.00	
Enhanced Care Services Total:							2565496.80
Enhanced Care Services		6-12 hours	137	199.96	93.65	2565496.80	
Home and Environmental Modification Services (HEMS) Total:							257400.00
Home and Environmental Modification Services (HEMS)		1 purchase	80	1.00	3217.50	257400.00	
Home-Delivered Meals Service Total:							1734160.47
Home-Delivered Meals Service		1 meal	678	423.47	6.04	1734160.47	
Medication Reminder Services Total:							27985.68
GRAND TOTAL:							34607255.93
Total: Services included in capitation:							34607255.93
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							1445
Factor D (Divide total by number of participants):							23949.66
Services included in capitation:							23949.66
Services not included in capitation:							
Average Length of Stay on the Waiver:							268

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Medication Reminder/Dispenser Installation		1 installation	16	1.04	27.18	452.28	
Medication Reminder/Dispenser		1 month	117	7.26	27.18	23087.24	
Medication Reminder		1 month	33	7.08	19.03	4446.17	
Personal Emergency Response System and Installation Total:							195980.13
Personal Emergency Response System Installation		1 installation	80	1.01	54.36	4392.29	
Personal Emergency Response System		1 month	598	8.42	38.05	191587.84	
Specialized Medical Equipment and Supplies (SMES) Total:							42900.00
Specialized Medical Equipment and Supplies (SMES)		1 purchase	80	1.00	536.25	42900.00	
Transitional Living Skills Total:							836915.82
Transitional Living Skills		15 minutes	131	852.96	7.49	836915.82	
Vehicle Modification Services (VMS) Total:							128700.00
Vehicle Modification Services (VMS)		1 purchase	10	1.00	12870.00	128700.00	
GRAND TOTAL: Total: Services included in capitation: Total: Services not included in capitation: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: Average Length of Stay on the Waiver:							34607255.93 34607255.93 1445 23949.66 23949.66 268

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care Total:							17454891.01
Personal Services - Agency-Directed		15 minutes	309	5122.27	4.55	7201655.51	
Personal Services - Self-Directed		15 minutes	571	4933.14	3.64	10253235.50	
Occupational Therapy Total:							2364545.55
Occupational Therapy		15 minutes	455	273.66	18.99	2364545.55	
Physical Therapy Total:							2649885.49
Physical Therapy		15 minutes	510	273.61	18.99	2649885.49	
Speech and Language Therapy Total:							1015270.73
Speech and Language Therapy		15 minutes	236	226.54	18.99	1015270.73	
Financial Management Services Total:							775154.16
Financial Management Services		1 month	657	8.41	140.29	775154.16	
Behavior Therapy Total:							1234720.12
Behavior Therapy		15 minutes	313	207.73	18.99	1234720.12	
Cognitive Rehabilitation Total:							3323250.00
Cognitive Rehabilitation		15 minutes	700	250.00	18.99	3323250.00	
Enhanced Care Services Total:							2565496.80
Enhanced Care Services		6-12 hours	137	199.96	93.65	2565496.80	
Home and Environmental Modification Services (HEMS) Total:							257400.00
Home and Environmental Modification Services (HEMS)		1 purchase	80	1.00	3217.50	257400.00	
Home-Delivered Meals Service Total:							1734160.47
Home-Delivered Meals Service		1 meal	678	423.47	6.04	1734160.47	
Medication Reminder Services Total:							27985.68
GRAND TOTAL:							34607255.93
Total: Services included in capitation:							34607255.93
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							1445
Factor D (Divide total by number of participants):							23949.66
Services included in capitation:							23949.66
Services not included in capitation:							
Average Length of Stay on the Waiver:							268

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Medication Reminder/Dispenser Installation		1 installation	16	1.04	27.18	452.28	
Medication Reminder/Dispenser		1 month	117	7.26	27.18	23087.24	
Medication Reminder		1 month	33	7.08	19.03	4446.17	
Personal Emergency Response System and Installation Total:							195980.13
Personal Emergency Response System Installation		1 installation	80	1.01	54.36	4392.29	
Personal Emergency Response System		1 month	598	8.42	38.05	191587.84	
Specialized Medical Equipment and Supplies (SMES) Total:							42900.00
Specialized Medical Equipment and Supplies (SMES)		1 purchase	80	1.00	536.25	42900.00	
Transitional Living Skills Total:							836915.82
Transitional Living Skills		15 minutes	131	852.96	7.49	836915.82	
Vehicle Modification Services (VMS) Total:							128700.00
Vehicle Modification Services (VMS)		1 purchase	10	1.00	12870.00	128700.00	
GRAND TOTAL:							34607255.93
Total: Services included in capitation:							34607255.93
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							1445
Factor D (Divide total by number of participants):							23949.66
Services included in capitation:							23949.66
Services not included in capitation:							
Average Length of Stay on the Waiver:							268