KDADS LTSS PUBLIC COMMENT MATRIX

Comment Period: 2/14/2024 - 3/18/2024 Program: Brain Injury

BRIEF DESCRIPTION OF DOCUMENT SUBMITTED FOR PUBLIC COMMENT AND COMMENT SUMMARY

Kansas Department for Aging and Disability Services

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#	Sender	Public Comment	KDADS Response
1.	Barb Conant, KanCare Advocates Network	1. Thank you for the opportunity to provide feedback on KDADS's proposed amendments to the Brain Injury Waiver. As a coalition, the KanCare Advocates Network (KAN) closely monitors KanCare policies, regulations, and legislation. Since its inception, our more than 50 partner organizations have worked with State agencies and the legislature to advocate for the 400,000 Kansans who depend upon KanCare, and its seven HCBS waiver programs for their health care and long-term supports and services.	
		2. We appreciate clarification on several important aspects of the waiver, including attendant care services, overlapping with rehabilitation services, PCS provision from family members and legal guardians, definition and diagnosis clarification, waiver to waiver transitions, and responsibility related to the person-centered service plan. One of our main concerns is the news that the waiver will be limited to three years for participants.	
		3. Over the past five years, work groups were convened to clarify the definition of progress on the waiver and develop a clear and consistent transition policy. However, the status of these efforts has not been communicated to waiver participants, providers, or to the KanCare managed care organizations (MCOs).	
		4. Our partners report waiver participants who choose not to receive services are continually re- referred for services after a provider recommends their transition. It appears the justification for a three-year cap on receiving waiver services is to avoid a waitlist and manage waiver volume. Avoiding a waitlist is a priority but there are better ways to manage volume such as enforcing current policies. For example, if the requirement were enforced requiring recipients to receive at least one rehabilitative service every 30 days an estimated 200 individuals could transition off the waiver.	4. Thank you for your comment. We will take this under further review.
		5. Requiring an MCO to initiate the proposed process for waiver participants who need to exceed the three-year timeframe creates a conflict of interest because the company is also responsible for authorizing services. As a person-centered waiver, the participant should be allowed to initiate this request. The proposed renewal application does not include a description outlining how participants coming can apply for an exception to stay on the waiver after three years. While three years may be enough time for some participants, it is not sufficient for everyone. This waiver is meant to be person-centered and should allow enough time for individuals to realize their full potential, both physically and cognitively, and in terms of work and community navigation. We are also concerned about the lack of specificity in the description of virtual delivery of services.	5. Thank you for your comment. We will take this under further review.
		6. The current description seems to be a one-size-fits-all approach, primarily focused on the delivery of PCS services. However, the proposed waiver amendments include the same description for each rehabilitative waiver service.	6. Thank you for your comment.
		7. The services vary greatly and should have respective descriptions that can be easily understood and implemented by both consumers and providers. Again, this seems counter to the goal of providing services that are person-centered. KAN supports the following recommendations offered by stakeholders during work group discussions. Implementing these recommendations enhances the quality and effectiveness of the services provided to consumers, ensuring that they receive the necessary therapy and support to achieve their goals and make meaningful progress.	7. Thank you for your comment.
		7a. The establishment of a review committee after four years of waiver participation. This committee would conduct ongoing utilization reviews to ensure that consumers are receiving the therapy services they desire and require.	

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		7b. Ongoing monitoring to ensure that consumers are actively working on their goals and making progress. This monitoring process will involve regular reviews of progress and goals with MCOs and providers. 8. In summary, we believe the focus of all efforts should be helping people become as self- sufficient as possible in their own home and community. We join other advocates in asking you to remove the three-year cap. Policies should support the management of the waiver to avoid a waiting list while assuring participants receive the right services, in the right place and the right time. Sean Gatewood, KAN co-administrator Barb Conant, KAN co-administrator	
2.	Janet Williams, Minds Matter, LLC	Our team at Minds Matter LLC has reviewed the Application for the BI Waiver with recommendations as it relates to the equipment approval process for members. Our organization has experienced significant challenges with members being able to access their benefits which offer standard medical equipment and home modifications. 1) This waiver also includes an additional vehicle modification section, which may increase the number of equipment needs/recommendations being made for members of the BI waiver. Members currently face many barriers to receiving equipment in a timely manner, which includes issues such as: -lack of identifying necessary medical equipment/home modification needs early in the MCO Service Coordination process -lack of communication between MCO and physician/provider/member in following the appropriate steps to approve medical equipment -poor responses from DME providers, leading to lengthy wait times -member being left out of all communication once an MCO has identified service providers for home modifications -members not being provided with a “denial” when equipment has been denied, thus they are unable to initiate an appeal process -members needs being disregarded for the sole focus of not exceeding the $10,000 lifetime threshold in spite of the availability of ILO funding -members with cognitive, communication, and physical challenges being held responsible for follow-up with physician pre-authorization process, filing through Medicare/primary, Medicaid/secondary, initiating Assistive Services review -lack of transportation accountability through the MCO provided program, which can oftentimes lead to missed appointments, inability to access scripts for equipment, inability to get assessed for specific equipment, etc. 2) For this reason, our team believes there are significant improvements which can be made to this process to promote the health and safety of members returning to their homes following a brain injury. Identifying equipment needs and improving the timeline for members to received recommended equipment will lead to improved health and safety, reduce risk of hospital readmissions, reduce caregiver burden/burnout, improve functional mobility/independence, reduce health issues associated as secondary diagnoses for individuals following a brain injury, and will maximize the length of time the individual is able to remain in their own home/community setting. Please see the following recommendations noted by our experienced team for updates/additions to the waiver as it is currently written:	1) Thank you for your feedback. We will take this back for further review as policy is being developed. 2) Thank you for your feedback. We will take this back for further review as policy is being developed.

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		3) Page 112, HEMS Paragraph 1: 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 3a) From any qualified provider? Does this mean they won't have to choose an in-network provider from the MCO list? Can they choose their own contractors to provide bids/assessments? a. Currently there are limited choices for consumers to choose for home modifications 3b) Most economical option available – Consumer's should have the option to see the bids. This is not currently being provided in all cases (maybe in any cases). 3c) Meets participants needs as documented by the chosen MCO – Currently, most instances requiring home modifications are being recognized by the provider level, not the MCO. Does this mean the MCO will have to identify and make recommendations? Or will the provider be able to make recommendations as is currently occurring?	3) Thank you for your feedback. We will take this back for further review as policy is being developed.
		4) Page 112, HEMS Paragraph 2: HCBS waiver funding is used as the funding of last resort and requires prior authorization from the MCO 4a) Previously, the waiver was amended to remove the need to seek outside resources for equipment. This should be upheld as there were significant delays from MCOs in requiring consumers/providers to seek outside funding resources (without limitation) leading to lengthy delays in obtaining equipment. Consumers/providers should not have to seek grants, funding, community resources, etc. prior to activating their waiver benefits for assisted services to ensure quick turnaround of updates which will improve quality of life and safety within the home setting.	4) Thank you for your feedback. We will take this back for further review as policy is being developed.
		Other: 5) Could there be a consideration for a timeframe the MCO/Home Modification Company can be held accountable for during this process? Currently, it is taking months to secure a company to complete bids, and at times, taking an additional 1-2 months from assessment/bid to submission of bids. The significant length of time being required from time of OT/PT home modification assessment by provider to the time work is approved can vary from 3 months to 1+ years, plus the time required to secure materials/labor to initiate project (an additional 4-6 week wait). This places consumers at significant risk for injury, increased risk for hospitalization, significant risk for depression/social isolation, sedentary lifestyle due to inability to access the home, and limits ease/accessibility to transportation/physician appointments/community access	5) Thank you for your feedback. We will take this back for further review as policy is being developed.
		6) Page 123, SMES Top Box: "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" 6a) Previously, the waiver was amended to remove the need to seek outside resources for equipment. This should be upheld as there were significant delays from MCOs in requiring consumers/providers to seek outside funding resources (without limitation) leading to lengthy delays in obtaining equipment. Consumers/providers should not have to seek grants, funding, community	6) Thank you for your feedback. We will take this back for further review as policy is being developed.

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		resources, etc. prior to activating their waiver benefits for assisted services to ensure quick turnaround of updates which will improve quality of life and safety within the home setting. 6b) Additionally, for low cost items (< $100-$200), has the state considered any options with contracting with online resources for quicker turnaround times to receive equipment? (i.e., prefabricated splints which could be ordered and delivered in < 1 week are currently taking months to go through the Medicaid approval process, MCO choosing of a DME provider, etc.). Again, quicker receipt of necessary equipment will reduce negative outcomes and promote increased independence/quality of life.	
		7) Page 123, SMES Payment: -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	7) Thank you for your feedback. We will take this back for further review as policy is being developed.
		8) Comment: Need a statement similar to the appeals process statement; a. "Members will receive a Notice of Denial in the mail if a denial of requested equipment has occurred." 8a) There is no guidance on approving these requests, and the waiver doesn't say anything about "members" requesting equipment, only that the MCO would determine if SMES is needed. 8b) It would be beneficial to have verbiage in this section about improving equipment to increase the safety and well-being of the member in the home, funds not to exceed $10,000 unless an ILO is created, with an appeals process lined out exactly as the one for services. This would improve the member's ability to understand the process and for providers to assist in the educational/advocacy component for members. Otherwise, MCO will not have the incentive to improve the current process which is leading to very lengthy delays/wait time for needed equipment items.	8) Thank you for your feedback. We will take this back for further review as policy is being developed.
		9) Page 129, VMS: Reimbursement for this service is limited to the participants disability and based on the person-centered service plan. Participants will have the choice to choose any qualified provider with consideration give to the most economical option available to meet the participant's assessed needs.	9) Thank you for your feedback. We will take this back for further review as policy is being developed.
		10) Is it participants choice, or is it per the MCO's in-network list of providers?	10) Thank you for your feedback. We will take this back for further review as policy is being developed.

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<tr><th>#</th><th>SENDER</th><th>PUBLIC COMMENT</th><th>KDADS RESPONSE</th></tr>
<tr><td></td><td></td><td>11) Most economical option via the in-network list, or via the consumer's provided contractors/providers? HCBS funding is used as the last resort funding source…

12) Previously, the waiver was amended to remove the need to seek outside resources for equipment. This should be upheld as there were significant delays from MCOs in requiring consumers/providers to seek outside funding resources (without limitation) leading to lengthy delays in obtaining equipment. Consumers/providers should not have to seek grants, funding, community resources, etc. prior to activating their waiver benefits for assisted services to ensure quick turnaround of updates which will improve quality of life and safety within the home setting. The MCO shall request an in-home or remote assessment, as appropriate, of the participant's needs and recommendations from a therapist or person qualified to complete home usability/accessibility assessments.

13) Does this mean the MCO will pay for a driving assessment as well for individuals who may need accommodations to their vehicle? The qualifying vendors/providers (such as RHOP Driving Program or AbilityKC driving program) would not be able to complete recommendations without the necessary assessment.

14) Will training on the use of the modifications include these driver rehabilitation programs specifically focused to ensure safety with use of compensatory/adaptive strategies to return to driving? Will training be paid for based on recommendations from the qualifying vendor (i.e. 1 treatment session, 10 treatment sessions, etc.)

Other:
15) Will insurance pay for annual (or more frequent if recommended by a professional) assessment of the functioning equipment/vehicle modifications to ensure proper upkeep? (I.e. wheelchair ramps, gas/brake pedal functioning, hand controls, battery functioning, etc.)

15a) This should be no different than annual assessments/upkeeps of power wheelchairs, hospital beds, generators, etc. for focus on safety and limiting exposure to malfunctioning equipment. 13. Is there any consideration in raising the cost of the $10,000 limit? Vehicle modifications and home modifications individually will meet this threshold/limit quickly. The limit was at $10,000 prior to the inclusion of vehicle modifications, and it significantly reduces the likelihood of insurance approving home modifications + vehicle modifications for the same consumer, even with the in lieu of services benefit. a. The cost of labor is increasing due to inflation.

15b) Cost of lumber, tile, materials, appliances, ramps, etc. is increasing due to inflation.

15c) Cost of vehicle modifications are significant (for wheelchair access, control adjustments, etc.)</td><td>11) Thank you for your feedback. We will take this back for further review as policy is being developed.

12) Thank you for your feedback. We will take this back for further review as policy is being developed.

13) Thank you for your feedback. We will take this back for further review as policy is being developed.

14. Thank you for your feedback. We will take this back for further review as policy is being developed.

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<tr><td>3.</td><td>Erica Bates, Minds Matter LLC</td><td>p 22, 1st bullet says CDDOs do the level of care evaluation initially, annually, and when there is a change in condition. This should be the ADRCs</td><td>Thank you for your feedback. We will amend language in the policy.</td></tr>
<tr><td>4.</td><td>Erica Bates, Minds Matter LLC</td><td>1) We appreciate clarification on several important aspects of the waiver, including attendant care services, overlapping with rehabilitation services, PCS provision from family members and legal guardians, definition and diagnosis clarification, waiver to waiver transitions, and responsibility related to the person-centered service plan.</td><td>Thank you for your feedback. We will take this back for further review.</td></tr>
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		2) One of our main concerns is the news that the waiver will be limited to any timeframe. Over the past five years, work groups were convened to clarify the definition of progress on the waiver and develop a clear and consistent transition policy. However, the status of these efforts has not been communicated to waiver participants, providers, or MCOs (Managed Care Organizations). We have observed that there are participants on the waiver who do not receive services simply because they do not want them, but they are continually re-referred for services after a provider recommends their transition. 3) It seems that implementing a three-year maximum participation timeframe on the waiver is primarily to avoid a waitlist and manage waiver volume. While avoiding a waitlist is important, there are better ways to manage volume. 4) According to the BI waiver provider manual, eligibility for the waiver is contingent upon participation in at least one rehabilitative service every 30 days. If this requirement were enforced, approximately 200+ individuals could transition off the waiver currently. 5) We appreciate that there is a proposed process for waiver participants who need to exceed the three-year timeframe, but it is concerning that this process must be initiated by the MCO. This creates a conflict of interest, as the MCO is the entity responsible for authorizing services. 6) As a person-centered waiver, the participant should be allowed to initiate this request. Furthermore, there is no description provided on how new participants coming onto the waiver can apply for an exception to stay on the waiver after three years. While three years may be enough time for many participants, it is not sufficient for everyone. 7) This waiver is meant to be person-centered and should allow enough time for individuals to realize their full potential, both physically and cognitively, and in terms of work and community navigation. During work group participation, we have consistently recommended the following measures, which have also received agreement from other stakeholders. 7a) Firstly, we propose the establishment of a review committee after four years of waiver participation. This committee would conduct ongoing utilization reviews to ensure that consumers are receiving the therapy services they desire and require. 7b) Secondly, we advocate for ongoing monitoring to ensure that consumers are actively working on their goals and making progress. This monitoring process will involve regular reviews of progress and goals with Managed Care Organizations (MCOs) and providers. 7c) By implementing these recommendations, we aim to enhance the quality and effectiveness of the services provided to consumers, ensuring that they receive the necessary therapy and support to achieve their goals and make meaningful progress. Another glaring concern is the lack of specificity in the description of virtual delivery of services (VDS). 8) Currently, the description seems to be a one-size-fits-all approach, primarily focused on the delivery of PCS services. However, the proposed waiver amendments include the same description for each rehabilitative waiver service. This is problematic as the services vary greatly and should have respective descriptions that can be easily understood and implemented by both consumers and providers.	

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		9) Last year during the public feedback sessions, these same concerns were communicated by providers. KDADS responded by saying the focus was on PCS, but that is not conveyed in this document. In summary, we have outlined specific comments and questions below: 10) Brief Waiver Description (p5) Comments about habilitative services. Remove the word, "youth" after habilitation as participants may need habilitative services regardless of age. Same on (p50, paragraph 1). 8. Authorizing Signature, Attachment 1: Transition Plan Section(p12) Comments about Those wanting to stay on that have currently been on 3+ years says MCO can request a special services review. The participant should be able to request this review as this is a person-centered waiver and the MCO presents a conflict of interest as the authorizing entity. Authorizing Signature, Attachment 11) Home and Community-Based Settings Waiver Transition Plan, Additional Information Needed 11a) (p14)-What entity approved written VDS policies? How are requirements from rehabilitation providers different from PCS providers? 11b) . 14 b. How will you know the virtual delivery service does not isolate the participant from the community? 11c) e. VDS is not and shall not be used for the provider's convenience. –What if there is a staffing issue in rural areas for example, this could be viewed as convenient? 11d) h. Development of written policies, train direct support staff on those policies: How will virtual PCS services be different from duties that direct support staff may be completing? For the PCSP – does it need to be specified that it's VDS only or can there be verbiage "and/or" for flexibility of choice or special circumstances? 12) Appendix B: Participant Access and Eligibility, 12a) B-1: Specification of the Waiver Target Group(s) 12b) b. Additional Criteria (p32)-5th bullet says documentation should also include recommendation of the need for extended therapies are needed to regain physical and independent living skills for adults and assist youth with relearning/developing skills peers have-can be clinical doc or KDADS form-has this changed? 13) Appendix E: Participation Direction of Services, E-1: Overview (12 of 13), m. Involuntary Termination of Participant Direction (p187): Comments about MCO may, if appropriate, discontinue the participant's choice to selfdirect. Again, as an entity responsible for managing and authorizing one's care, the MCO should not have this level of authority as it is not person centered and presents a conflict of interest. In summary, we believe the focus of all efforts should be on maximizing the use of the brain injury waiver so people can become as self-sufficient as possible in their own home and community. 14) To that end, we urge that people not be cut off from services at 3 years and instead, the waiver be managed in a way to that not only avoids a waiting list but also makes sure that all participants receive the right services, in the right place and the right time.	

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5.	Amber Ring	My daughter just had to switch to IDD to receive services she needs. She should not have been made to do this. BI are different from IDD in ways. She does not feel she fits in where she is. Providers are doing minimum where she is. Thank you for your time.	Thank you for your comment and testimony.
6.	Kelli Robinson Parent of TBI child	Please do not put a time limit put in the brain injury waiver amendment. Please, if you if you put that in policy, have a process to review progress, not something that puts people on a time limit. My daughter had a severe TBI and continues to make progress, 10 years later. TBIs do NOT go away. There is no cure. people with brain, injuries and family should not be penalized for a broken system.	Thank you for your comment and testimony.
7.	AmyRenee Sheldon BIAKS	Recovery from a Brain injury lasts a lifetime. The rule that you only had 2 years of meaningful recovery has been proven wrong. Recovery from a brain injury is like recovery from any injury, there will be a plateau period where there is no progress because the brain is resting and healing. Think of weight loss, you can lose the first 5-10 lbs easily, then you hit a plateau where you lose very little weight. Your body is not failing, it is resting and adjusting. As soon as your body rests, heals, and adjusts, you can start doing harder, longer, different workouts, and then you will lose more weight. So too with the brain. it is healing, resting, and adjusting. Do you want all those neurons in the brain to heal correctly or heal fast? Because you cannot have both. It took me 5 years to start to feel normal after my brain injury. During my rehab, my parents and I were constantly told that after the initial plateau, I would have no more recovery. I was told that I had 2 years to recover from a brain injury. Thankfully, I did not listen to the experts. Two years after my brain injury, I could not hold a job, barely passed college classes, and could not live by myself. 24 years later, I earned my 2nd Bachelor's degree with a GPA of 3.96 and am working on my Master's degree. I work as a para, live with my parents because they are elderly and in poor health, but run the house on my own. Had I listened to the experts, I would have given up and stopped working to recover and learn. it takes a long time for the brain to create new pathways for neurons. There should be no limit on the brain injury waiver. I saw the years of mess in chaos in Overland Park as the 435-I-35-69 highway interchange was fixed. It was horrible, a mess, slow, and confusing during construction. Everyone kept telling the public to just wait, construction will be finished and everything will be better. Completion was delayed because of weather and other issues. The public waited and dealt with the chaos that was 435-I-35-69 highway interchange. Then it was finished. It is great. I can go I-35 south to 435 West on to 435 north without changing lanes, merging over, or exiting. It is faster to go this route than to go down 87th Street parkway to get to 435 north. This is not about construction. This is an analogy of healing after a brain injury. A brain does heal, but it takes time. In the early stages of recovery, the brain in a mess. Just like the 435-I-35-69 highway interchange mess. I could not exit I-35 from 435 for over a year, I had to go longer time wise and further distance to 69 highway to exit onto 87th street or 95th street. It was a royal mess, it took longer and cost more gas money. The brain is a confusing, jumbled mess while it is healing. Then, I got used to either going 435 north to 87th street parkway in Lenexa or 435 east to 69 highway to exit on 87th St in Overland Park. It was the new normal, a plateau if you will. Then I-35 opened back up and the new lane from I-35 to 435 West-north is smooth, fast, and convenient. It took awhile, but the new 435 west/north exit is one complete	Thank you for your comment and testimony.

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		loop and I do not have to enter a highway, merge, exit, and merge again. This is is how a brain works when new neuron pathways regrow. neurons do not grow like a broken bone, they take a long time -years- to regrow. The brain will work to heal itself. Neurology has researched this. I am living proof of brain plasticity. I was not supposed to complete my college degree (I have 2 bachelor degrees and am working on my masters), I was not supposed to get over a 2.0 GPA (I graduated with my 2nd Bachelor's earning a 3.96 GPA). I was not supposed to be able to take care of myself (I am a caregiver for my elderly parents). I was not supposed to drive (I haven't had a speeding ticket or car accident that was my fault for over 15 years). I healed over 90% from my brain injury (I was t-boned by a speeding semi, in a coma for 12 days, and verbally and emotionally abused by nursing staff in the rehab hospital). Every person with a brain injury should be able to recover for however long it takes them. The brain does not know time limits when it is healing, waivers should not know time limits either. Let the brain heal without time limits!	
8.	Leslie Anderson K4AD	**1 Appendix A: Waiver Administration and Operation** **3. Use of Contracted Entities b. Medicaid Agency Oversight of Operating Agency Performance.** **KDADS proposes:** KDADS contracts with the Aging and Disability Resource Centers (ADRC) to: -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. **k4ad response:** Aging and Disability Resource Centers (ADRC) perform initial and annual assessments for individuals seeking access to the BI Waiver. However, proposed waiver language omits this responsibility under the list of contractual responsibilities of the ADRC, and vaguely implies the ADRC may include the function of assessments. Comparing the existing waiver language, KDADS intends to eliminate the single point of entry or No Wrong Door system. Medicaid is complex and often disjointed, and separating services will cause fragmentation and significant confusion, although the ADRC is designed as a single entryway into long-term supports and services for the BI, FE, and PD waiver populations. Well-intentioned actions have unintended consequences to making things ineffective and inefficient and causing fragmentation; resulting in ineffective and inefficient methods. Subsequently, fragmentation is often a strategy designed to decrease health care utilization. **K4ad recommendation:** Replace proposed language with existing language that supports an effective and efficient single point of entry or No Wrong Door system using existing waiver language: -KDADS contracts with the Aging and Disability Resource Centers (ADRC) to receive HCBS referrals, provide options counseling, complete the standard intake and conduct the functional eligibility assessment for the BI waiver. **5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** **KDADS proposes:** Level of care evaluation (initially, annually and when there is a change in condition) Assessment is completed by the CDDO.	Thank you for your feedback. We will take this back for further review.

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		k4ad response: Under the current waiver, a CDDO has the responsibility to "assess all persons with developmental disabilities for the I/DD Program," and may "accept a referral of an individual prior to BI screening." The proposed language reflects that a CDDO will have responsibility to identify whether an individual has a brain injury or I/DD, which is a perceived conflict of interest, whereas, the assessing entity must be conflict-free regarding a perceived or actual conflict of interest. An ADRC provides information to every consumer in the situation where Reasonable Indicators suggest potential eligibility for I/DD waiver services, and make an appropriate referral to the CDDO. The amended language is a perceived conflict-of-interest addressed in the Kansas Response to Site CMS Visit March 2023: Summary of Findings, dated June 23, 2023. **k4ad recommends:** Replace proposed language with language in the existing waiver: -KDADS contracts with the Aging and Disability Resource Centers (ADRC) to receive HCBS referrals, provide options counseling, complete the standard intake and conduct the functional eligibility assessment for the BI waiver. **KDADS proposes:** The State contracts with a number of entities to assist with carrying out needed waiver administration and operation activities, and exclusively states: • Level of care evaluation (initially, annually and when there is a change in condition) Assessment is completed by the CDDO. **k4ad response:** Current waiver language designates the Kansas Department for Aging and Disability Services / Community Services and Programs Commission for the function to assess performance. However, under the proposed waiver amendment, KDADS and the Commission are omitted and replaced with substantial changes, which signals preference and initiates a conflict-of-interest. Under K.S.A. 39- 1803(d), a "Community developmental disability organization means any community facility for people with intellectual disability that is organized pursuant to K.S.A. 19-4001 through 19-4015, and amendments thereto." The ADRC is omitted from this section, signaling a preference of a CDDO for all assessments, and thus initiating a conflict-of-interest. **k4ad recommends:** Replacing the proposed language "Level of care evaluation (initially, annually and when there is a change in condition) Assessment is completed by the CDDO" with "Level of care evaluation (initially, annually and when there is a change in condition) by the contracted assessing entity **Appendix B: Participant Access and Eligibility. B-1: Specification of the Waiver Target Group(s).** **KDADS proposes:** 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[s] them in the designated state management information system. Administrative Case Management may be utilized to obtain needed documentation and to apply for KanCare. **k4ad response:** The reference to the ADRC's responsibility significantly contradicts other proposed waiver language, referenced in these comments. We commend KDADS for the inclusion of the ADRC to screen for reasonable indicators, although the ADRC (assessing entity) also performs the functional eligibility assessment to determine the level of care and additional responsibilities for KDADS to determine functional eligibility. The ADRC specialized expertise and longevity of	

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		contracting to provide information, referral and assistance, options counseling, and functional assessments demonstrates the commitment of Kansas to implement an effective coordinated health care system to ensure access to needed supports and services. We sincerely applaud KDADS/KDHE for implementing a Single Point of Entry or single doorway into HCBS for long-term supports and services. **k4ad recommends:** Amend proposed language in the previous sections, as noted above, to align with language in B-1 of Appendix B. **2 Appendix B: Participant Access and Eligibility. 8-6: Evaluation/Reevaluation of Level of Care: c: Qualifications of Individuals Performing Initial Evaluation.** **KDADS proposes:** Maintaining current waiver language: "Qualifications of functional eligibility assessors [to require a] 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. **k4ad response:** We commend KDADS for recognizing that professionalism enhances relationships and advances person-centered care. The level of assessor qualifications underpins the delivery of accountability, evidence-based principles, and consistent services provided by an ADRC. With the growing importance of professionalism in our healthcare system, it *is* crucial that assessing entities implement a level of knowledge, technical skills, clinical reasoning and behaviors that attribute to professional conduct and competence. **k4ad recommends:** Preserve existing language requiring a four-year degree. **3 f. Process for Level of Care Evaluation/Reevaluation:** **KDADS proposes:** 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 **k4ad response:** The Reasonable Indicators determine eligibility for the Physical Disability Waiver, which means that if the BI eligibility criteria requires screening for habilitative/rehabilitative therapies, a modification of the indicators is necessary. **k4ad recommends:** Upon approval from CMS, KDADS modifies the Reasonable Indicators. .**Procedures to Ensure Timely Reevaluations.** **KDADS proposes:** Maintaining language in the current waiver: The contractor receives a monthly reassessment report from KDADS with a list of all waiver participants that have assessments expiring within 30 days. **k4ad response:** The monthly reassessment report from KDADS is a valuable tool for continuous improvement processes. However, considering the challenges of locating an HCBS beneficiary, the timeline must be extended to meet the reassessment	

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		deadline of 365 days. In some instances, a guardian and/or power of attorney must be included in the assessment/reassessment, and it takes a substantial amount of coordination to accompany legal representatives. **k4ad proposes:** Amend the reassessment expiration within 30 days to 60 days. **4 General comments on BI Waiver Amendment:** The term "contracted assessor" is used throughout the BI Waiver. Although this term may imply "contracted assessing entity," the language should specifically designate the contracted assessing entity as a whole. The BI Waiver application may contain errors or unintentional language, as discovered in Section 5 (above). Although this may simply be an oversight, CMS approves content within the submitted application or as amended with specific CMS recommendations. This means that policies and operational protocol, governed by an approved waiver containing errors or unintentional language, must also be amended, or KDADS must submit an amendment for corrections to be made, which is at their discretion. Therefore, k4ad recommends that errors and unintentional language brought to KDADS' attention be strongly considered for an amendment contingent upon the level of risk and/or harm to beneficiaries, caregivers, and/or the provider network. We appreciate the opportunity to provide comments and recommendations on the proposed amendments to the Brain Injury Waiver application. Our overall arching goal is that an individual has the ability to access appropriate long-term supports and services. To ensure this goal is achieved, k4ad strongly recommends the waiver to support conflict-free relationships. Our recommendations may cause additional questions to arise, and we will be available to provide clarification as needed.	
9.	Daniel Goodman Kansas Advocates for Better Care	RE: Public Comment for Brain Injury Waiver Proposed Amendments Thank you for allowing public comment on this important issue. Kansas Advocates for Better Care seeks to provide feedback on proposed amendments to the Brain Injury Waiver. Our main concern is the potential limitation of the waiver being tied to a specific timeframe, as this could affect individuals' access to necessary services. KABC advocates for a comprehensive person-centered approach that ensures individuals receive appropriate support tailored to their needs. Attaching a timeframe to a persons access to care could be detrimental to an individual's ability to recover from injury. We believe that the goal should be to maximize the effectiveness of the waiver in promoting independence of the individual and their well-being within the community	Thank you for your feedback. We will take this back for further review.
10.	Heather Pinkerton Brain Injury Association of Kansas and Greater KC	We would like to provide feedback on the proposed amendments to the Brain Injury Waiver. We appreciate clarification on several important aspects of the waiver, including attendant care services, overlapping with rehabilitation services, PCS provision from family members and legal guardians, definition and diagnosis clarification, waiver to waiver transitions, and responsibility related to the person-centered service plan. One main focus is that the waiver has a timeframe listed. The BI Waiver is rehabilitative, and each individual's rehabilitative journey is unique. While three years may be enough time for many participants, it is not sufficient for everyone. KDADS and the TBI Advisory board have collaborated on the definition of progress on the waiver, developed a clear and consistent transition plan. This would be better documented in a KDADS policy, than in the BI Waiver. KDADS policy provides greater flexibility to change than a Waiver. Utilize the Policy to train all stakeholders to include Individuals accessing the waiver,	Thank you for your feedback. We will take this back for further review for policy updates.

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		Family/Care Giver Supports, Providers and Managed Care Organizations. According to the BI waiver provider manual, eligibility for the waiver is contingent upon participation in at least one rehabilitative service every 30 days. If this requirement were enforced, approximately 200+ individuals could transition off the waiver currently. We appreciate that there is a proposed process for waiver participants who need to exceed the three-year timeframe, but it is concerning that this process must be initiated by the MCO. As documented in the Kansas Brain Injury Needs Assessment and Kansas State plan, Person Centered Planning is extremely important. Ensuring individuals accessing the waiver are able to drive goal planning with assistance from Family, Providers and the Care Manager with the MCO. Individuals should be able to initiate their meetings and request for reviews. In summary, we believe the focus of all efforts should be on maximizing the use of the brain injury waiver so people can become as self-sufficient as possible in their own home and community. To that end, we urge that people not be cut off from services at 3 years and instead, the waiver be managed in a way that not only avoids a waiting list but also makes sure that all participants receive the right services, in the right place at the right time.	
11.	In-person Comment Session	Timeframes going from 5 year to 3 year max, how does that directly impact people on current waiver services who are nearing or past those timeframes?	Thank you for your feedback. We will take this back for further review.
12.	In-person Comment Session	Appreciate clear language about changes for the 3 year timeframe. What about people who come onto waiver and need more than 3 years to achieve independent living goals? Want this to be clearly communicated in the waiver.	Thank you for your feedback. We will take this back for further review.
13.	In-person Comment Session	How will active monitoring for participation work? I think lots of people would come off the waiver. Is this something that could offset the tighter timeframe you are proposing?	Thank you for your feedback. We will take this back for further review.
14.	In-person Comment Session	Not clear whether or not we are covered in certain places to provide therapy. Where can we help members who are in assisted living or home plus? I haven't seen any clarity to help us understand.	Thank you for your feedback. We will take this back for further review.
15.	In-person Comment Session	In talking about no criteria for degenerative diseases to qualify, does that include MS, MB, CP, or inoperable brain tumors? Would that remove people from the waiver if it's terminal? Is it more case by case?	Thank you for your feedback. We will take this back for further review.
16.	In-person Comment Session	It says providers need approval for virtual service delivery. Who approves providers virtual services policies? It doesn't say.	Thank you for your feedback. We will take this back for further review.
17.	In-person Comment Session	How do you determine which comments you will use?	The KDADS team reviews all comments and update the policies as necessary.

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18.	In-person Comment Session	With the transition plan, I noticed very few people have gotten a transition plan, and no one seems to know which agency is responsible for the plan. Is that part of the waiver and who is responsible?	The transition plan is included in the waiver and updated policies will be forthcoming.
19.	In-person Comment Session	Have you considered cognitive services for people transitioning to the PD waiver.	Thank you for your feedback. We will take this back for further review.
20.	In-person Comment Session	Is there language about qualifications for virtual services? I'm concerned some virtual supports are being used inappropriately by agencies that should be providing the service in-person to help the person.	Thank you for your feedback. Any concerns directly related to a BI waiver participant, please share those with the MCO or the BI Waiver Program Manager for follow up.
21.	In-person Comment Session	Are there TLS services available? My son really benefitted from them, but we are having trouble finding providers.	We appreciate your feedback. KDADS is aware of TLS and PCS shortages and is working to address those.
22.	In-person Comment Session	Is there a timeline to update the KMAP manual for the BI Waiver?	The BI waiver renewal will be finalized upon CMS approval. This will include the manual and subsequent policies and procedures.
23.	In-person Comment Session	KDADS approved skill training requirements (page 64) - it looks like those came over from a behavioral waiver. What is the expectation with this? What is the context?	Thank you for your feedback. We will take this back for further review.
24.	In-person Comment Session	Are the program manuals up to date? Some of the other waivers are not. Is BI updated and current?	The BI Waiver should be your source of truth. The BI waiver renewal will be finalized upon CMS approval. This will include the manual and subsequent policies and procedures.
25.	In-person Comment Session	Why remote patient monitoring and telehealth is not included in the renewal? It has shown to be highly effective in PD and FE waivers. I think this would help people stay in the home and community, or return to the home and community, and help manage their conditions.	Thank you for your feedback. We will take this back for further review.
26.	In-person Comment Session	I have a concern. There's a lack of resources in Southwest Kansas. Some members can lose services because we don't have resources or providers. Some places only have a provider once a month.	KDADS will take this into consideration, thank you for your comment.
27.	In-person Comment Session	Confused about allowing MCO to discontinue participant's choice to self-direct. I know there are some valid reasons, and KDADS has ability to approve/deny. I just don't think MCOs as authorizing entity should have that ability	Thank you for your feedback. We will take this back for further review.
28.	In-person Comment Session	Concerned about virtually delivery of services. It seems heavily regulated. Can we refine language for rehabilitative services so it's not the same as PCA. We have consumers who prefer therapy via phone. There's a difference between doing one hour of therapy and expecting someone to provide hours long services like PCA.	Thank you for your feedback. We will take this back for further review.

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29.	In-person Comment Session	We are seeing very few agencies provide TLS and I think there needs to be a re-definition of TLS and cognitive therapy. We need more oversight because cognitive therapists are not always certified and they are doing what a TLS does. It is confusing to families and they might not get what they think they are getting.	KDADS will take this into consideration, thank you for your comment
30.	In-person Comment Session	Needs to be more oversight of MCOs and providers. MCOs should know when someone isn't using services. There used to be a utilization review committee and I think that committee should come back to look at cases. Lots of people are still on waiver not using funding.	KDADS will take this into consideration, thank you for your comment
31.	In-person Comment Session	Need to look at the other medical conditions that occur with the brain injury	KDADS will take this into consideration, thank you for your comment
32.	In-person Comment Session	Need to look at improvement but also reduce measurable decline that could result in institutionalization which is more costly to the government and decreases quality of life. Weneed common sense regulations. Please clearly state that these individuals can stay on the waiver	KDADS will take this into consideration, thank you for your comment
33.	In-person Comment Session	Person centered planning on page 153 it says the policy is really wonderful, and I want everyone to be aware of this. You should train people on this to help them understand their role and options. This includes people getting services, parents, guardians, DPOAs, etc. to make sure the plan is the best plan to meet individuals' needs.	Thank you for your comment.
34.	In-person Comment Session	Need clarity on the total number of hours that can be used across all the therapies.	Thank you for your comment.
35.	In-person Comment Session	The payment for training doesn't have a mechanism to pay DSWs for training time. I think there should be.	Thank you for your comment.
36.	In-person Comment Session	The number of available hours should be clarified for the combination of therapies.	Thank you for your comment.
37.	In-person Comment Session	Regarding renewal and emphasis on 3 year limit, then on page 12 that wording may impact participants who have been on the waiver and are not ready to transition. There has been a lot of information coming forth about the long-term consequences of brain injuries. Not everyone wants them, but there are a number of people who desire the therapies because they want to stay in their home and community, and the literature shows that people with brain injuries need these services. I recommend the language be changed to look at two sides of the coin. One side total independence, the other side is prevention and slowing of decline that leads to institutionalization and death. After three years we should still prevent decline that would result in institutionalization. I think there's enough documentation in literature to show people with severe and chronic conditions need treatment or they will decline. Nationally there's a push to treat it as a chronic condition. The recognized treatments like PT and OT are necessary and can prevent institutionalized.	KDADS will take this into consideration, thank you for your comment
38.		If there's a risk of needing to transfer to another waiver like PD, can we still have care coordination, special agreements, etc.? If someone doesn't have an advocate they won't be able to develop a good plan of care. There's risk to get lost in the shuffle with the larger waivers and the waitlists. It doesn't make sense to transition people from the waiver that works for them to larger waivers that have other problems. If people can show they want the services and they actively participate in the community I think they should be able to stay on the waiver.	KDADS will take this into consideration, thank you for your comment
39.		Some patients take time to accept where they are, and progress may not come until year 2 or year 3. Everyone works at their own pace. How do we speed up transition knowing their time is ending at 3 years but making sure they are ready to integrate into independent living.	KDADS will take this into consideration, thank you for your comment

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40.		It does state that if someone has been on longer than 3 years there is a process to extend the timeframe. But I'm concerned that it states the process is initiated by the MCO. People should be able to make that process start on their own in the	Thank you for your comment.
41.		My concern is that we've put lots of effort into defining progress. We've developed tools. But I don't think we've reached our goal. There are so many different needs in this waiver. People need different times. I think we should go back to having the committee we had before MCOs to have a blind review of cases and determinations are made without MCOs.	Thank you for your comment.
42.		I agree there must be parameters in place to protect people who need access to services. There needs to be a plan for people already on services who haven't been told about the three years. If they knew there was less time for services they might work on other things at the same time. But we also need to not overwhelm them. This can significantly impact how we work with members. This change needs to be communicated well to everyone so we all say the same thing and move forward together.	Thank you for your comment.
43.		We receive regular referrals for people we transitioned off for different reasons.	Thank you for your comment.
44.		Like that active participation will be monitored, but don't want consumer to be impacted because provider was unavailable. The 30 day clock should not start until they have access to services and providers.	Thank you for your comment.
45.		People go into hospitals or lose housing, and clock is ticking against them but it's because something else is taking their time. Instead of length of time, what if we do same standard for year with measure of utilization and give members power to use their services on the timeline that works for them. Everyone has same access to what they can utilize, but have longer time to use it.	Thank you for your comment.
46.		I think adding time limits is a slippery slope. We used to say four years. There isn't enough training or accountability in Kansas to have everyone understand and follow. We need to hold MCOs, providers, and the State accountable. It shouldn't fall on the person getting services. Our job is to support them. We've encountered situations where people aren't getting services, but MCOs still get paid for those people. We should have requirements for MCOs to have training and sign off that they understand policies and procedures. I think the rewrite is putting too much on people with brain waivers. We need accountability for others in the system. There needs to be standardized processes, milestone measures across time, a program manager, and criteria for coming back on the waiver.	Thank you for your comment. KDADS will review the processes.
47.		We need to standardize processes and communicate the same things.	Thank you for your comment.
48.		MCOs are not uniform in what they do or say.	Thank you for your comment.
49.		We need standards for what qualifications a case manager needs to be in the field.	Thank you for your comment.
50.		Want to recognize the great work in opening TLS regulations. This will help people greatly. Thanks for opening it and giving providers the opportunity to help patients shine in what they can do.	Thank you for your comment.
51.		Agree about TLS regulations. We talked about it last year and it's great to see it happening. I can't wait and would like to see this effect happen in other therapies in PT and OT.	Thank you for your comment.
52.		I'm with an MCO, when we close someone we submit to our manager and they approve, then member has 60 days to appeal, and if it doesn't go through they can go to the State, and the State is responsible for closing it.	Thank you for your comment.
53.	Kathy Keck	The BI waiver should not be time limited. There is no way to predict how a brain injury will heal. Allowing review intervals is more appropriate than setting time limits for the waiver.	Thank you for your feedback. We will take this back for further review.
54.	Heather Pilkinton, BI Assoc. of Kansas and Greater KC	We would like to provide feedback on the proposed amendments to the Brain Injury Waiver. We appreciate clarificaGon on several important aspects of the waiver, including alendant care services, overlapping with rehabilitaGon services, PCS provision from family members and legal guardians, definiGon and diagnosis clarificaGon, waiver to waiver transiGons, and responsibility related to the person-centered service plan. One main focus is that the waiver has a timeframe listed. The BI Waiver is rehabilitative, and each individual's rehabilitative journey is unique. While three years may be enough time for many participants,	Thank you for your feedback. We will take this back for further review.

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		it is not sufficient for everyone. KDADS and the TBI Advisory board have collaborated on the definition of progress on the waiver, developed a clear and consistent transition plan. This would be better documented in a KDADS policy, than in the BI Waiver. KDADS policy provides greater flexibility to change than a Waiver. Utilize the Policy to train all stakeholders to include Individuals accessing the waiver, Family/Care Giver Supports, Providers and Managed Care Organizations. According to the BI waiver provider manual, eligibility for the waiver is contingent upon participation in at least one rehabilitative service every 30 days. If this requirement were enforced, approximately 200+ individuals could transition off the waiver currently. We appreciate that there is a proposed process for waiver participants who need to exceed the three-year timeframe, but it is concerning that this process must be initiated by the MCO. As documented in the Kansas Brain Injury Needs Assessment and Kansas State plan, Person Centered Planning is extremely important. Ensuring individuals accessing the waiver are able to drive goal planning with assistance from Family, Providers and the Care Manager with the MCO. Individuals should be able to initiate their meetings and request for reviews. In summary, we believe the focus of all efforts should be on maximizing the use of the brain injury waiver so people can become as self-sufficient as possible in their own home and community. To that end, we urge that people not be cut off from services at 3 years and instead, the waiver be managed in a way that not only avoids a waiting list but also makes sure that all participants receive the right services, in the right place at the right time.	
55.	JD Kemp, Life Streams	We would like to provide feedback on the proposed amendments to the Brain Injury Waiver. We appreciate clarification on several important aspects of the waiver, including attendant care services, overlapping with rehabilitation services, PCS provision from family members and legal guardians, definition and diagnosis clarification, waiver to waiver transitions, and responsibility related to the person-centered service plan. Our main objection is that the waiver has a timeframe listed. The BI Waiver is rehabilitative, but each individual's rehabilitative journey is unique. While three years may be enough time for many participants, it is not sufficient for everyone. Although some research shows that early and significant interventions such as the therapies on the waiver may lead to increased recovery outcomes in the short-term, it does not exclude the equally important need for services to continue until an individual has reached the highest level of independence possible. This takes more time than the first year, and most often more than a 3 year period. With the transition planning outlined below, outcomes are consistently tracked and should be utilized on a case-by-case basis, and when higher levels of functioning and independence are achieved by the individual due to these valuable services, it lessens the long-term dependence on the system as whole for the remainder of a person's life including significantly lower health care costs paid by Medicaid over time, and delayed decline in later years leading to longer community participation and shorter durations in long-term care. Many stakeholders and partners worked closely with the State for many years to ensure that the current waiver did not include a specified timeline for waiver participation, but rather would be evaluated with on-going transition planning already being done through policy and practice in coordination with waiver management, MCO case management and utilization review, service provider(s), and most importantly the individual electing and receiving services. These policies and practices can and should be reviewed on an on-going basis but should not be limited by such extreme limitations in the waiver language itself. We propose that the time limitation be stricken altogether from the waiver and replaced with language identifying on-going transition planning	Thank you for your feedback. We will take this back for further review.

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		as the policy to determine length of time that Brain Injury wavier services are needed, provided, utilized, and effective. The Kansas Brain Injury waiver program also has data showing that the vast majority of individuals do not trend toward an excessive number of years on the waiver. This section of the amendment seems to want to address a problem that is non-existent and does not show any causal link to the potential of any waiting list or higher costs. KDADS, BI Advisory board, and many stakeholders and workgroups already collaborated on the definition of progress on the waiver, and developed a clear and consistent transition plan including a transition team for each individual that is unbiased and inclusive all parties across the person's services to continually monitor utilization, progress, and develop smooth transition plans when the time is appropriate, rather than an arbitrary 'timeline' of number of years. KDADS policy also provides greater flexibility to change than a Waiver. We appreciate that there is suggested language for a process to exceed a three-year timeframe, but it is concerning that this process must be initiated by the MCO. As documented in the Kansas Brain Injury Needs Assessment and Kansas State plan, Person Centered Planning is extremely important. Ensuring individuals accessing the waiver are able to drive goal planning with assistance from Family, Providers and the Care Manager with the MCO. Individuals should be able to initiate their meetings and request for reviews. Please accept these suggestions to remove any specified timeframe from the waiver amendment, and instead focus on policies and practices that are already in place to manage the number of individuals served and appropriate length of time they are on the waiver.	