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:

1. The maximum years of service for eligibility from three years of service to four years of service, or when no longer eligible for the
Autism Waiver.
2. Add self-directed Respite Services
3. Add telehealth option for Parent Support and Training and Family Adjustment Counseling.
4. Increase Family Adjustment Counseling from 12 to 15 hours a year.
5. Provisions for seclusion and restraint removed.
6. Removal of Performance Improvement Team.

The state will not be making changes to Performance Measures for the renewal and will be submitting a future amendment by 08/01/2023 to update the Performance Measures.

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*):

Autism 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**

Waiver Number:KS.0476.R03.00
Draft ID: KS.004.03.00

D. Type of Waiver *(select only one):*

Regular Waiver

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

04/01/22

Approved Effective Date: 04/01/22

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:

◉ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 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:

  KanCare 1115 Demonstration Project

H. Dual Eligiblity 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 purpose of the Kansas Autism Waiver is to provide eligible Kansans the option to receive parental support in their home and community in a cost-efficient manner. The goal of the Autism Waiver is to divert children from entering an inpatient psychiatric facility for individuals age 21 and under as provided in 42CFR440.160 by providing parental support and training. Autism Waiver services are available to children who have received a diagnosis of an Autism Spectrum Disorder (ASD), including Autism, Asperger Syndrome, and Other Pervasive Developmental Disorder-Not Otherwise Specified from a licensed Medical Doctor or Ph.D. Psychologist using an approved Autism specific screening tool. Since research has shown that early intensive interventions with ASD children are effective, a child must be between the age of zero through their fifth year of age upon entering the waiver and be financially eligible for Medicaid. Children must also meet the Level of Care eligibility determination conducted initially and annually by a qualified Functional Eligibility Specialist. The level of care instrument used to determine initial and annual eligibility for the Autism waiver must be the state approved functional eligibility instrument. The Kansas Autism Waiver has a service limit of four years. Kansas Autism Waiver provides three distinctive services to participants and their families.These services are: Respite Care, Parent Support and Training (peer to peer) Provider, and Family Adjustment Counseling.

Once a child has completed the four years of service or been found to be no longer eligible for the HCBS Autism Waiver, the child may transition to which ever waiver the family and the child feels will meet the needs of the child and that the child meet functional eligibility criteria.

In the case of each waiver:

HCBS Intellectual and Developmental Disability (I/DD): If the child meets the eligibility criteria, as determined by the IDD waiver, for the IDD wavier they may bypass the waitlist during their transition.
HCBS Severe Emotional Disturbance (SED): If the child meets the eligibility criteria, as determined by the SED waiver, the child may transition to the SED waiver: or the
HCBS Technology Assistance (TA): If the child meets the eligibility criteria, as determined by the TA waiver, the child may transition to the TA waiver.

Each waiver participant will have a Person-Centered Service Plan referred as Service Plan. The Service Plan is developed by the Managed Care Organization (MCO) and will describe waiver services the child is to receive, their frequency, and the type of provider who is to furnish each service. All waiver services will be furnished pursuant to a written Service Plan. The Service Plan will be subject to the approval by the selected KanCare MCO. Federal Financial Participation (FFP) will not be claimed for waiver services which are not included in the child's written Service Plan

Programmatic oversight and control of the waiver is provided by Kansas Department for Aging and Disability Services (KDADS). KDADS has taken the necessary safeguards to protect the health and welfare of children receiving services under this waiver by setting adequate standards for all types of providers that furnish HCBS/Autism waiver services; those standards of any State licensure or certification requirements are met for services or for individuals furnishing services through the waiver.

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. Statewideness. Indicate whether the state requests a waiver of the statewideness 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 in-patients 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 Public Comment process can be found in 8.b.

Commenter: CMHCs statewide do not have expertise in serving children with Autism. SED Waiver billing should be opened up so families can choose other providers who have Autism expertise and bill under the SED Waiver. -KDADS Response: KDADS has set up a task force to provide recommendations to resolve some of the concerns raised. In addition, the agency plans to provide training for families and providers to address gap in service delivery for people with the autism.

Commenter: GT Independence recognizes the importance of the proposed amendments in respect to each of the two waivers and will provide specific comments to each waiver.
KDADS Response: - Thank you for your comment.

Commenter: Self-direction empowers individuals to have the choice to manage and control their services, choosing where, when, and how these services are delivered.
KDADS Response: -Thank you for your comment.

Commenter: GT Independence is pleased to see that KDADS proposes changes to the respite services offering a self-direction option for the Autism Waiver. GT Independence believes strongly that each participant/member be provided the opportunity to live a life of their choosing.
KDADS Response: -Thank you for your comment.

Commenter: GT Independence would request that Kansas consider making self-direction an option for all seven Kansas Medicaid 1915(c) Waivers.
KDADS Response: -Thank you for your comment.

Commenter: The State of Kansas Autism waiver should be terminated. This waiver is of low value and takes up more money in administrative fees than what is actually used by the measly 65 members it is able to serve on an annual basis.
KDADS Response: -Thank you for your comment.

Commenter: I'm looking for clarification on the part about seclusion and restraint. Are you removing that or adding it? Is it being replaced?
KDADS Response: -We are proposing to remove seclusion and restraint from the waiver.

Commenter: I would like to see more training for care attendants working with children.
KDADS Response: -We hope to see more as well.

Commenter: Once children are eligible for the waiver does this open access to the medical card and access to other services as well?
KDADS Response: - Children do receive a medical card when they are approved for the waiver if they don't have one already.

Commenter: Can we change the number of children that are eligible and open the waiver to more than 65 children? - Appropriations for the Autism waiver come from the legislative level.
KDADS Response: KDADS will note the continued desired for additional waiver spots.

Commenter: Will there be any expansion for the number of children who can be served on the Autism Waiver?
KDADS Response: -KDADS will note the continued desired for additional waiver spots.

Commenter: Referring to changing the time on the waiver from three years to four years. The condition of "or" no longer applies to the Autism waiver. Can you speak more to that?
KDADS Response: -The way it reads currently is three years on the Autism waiver with an option for a fourth year. An assessment is completed every year to determine eligibility for the waiver. After the 3rd year if eligible for the Autism waiver they are ineligible for the IDD Waiver. We decided after the 4th year they qualify to move to another waiver if eligible.

Commenter: We are seeing gaps in kids with multiple diagnoses who qualify for the Autism and SED waivers and are working to figure out as a provider how to provide the most appropriate services. We suggest to raise the age limit for the

Autism waiver and the number of kids who can be on it so that kids who need these services can still be on that waiver and receive them.
KDADS Response: -Thank you for your comment.

Commenter: I really like the proposed change of making respite self-directed. I also wanted to point out that several of the families I work with are starting the waiver but are not interested in ABA and it becomes a barrier of finding an agency who will provide the services but without ABA. Some families are stuck between not wanting to use the only type of therapy available or losing the waiver services.
KDADS Response: -Thank you for your comment.

Commenter: The feedback I have gotten from families is that they have read up on ABA and they do not believe it is ethical or appropriate. They are looking for respite, parent support and training, counseling and other services excluding ABA.
KDADS Response: - Thank you for your comment.

Commenter: Some families have already completed ABA through private insurance before coming onto the waiver so they have moved past that part of the work and need services like respite.
KDADS Response: -Thank you for your comment.

Commenter: What is the income limit? Is it still based on the child's income?
KDADS Response: -Eligibility will continue be based on the child's income.

Commenter: The limit of 65 children on the waiver statewide makes it difficult for provider agencies to justify bringing in new providers and training and hiring people to provide services.
KDADS Response: -Thank you for your comment.

Commenter: Has anyone looked into other options about adding different services to the waiver besides ABA? ABA is an intense process and may be more than some families can do with their child. What other services could be under the waiver?
KDADS Response: - ABA therapy services were removed from the waiver in 2017 and are now part of the State plan services.

Commenter: Who will be managing the Autism waiver?
KDADS Response: -Matthew Beery will be in charge of the Autism waiver.

KDADS received no public comments from the Tribal Governments.

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

Title: Waiver Program Manager

Agency: Kansas Department of Health and Environment

Address: 900 SW Jackson

Address 2: Room 900 N

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: Heydon

First Name: Michele

Title: KDADS HCBS Director

Agency: Kansas Department on Aging and Disability Services

Address: 503 S Kansas Ave

Address 2:

City: Topeka

State: **Kansas**

Zip: 66604

Phone:

(785) 296-0935 **Ext:** ☐ **TTY**

Fax:

(785) 296-0256

E-mail:

Michele.Heydon@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: Kurt Weiter

State Medicaid Director or Designee

Submission Date: May 25, 2023

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

Last Name: Weiter

First Name: Kurt

Title: Waiver Program Manager

Agency: Kansas Department for Health and Environment

Address: 900 SW Jackson Avenue, Suite 900N

Address 2:

City: Topeka

State: **Kansas**

Zip: 66612

Phone: (785) 296-8623 **Ext:** ☐ **TTY**

Fax:

(785) 296-4813

E-mail:

Kurt.Weiter@ks.gov

Attachments

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:

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 state assures that this waiver renewal will be subject to any provisions or requirements included in the states most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Kansas has held two public stakeholder workgroups, In 2019, KDADS held a workgroup to get feedback on how we can better serve person's with autism. A major issue that was addressed as a result of this workgroup was to submit a state plan amendment to expand credentials acceptable to serve as an Autism Specialist. The state expects to see more providers qualify to provide much needed services. The SPA was approved in 2020. In September 2021, KDADS Secretary formed another workgroup with stakeholders to identify gaps in services and develop a plan to address these gaps for Kansans with autism. Kansas expects to see changes in the current waiver once the workgroup concludes their work and amendments to the Autism Waiver will be submitted as necessary to reflect the recommendations of the group.

The public comment session for the Autism Waiver ran from 10/1/2021 through 11/15/2021. The Autism Waiver Renewal Public Comment was hosted by Wichita State University and lead by KDADS staff. The public comment sessions were held at three different times: October 19, 2021 at 10 am, October 19, 2021 at 2 pm, and October 21, 2021 at 6pm. All public comments can be found at https://kdads.ks.gov/kdads-commissions/long-term-services-supports/ltss-public-comment-section. There was a total of 20 public comments. A transcription of the comments and responses are found in 6.I.

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/Long Term Services and Supports 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.:*

The assessing entity is a contracted entity to complete the waiver enrollment request with the participants and submits the request to KDADS for processing. The assessing entity is a contracted entity to provide the level of care assessment and upon completion submitting them to KDADS for determination. The waiver determination is made by KDADS and KDHE for all initial eligibility and continued eligibility requests. The MCOs engage the child and family or responsible adult to develop a Person-Centered Service Plan for the participant. The MCOs are responsible for ensuring paid support staff or other professionals carry out the Service Plan that supports the child's functional development and inclusion in the community. Once the MCOs complete the Person-Centered Service Plan with the child and family or responsible adult, a review is completed to ascertain the specific services, frequency and duration required to meet the needs of the child 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 Autism 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:

☐ **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 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:

Kansas Department of Health and Environment(KDHE) holds the contract for the Managed Care Organizations(MCO) and KDHE completes regular quality assurance and oversight activities of the MCO's carrying out the contract. KDADS manages the qualified assessor contract and KDHE monitors KDADS Quality Assurance reviews of the Level of Care assessing entity.

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 1115 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 Vineland-3 assessment with children in Kansas. KDADS oversees the process to ensure the qualified assessor completes a Vineland-3 assessment every 365 days to determine functional eligibility while the child is on the Autism waiver. The Level of care assessment, the Vineland-3 assessment, is completed by the assessing entity, reviewed and approved by the KDADS Program Manager. Functional determination decisions are sent to KDHE for review and financial eligibility determination.

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 children, 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 Vineland-3 assessments are being completed correctly within the appropriate timeframe. KDADS Quality Assurance Team requires the contracted assessor to provide the following documents for each child assessed:

1. Vineland-3 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 waiver children, 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
Participant waiver enrollment	☒	☒	☐
Waiver enrollment managed against approved limits	☒	☒	☐
Waiver expenditures managed against approved levels	☒	☒	☐

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Level of care evaluation	☒	☒	☒
Review of Participant service plans	☒	☒	☒
Prior authorization of waiver services	☒	☒	☒
Utilization management	☒	☒	☒
Qualified provider enrollment	☒	☐	☒
Execution of Medicaid provider agreements	☒	☒	☒
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 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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency N=Number of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency D=Number of Quality Review reports

Data Source (Select one):
Other
If 'Other' is selected, specify:
Quality Review 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):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS by the State Medicaid Agency
N=Number of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS D=Total number of waiver amendments and renewals

Data Source (Select one):
Other
If 'Other' is selected, specify:
Number of waiver amendments and renewals

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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver policy changes that were submitted to the State Medicaid

Agency prior to implementation by the Operating Agency N=Number of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency D=Number of waiver policy changes 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*(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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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 part of the KanCare program, staff of the three MCOs are 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 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 measures. These processes are monitored by both program managers and other relevant State and MCO staff.

Monitoring and survey results are compiled, trended, reviewed, and disseminated consistent with protocols. identified in the statewide quality improvement strategy policy. 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 evidence has shown noncompliance of 86% or below for an assurance.

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:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☒ Intellectual Disability or Developmental Disability, or Both					
	☒	Autism	0	5	☐
	☐	Developmental Disability			☐
	☐	Intellectual Disability			☐
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

To be eligible for the HCBS/Autism Waiver services, the child must have a diagnosis of Autism Spectrum Disorder, (ASD) including Autism, Asperger Syndrome, and Other Pervasive Developmental Disorder-Not Otherwise Specified from a Medical Doctor or Ph.D. Psychologist. The State relies on Ph.D. level psychologists or a licensed physician for a diagnosis of an Autism Spectrum Disorder and the most appropriate diagnostic tools that they use based on their observations. The diagnosis is supplied to KDADS along with applicable supporting documentation.

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:

If the child will require additional waiver services after exiting the HCBS/Autism Waiver, the KanCare MCO will assist the child/family in gaining access to other appropriately identified services. The family may choose to transition the child to the HCBS/IDD waiver, HCBS/SED waiver or HCBS/TA waiver, providing the established criteria for the waiver the family has chosen meets established guidelines. The KanCare MCO and/or the Targeted Case Manager (TCM) if one is assigned via the I/DD or SED programs will contact the appropriate agency 6 months prior to the child transitioning off the HCBS/Autism waiver to develop a transition plan to the appropriate waiver program or other service options. Only members who are IDD eligible are able to receive TCM services.

Children may utilize services provided through IDEA with their Individual Education Plan (IEP) Kan-Be Healthy (EPSDT), their regional Community Developmental Disabilities Organization (CDDO) or other available programs. Children meeting program-specific eligibility requirements may receive appropriate services through the Early Childhood Intervention Programs (ECI), the Local Education Agency (LEA) program or services meeting the medical necessity criteria under EPSDT provisions.

A child may be offered services prior to turning age six (6). A child can receive up to four years of service on the waiver and could be on the waiver until age nine (9).

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	82
Year 2	82
Year 3	82
Year 4	82
Year 5	82

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	65
Year 2	65
Year 3	65
Year 4	65
Year 5	65

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	
Temporary Institutional Stay	
Military Inclusion	

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 as hospitals or ICF/ID for seeking treatment for acute, habilitative or rehabilitative conditions on a temporary basis less than 90 days. Temporary stay is defined as a stay that includes the month of admission and two months following admission. Consumers that remain in the institution following the two-month allotment will be terminated from the HCBS program. The consumer can choose to reapply for services later and will be reinstated if the consumer meets program eligibility requirements or placed on a waiting list if applicable.

Describe how the amount of reserved capacity was determined:

There reserved capacity was determined based on historical utilization and the fact there have not been more than two individuals who have requested it for the same time period.

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

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

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 dependents and immediate family members of military personnel who have been determined program eligible to bypass waitlist upon approval by KDADS. In the event Kansas instituted a waitlist, individuals who have been determined to meet the established Autism waiver criteria will be allowed to bypass the waitlist and access services.

Describe how the amount of reserved capacity was determined:

There reserved capacity was determined based on historical utilization and the fact there have not been more than two individuals who have requested it for the same time period.

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

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

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:

Once the child has received a diagnosis of ASD they must also meet the level of care (functional) eligibility guidelines utilizing the State approved functional eligibility instrument. Entrance to the waiver is determined on a first come first serve basis. The date and time request for waiver services received at KDADS will be the determining factor. The number of eligible entrants into the program is limited to the number of waiver capacity allowed by funding.

The Autism Program Manager maintains a statewide "Proposed Recipient List" of those children who have a diagnosis of ASD, request Autism Waiver services, and have completed the necessary form indicating the name of the child, diagnosis, address, date of birth, phone number, and name of parent/guardian. The form can be faxed, mailed, or emailed to the Autism Program Manager where it will be date/time stamped. The date/timed stamped and/or faxed date/time will be the determining factor for the first come first serve policy. The "Proposed Waiver Recipient" list is being utilized to determine when a child will be offered services as HCBS/Autism slot becomes available. When a slot becomes available, the Autism Program Manager will send a letter to the family using the address on file notifying them of the available position. The family is given two weeks to respond to the letter informing the Program Manager if they would like to continue with the eligibility process. If the Program Manager does not receive a response, they will reach out by phone confirming receipt of the letter and the parents' choice. If the parent indicates they would like to pursue the Autism Waiver the Program Manager will notify the contracted functional assessor that an assessment is needed. Families are given a notice of action (NOA) if the child is found either functionally eligible or functionally ineligible. The NOA also contains appeal rights.

The Autism waiver consists of a continued interest list and does have a waiting list, however, the State does not serve more than the allotted 65 at any point in time .

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)
Infants and Children under the age of 19 (42 CFR 435.118)
Newborn Children (42 CFR 435.117)

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

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

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: 1

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:

KDADS Autism Waiver Program Manager holds a Bachelors Degree.

The Qualified Assessor must meet the following requirements:

They must meet the qualifications specified by Pearson Assessments, as a level B user the assessor must meet one of the following qualifications:

"A master's degree in psychology, education, occupational therapy, social work, counseling, or in a field closely related to the intended use of the assessment, and formal training in the ethical administration, scoring, and interpretation of clinical assessments.
OR
Certification by or full active membership in a professional organization (such as ASHA, AOTA, AERA, ACA, AMA, CEC, AEA, AAA, EAA, NAEYC, NBCC) that requires training and experience in the relevant area of assessment.
OR
A degree or license to practice in the healthcare or allied healthcare field.
OR
Formal, supervised mental health, speech/language, occupational therapy, social work, counseling, and/or educational training specific to assessing children, or in infant and child development, and formal training in the ethical administration, scoring, and interpretation of clinical assessments."

-"User has a licensure to practice psychology independently, or User has completed a doctoral (or in some cases masters) degree program in one of the fields of study indicated for the test that included training (through coursework and supervised practical experience) in the administration and interpretation of clinical instruments. If neither of these qualifications are met, Users must provide proof that they have been granted the right to administer tests at this level in their jurisdiction".

*Must be able to provide proof of professional liability insurance and automobile liability insurance coverage

*Must complete KDADS approved training criteria, and

*Must successfully pass Kansas Bureau of Investigation (KBI), Adult Protective Services (APS), Child Protective Services (CPS), Nurse Aid, and Motor Vehicle screen.

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.

A qualified Functional Eligibility Specialist conducts the level of care (functional eligibility) assessment of the child who is applying for waiver services within five (5) business days of the referral, unless a different timeframe is requested by the participant/family applying for services or their legal representative.

The Functional Eligibility Instrument (FEI) measures the personal and social skills of individuals from birth through adulthood. Because adaptive behavior refers to a participant's typical performance of the day-to-day activities measuring personal and social skills, these scales assess what a person actually does, rather than what they are thought to be capable of performing. The FEI assesses adaptive behavior in four domains: Communication, Daily Living Skills, Socialization, and Motor Skills. It then provides a composite score that summarizes the participant's performance across all four domains.

The child must have a total score or a score on any two elements of the Adaptive Areas (Communication, Daily Living skills, Socialization, and Motor skills) of two standard deviations below the mean of 100 (i.e., a score of 70 or below) in order to be eligible for the waiver.

Or

A total score or a score on any two elements of the Adaptive Areas (Communication, Daily Living Skills, Socialization and Motor skills) of one standard deviation below the mean of 100 (score of 71-85), prompts the assessor to review the scores on the Maladaptive Behaviors (internal, external or total). If the child's v-scale score on any subdomain of the Maladaptive domain is between 21-24, the child is eligible for the Waiver.

The FEI is the Autism Waiver functional eligibility tool (Level of Care Determination) to be utilized to determine functional eligibility. The FEI is a measurement of personal and social skills from birth to adulthood. The FEI focuses on four adaptive domains and one maladaptive domain: within all of the domains there are sub-domains which allow for greater in-depth holistic approach in developing the Service Plan. The following domains and sub-domains are: 1) communication, (subdomain-receptive, expressive, and written), 2) Daily Living Skills (sub-domain-personal, domestic, and community), 3) Socialization (subdomain- interpersonal relationships, play and leisure time, and coping skills), 4) Motor Skills (subdomain-fine and gross), 5) Maladaptive Behavior Index (subdomain-internalizing, externalizing, and other).
KDADS Program Manager sends offer letters to persons on the Proposed Recipient's List during an offer round. When the family accepts the offer, the Program Manager sends referral to the assessing entity to conduct the Vineland. When the Vineland is completed, the assessing entity sends the completed Vineland to the KDADS Program Manager. The Program Manager reviews and approves program eligibility and sends to KDHE to determine financial eligibility. KDHE sends completed eligibility packet to the chosen MCO and back to KDADS.

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.

The state assessing agency screening form is utilized to screen for a variety of intensive inpatient psychiatric services. The form includes information on presenting problem, risk factors, clinical impressions, and inpatient criteria. The form is not based on a standardized tool or assessment, but solely on the self-report of the participant or participant's family and the clinical observation and judgment of a qualified mental health practitioner. The Vineland 3 is the instrument used to assess the Level of Care (LOC) for institutional care.

Although the Vineland 3 are comparable in addressing the domains of a child's life, the State of Kansas chooses the Vineland because the tool provides greater details in each domain, which in turn allows the assessor to identify the specific troublesome areas a child is experiencing. This is accomplished because the Vineland is a standardized tool; it guides the assessor throughout all domains by having set specific questions. The assessor must rate each question according to the following rating scale;

2 (behavior is usually or habitually performed),
1 (sometimes or partly performed),
0 (never performed).

Additionally, code N, for instance, is used when the child has never had the opportunity to perform the activity and/or behavior. A code of DK, is used when the caregiver does not know if the child preformed the activity an/ or experienced the behavior. The Vineland also provides a composite score that summarizes the individual's performance across the domains. Therefore, Kansas views the FEI to not only be comparable or equivalent to the Mental Health Screening Instrument but to exceed it by identifying and addressing the child's specific needs.

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:

KDADS Program Manager sends referral to the assessing entity to conduct the Vineland. When the Vineland is completed, the assessing entity sends the completed Vineland to the KDADS Program Manager. The Program Manager reviews and approves and sends to KDHE to determine financial eligibility. KDHE sends completed eligibility packet to the chosen MCO and back to KDADS.

Notice of Action- When a child is found functionally eligible or ineligible during the initial evaluation or the annual reevaluation, the child/family will receive a Notice of Action advising them of the status of their functional eligibility evaluation

All functional eligibility documentation including the initial evaluation, the annual re-evaluation, freedom of choice and the notice of action are to be maintained in the child's case file

KDADS has contracted with one provider who will administer the Vineland in order to determine the level of care (LOC) for functional eligibility and assist the child/family in determining eligibility for waiver services. The following criteria apply for waiver eligibility:

1)Age- at the time of entrance to the waiver a child must be between the ages of zero (0) through age five (5) years and 11 months

2)Diagnosis: the child must have a diagnosis of Autism Spectrum Disorder (ASD) from a Licensed Medical Doctor or Ph.D. Psychologist using an approved American Academy of Pediatrics (AAP) Autism specific screening tool.

3)LOC determination: The Vineland 3 must be completed and the child must meet the established scoring criteria in order to be determined functional eligible

4)A child must be determined to need inpatient psychiatric facility level of care in the absence of waiver services.

5)Family Choice form: Documentation to support Parents/Guardians choice of waiver services.

6)Annual Revaluation - The need for HCBS Autism Waiver services is re-evaluated (face to face or virtually) at a minimum on an annual basis but can also be conducted at any time the family feels it is appropriate, as needs change, and/or as goals are accomplished. The Vineland is completed each time the child is assessed and follows the same process as initial eligibility.

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):*

The contracted state assessing agency manages reevaluation lists and provides documentation to the State for each annual reevaluation that is completed.

The State currently contracts with KVC to do the initial evaluation and reevaluation of children on the Autism Waiver. KVC provides KDADS with a list of children that are due for reevaluation. KVC also provides KDADS with the evaluation scheduled day and time and if a meeting had to be rescheduled for any reason. The Autism Program Manager verifies this list against KDAD's Autism Waiver tracking to ensure reevaluations are completed in a timely manner.

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:

Records are maintained by the state assessing agency for performing the initial eligibility determination and annual reevaluation. The state assessing agency also supplies the State with a copy of initial eligibility determination and annual reevaluation information. 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 §74.53. It will also be maintained in the State of Kansas Medicaid Management Information System(MMIS).

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Operating Agency's 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 = 95/5
☐ **Other** Specify:	☐ **Annually**	☒ **Stratified** Describe Group: Proportionate by MCO
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

Performance Measure:
Number and percent of waiver participants who receive their annual Level of Care evaluation within 365 days of the previous Level of Care determination N=Number of waiver participants who receive their annual Level of Care evaluation within 365 days of the previous Level of Care determination D=Number of waiver participants who received Level of Care redeterminations

Data Source (Select one):
Record reviews, off-site
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 = 95/5
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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 all Level of Care (LOC) determinations made by a qualified assessor N=Number of all Level of Care (LOC) determinations made by a qualified assessor D=Number of all Level of Care determinations

Data Source (Select one):
Other
If 'Other' is selected, specify:
assessor and assessor 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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **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:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Data Source (Select one):
Record reviews, off-site
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 = 95/5
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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: contracted assessing agencies	☐ **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 all Level of Care (LOC) determinations made where the LOC criteria was accurately applied N=Number of all Level of Care (LOC) determinations made where the LOC criteria was accurately applied D=Number of all Level of Care determinations

Data Source (Select one):
Record reviews, off-site
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 = 95/5
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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 remediation documentation when necessary. In addition, the performance of the contracted Functional Specialist will be monitored on an ongoing basis to ensure compliance with the state 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 agency (KDHE).

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 measures. These processes are monitored by both contract managers and other relevant State staff, depending upon the type of issue involved.

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**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: KanCare state contractors participate in analysis	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

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).

Kansas offers families a choice between an Inpatient psychiatric facility for individuals less than 21 years of age as provided in 42CFR 440.160 and Home Community Based Services (HCBS). Families shall be informed of any realistic alternative available under the waiver, and given the choice of either inpatient psychiatric facility or home and community -based services (HCBS) [42 CFR 441.302(d)]. Due to the age, numbers served and targeted population for the state of Kansas Autism waiver, if a family should choose an Inpatient psychiatric facility rather than HCBS, Kansas, through the managed care delivery model, enters into a contract with an out of state provider to provide services for that child.

After the child is determined to be eligible for the HCBS/Autism waiver services, the child/family receives:

1) A copy of the completed form(s) used to document freedom of choice and to offer a fair hearing;

2) A description of the contracted functional assessors procedure(s) for informing eligible children (or their legal representatives) of the feasible alternatives available under the waiver;

3) A description of the State's procedures for allowing participants to choose either institutional or home and community based services; and

4) A description of how the participant (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E.

5) The Freedom of Choice form is signed at the time the Level of Care assessment is completed.

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.

The Family Choice Document (freedom of choice) form, Rights and Responsibilities, and Request for a Fair Hearing is maintained in the child's case file at the state assessing entity per K.A.R 30-60-57 for a minimum of three years. A child's/family members signature on the Family Choice Document indicates and ensures they have been informed of the options available.

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 participants whose primary language is not English, 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 to individuals who have English as a second language or non-primary language. 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 non-English speaking participants, states are required to capture language preference information. This information is captured in the demographic section of the Vineland instrument.

The State of Kansas defines prevalent non-English languages as languages spoken by a significant number of potential enrollees and participants who are already enrolled. Potential enrollee and enrolled participant materials will be translated into the prevalent non-English language required by the participant.

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).

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	**Respite Care**		
Supports for Participant Direction	**Financial Management Services**		
Other Service	**Family Adjustment Counseling**		
Other Service	**Parent Support and Training (peer to peer) Provider**		

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:

Respite

Alternate Service Title (if any):

Respite Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09011 respite, out-of-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09012 respite, in-home
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):*

Respite Care provides temporary direct care and supervision for the child. The primary purpose is relief to families/caregivers of a child with an autism spectrum disorder. The service is designed to help meet the needs of the primary caregiver as well as the identified child. Normal activities of daily living are considered content of the service when providing respite care, and include support in the home, after school, or at night.

Transportation to and from school/medical appointments/ or other community based activities, and/or any combination of the above is included in the rate paid to providers of this services.

Federal financial participation (FFP) is not claimed for the cost of room and board.

Respite care does not duplicate any other Medicaid State Plan Service or service otherwise available to recipient at no cost.

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

1) Respite Care services are available to participants who have a family member who serves as the primary care giver who is not paid to provide any HCBS/ Autism service for the child.

2) Respite care may not be provided by a parent of the child.

3) Respite Care cannot be provided to an individual who is an inpatient of a hospital or State Mental Hospital when the inpatient facility is billing Medicaid, Medicare and/ or private insurance.

4) Respite Services are subject to prior approval.

5) Respite care is provided in planned or emergency segments and may include payment during the individuals sleep time

6) Respite has a limit to 168 hours per calendar year. However, families may request additional hours of Respite care by contacting their MCO care coordinator.

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	Self Directed Respite
Agency	Community Service Provider, (CSP) and Community Mental Health Center, (CMHC)
Agency	Financial Management Services

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:

Individual

Provider Type:

Self Directed Respite

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Adherence to KDADS training and professional development requirements; maintenance of clear background as evidenced through background checks of; Kansas Bureau of Investigation (KBI), Adult Protective Services (APS), Child Protective Services (CPS), Nurse Aide Registry, and Motor Vehicle screen.

The motor vehicle screen can be waived for positions which DO NOT require driving as a function of the position.

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.

High School Diploma or equivalent,

Eighteen years of age or older,

Must meet family's qualifications,

Must reside outside of child's home,

Completion of the state approved training curriculum, and

Medicaid Enrolled Provider

MCO contracted provider

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS Provider

Frequency of Verification:

Every 2 years by FMS Provider background checks are required on hired self-directed employees of participants.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:

Agency

Provider Type:

Community Service Provider, (CSP) and Community Mental Health Center, (CMHC)

Provider Qualifications

License *(specify):*

Community Service Provider will be licensed by KDADS,
Community Mental Health Center will be licensed under K.A.R. 30-60-1

Certificate *(specify):*

Other Standard *(specify):*

Adherence to KDADS training and professional development requirements; maintenance of clear background as evidenced through background checks of; Kansas Bureau of Investigation (KBI), Adult Protective Services (APS), Child Protective Services (CPS), Nurse Aide Registry, and Motor Vehicle screen.

The motor vehicle screen can be waived for positions which DO NOT require driving as a function of the position.

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.

High School Diploma or equivalent,

Eighteen years of age or older,

Must meet family's qualifications,

Must reside outside of child's home,

Completion of the state approved training curriculum, and

Medicaid Enrolled Provider

MCO contracted provider

Verification of Provider Qualifications

Entity Responsible for Verification:

Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.

Frequency of Verification:

Kansas provides monitoring and oversight of MCO's verification of HCBS-Autism provider qualifications. This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:

Agency

Provider Type:

Financial Management Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

All FMS providers must meet established provider qualifications prior to being contracted and credentialed with a KanCare Managed Care Organization (MCO) and providing FMS services. Qualified providers must have a valid FMS Agreement with KDADS, Medicaid Provider Agreement with the Kansas Medical Assistance Program (KMAP), and meet all other provider qualifications as outlined in the agreement, the applicable HCBS Program, and in the FMS policy.

Other Standard *(specify):*

All FMS providers must meet established provider qualifications prior to being contracted and credentialed with a KanCare Managed Care Organization (MCO) and providing FMS services. Qualified providers must have a valid FMS Agreement with KDADS, Medicaid Provider Agreement with the Kansas Medical Assistance Program (KMAP), and meet all other provider qualifications as outlined in the agreement, the applicable HCBS Program, and in this policy.

a. Provider Qualifications
To be considered a qualified FMS provider, the provider must meet Federal, KDADS and MCO requirements prior to providing FMS for participant-directed services. To enroll as an FMS provider for HCBS Programs, each FMS must meet the following provider qualifications prior to providing FMS for participants directing their care under an HCBS Program operated by KDADS:
1. Valid KDADS FMS Agreement
2. Kansas Medicaid Provider Agreement and valid KMAP Number
3. Registration and good standing with the Secretary of State's office, if required
4. Community Developmental Disability Organization's (CDDO) Affiliate Agreement, if serving participant's on the HCBS-IDD Program
5. Proof of Insurance – liability, worker's compensation, unemployment, and others
6. Financial solvency, including accepted GAAP or compliance audit, as required
7. Required Policies and Procedures Manual for FMS Operations
8. Federal Employer Identification Number as employer agent in accordance with §3504 of the IRS code, Revenue Procedure 70-6, 1970-1 C.B. 420, as modified by IRS Proposed Notice 2003-70

b. Provider Competencies
FMS Providers must meet Federal, state and HCBS Program requirements. To serve self-directing participants of HCBS programs, an FMS should be able to meet the following expectations:
1. Be an enrolled provider in the Kansas Medical Assistance Program;
2. Meet the FMS provider qualifications as outlined in this document;
3. Operate in accordance with §3504 of the IRS code, Revenue Procedure 70-6, 1970-1 C.B. 420, as modified by IRS Proposed Notice 2003-70 and any other future revenue procedures, notices or publication promulgated by the IRS in the future;
4. Operate in compliance with the Standards as outlined in this document and maintain documentation to support its compliance with these standards;
5. Demonstrate the capacity and continued capacity to perform the required responsibilities as identified in the Compliance Audit, onsite review, or FMS KDADS rev 12.21.15 eff. 4.10.15 6.5.C.2-2
6.5. Financial Services Manual (FMS) Participant-Directed Services and Supports
C. Qualified FMS Providers Requirements Section III
recertification review;
6. Support the principles and philosophy of KDADS's home and community-based programs as described in Section II.3 above;
7. Have management and staff that are knowledgeable and have experience in providing FMS and working with persons with disabilities and chronic conditions;
8. Comply with Medicaid requirements related to collecting client obligation and applying third party liability for all participants receiving HCBS Program services and supports;
9. Have a sound financial and reporting structure to efficiently serve participants;
10. Maintain books, records, documents, and other evidence of expenditures in with generally accepted accounting principles (GAAP);
11. Make all books, records and documents available for inspection by the KDADS, the MCOs, or other state and federal authorities, as applicable, and without prior notice;
12. Report all suspected cases of neglect, abuse, and exploitation of participants applying for or receiving waiver services within 24 hours of awareness to the appropriate authorities;
13. Comply with all relevant federal, state and local laws related to payroll, taxes, withholding, reporting, insurance, and related criteria;
14. Demonstrate its capacity to develop and implement an information system to manage FMS-related records and files effectively;
15. Conduct FMS activities separate and distinct from the agency-directed function if the organization is a direct care service provider and/or a supports coordination/care management provider for the KDADS;
16. Secure FMS provider personnel, office space, documentation and records to ensure confidentiality

and HIPAA compliance of all FMS records;
17. Report payroll, tax and other administrative duties to the participant on a regular basis to ensure participant control, choice and self-direction in participant-directed services;
18. Demonstrate the ability to monitor, identify and report instances of potential fraud, waste, and abuse to the appropriate authorities and ensure correct claims billing for HCBS Program participants directing their care;
19. Utilize AuthentiCare® KS for authorizations, billing, claims, reporting, and tracking direct service workers;
20. Demonstrate knowledge of and ability to stay current with federal, state and local tax, labor, workers' compensation insurance and program regulations related to the KDADS's HCBS Programs, Medicaid, the delivery of FMS, and household employers and domestic service workers; and
21. Demonstrate the ability to select, contract with and oversee the performance of a reporting agent effectively, if it so desires and as applicable.

Verification of Provider Qualifications

Entity Responsible for Verification:

KanCare MCO's, KDADS and KDHE.

Frequency of Verification:

Kansas provides monitoring and oversight of MCO's verification of HCBS-Autism provider qualifications. This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

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:

Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):

Financial Management Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12010 financial management services in support of self-directio
Category 2:	**Sub-Category 2:**
12 Services Supporting Self-Direction	12020 information and assistance in support of self-direction
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):*

****Respite Care services can be agency directed or self directed. Self directed is an added service to this waiver to offer increased flexibility for participants in finding caregivers. FMS is a needed service under the self directed option. The FMS provider is to perform background checks, assist families in finding and training attendants and provider other information and assistance. FMS is paid out at 1 unit per month. ****

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 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 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 or legal guardian that the participant 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 including:
1. Verification and processing of time worked and the provision of quality assurance;
2. 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;
3. Performance of fiscal accounting and expenditure reporting to the participant or participant's representative and the state, as required.
4. 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:
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 support workers (DSW), managing workers, and providing effective communication and problem- solving.

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

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.
Access to this service is limited to participants who choose to self-direct some or all 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.

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

FMS is limited to one unit per month. FMS can only be billed for months that respite is billed and used. Every FMS provider that credentials with the MCO is required to complete a readiness review to assure they are qualified to provide these services.

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 of Financial Management Services

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 of Financial Management Services

Provider Qualifications

License *(specify):*

Not applicable.

Certificate *(specify):*

Not applicable.

Other Standard *(specify):*

Enrolled FMS providers will furnish Financial Management Services according to the 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 Generally Accepted Accounting Principles (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 a prohibited offense, as listed in K.S.A. 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 KDADS 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:

- 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:

Family Adjustment Counseling

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
10 Other Mental Health and Behavioral Services	10060 counseling
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):*

Counseling can be provided to the family members of a child with an autism spectrum disorder in order to guide and help them cope with the child's illness and the related stress that accompanies the initial understanding of the diagnosis and the ongoing continuous, daily care required by the child with an autism spectrum disorder. Enabling the family to manage this stress improves the likelihood that the child with the disorder will continue to be cared for at home, thereby preventing premature and otherwise unnecessary institutionalization. Family Adjustment Counseling offers the family a mechanism for expressing emotions associated with the comprehension of the disorder and asking questions about the disorder in a safe and supporting environment. When acceptance of the disorder can be achieved the family is prepared to support the child on an ongoing basis. The service is provided by a Licensed Mental Health Professional (LMHP).

For the purposes of this service, "family" is defined as unpaid persons who live with or provide care to a person served on the waiver, and may include a parent, step parent, legal guardian, siblings, relatives, or grandparents. Services may be provided individually or in a group setting, are subject to prior approval, and must be intended to achieve the goals or objectives identified in the child's individualized person centered service plan.

Family Adjustment Counseling does not duplicate any other Medicaid State Plan Service or other services otherwise available to recipient at no cost. Family Adjustment Counseling provides the family the ability to meet with a counselor who is a Licensed Mental Health Professional to assist in coping with the child's illness and the related stress that accompanies the initial understanding of the diagnosis and the ongoing, continuous, and daily care required by the child with an ASD. This model allows the family to meet with a counselor without the child present. These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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 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. (e.g., Skype, Zoom, Facetime, telephonic, or another device that facilitates live two-way communication. Text messaging and e-mailing do not constitute virtual supports and, therefore, will not be considered provision of direct supports under this Waiver program service.

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 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. 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;
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. 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 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:
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.
- 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 or support 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.

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

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.
• The state may require the managed care organizations 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.

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

Family Adjustment Counseling is limited to 15 hours per calendar year.

Families may request more hours from their MCO if needed.

Services are subject to prior approval, and must be intended to achieve the goals or objectives identified in the child's person-centered service plan

Group setting cannot consist of more than 3 families.

The group membership requirement for Family Adjustment Counseling is that members each have a family member with a diagnosis of ASD.

Families must agree to a group setting

Delivery of this service may occur via telemedicine, telehealth or other modes of video distance monitoring methods that adhere to all required HIPPA guidelines and meet the state standards for telemedicine delivery methods. This service delivery model is subject to state program manager approval. The State intends for the family to receive in-person services if they desire. The telehealth option is to be used as a secondary option if desired by the family.

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	Community Mental Health Center
Individual	Family Adjustment Counseling Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Adjustment Counseling

Provider Category:
Agency

Provider Type:

Community Mental Health Center

Provider Qualifications

License *(specify):*

-Community Mental Health Center must operate and function within regulatory guidelines set forth in K.A.R. 30-60-1

Certificate *(specify):*

Other Standard *(specify):*

Adherence to KDADS training and professional development requirements; maintenance of clear background as evidenced through background checks of; Kansas Bureau of Investigation (KBI), Adult Protective Services (APS), Child Protective Services (CPS), Nurse Aide Registry, and Motor Vehicle screen.

The motor vehicle screen can be waived for positions which DO NOT require driving as a function of the position.

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.

Medicaid Enrolled Provider

MCO contracted provider

Verification of Provider Qualifications

Entity Responsible for Verification:

Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.

Frequency of Verification:

Kansas provides monitoring and oversight of MCO's verification of HCBS-Autism provider qualifications. This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Adjustment Counseling

Provider Category:

Individual

Provider Type:

Family Adjustment Counseling Provider

Provider Qualifications

License *(specify):*

a Licensed Mental Health Professional (LMHP) must hold a current licensed to practice in the state of Kansas by the Kansas Behavioral Sciences Regulatory Board, K.A.R. 28-5-564

Certificate *(specify):*

Other Standard *(specify):*

Adherence to KDADS training and professional development requirements; maintenance of clear background as evidenced through background checks of; Kansas Bureau of Investigation (KBI), Adult Protective Services (APS), Child Protective Services (CPS), Nurse Aide Registry, and Motor Vehicle screen.

The motor vehicle screen can be waived for positions which DO NOT require driving as a function of the position.

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.

Medicaid Enrolled Provider

MCO contracted provider

Verification of Provider Qualifications

Entity Responsible for Verification:

Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.

Frequency of Verification:

Kansas provides monitoring and oversight of MCO's verification of HCBS-Autism provider qualifications. This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

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:

Parent Support and Training (peer to peer) Provider

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
09 Caregiver Support	09020 caregiver counseling and/or training
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):*

Parent Support and Training is designed to provide the training and support necessary to ensure engagement and active participation of the family in the treatment process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. Support and Training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the child. This involves assisting the family with the acquisition of knowledge and skills necessary to understand and address the specific needs of the child in relation to their autism spectrum disorder and treatment; and development and enhancement of the family's specific problem-solving skills, coping mechanisms, and strategies for the child's symptom/behavior management.

For the purposes of this service, "family" is defined as persons who live with or provide care to a child served on the waiver, and may include a parent, step parent, legal guardian, siblings, relatives, grandparents, or foster parents. Services may be provided individually or in a group setting, are subject to prior approval, and must be intended to achieve the goals or objectives identified in the child's person-centered service plan.

1. Support, coaching and training provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the member.
2. This involves helping the families identify and use healthy coping strategies to decrease caregiver strain, improve relationships with family, peers and community members and increase social supports;
3. Assist the family in the acquisition of knowledge and skills necessary to understand and address the specific needs of the participant in relation to their mental illness and treatment;
4. Development and enhancement of the families' specific problem-solving skills, coping mechanisms, and strategies for the participant's symptom/behavior management;
5. Assist the family in understanding various requirements of the waiver or grant process, such as the crisis plan and plan of care process;
6. Educational information and understanding on the participant's medications or diagnoses; interpreting choice offered by service providers; and assisting with understanding policies, procedures and regulations that impact the participant with mental illness while living in the community; provide information on supportive resources in the community;
7. Service must be intended to achieve the goals and/or objectives identified in the participant's Person-Centered Service Plan.

Parent Support and Training does not duplicate any other Medicaid State Plan Service or other services otherwise available to recipient at no cost. Providers are required to be licensed with the Community Mental Health Center and they contract directly with the Managed Care Organizations.

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 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. (e.g., Skype, Zoom, Facetime, telephonic, or another device that facilitates live two-way communication. Text messaging and e-mailing do not constitute virtual supports and, therefore, will not be considered provision of direct supports under this Waiver program service.

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 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. 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;
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. 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 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:
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.
- 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 or support 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.

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

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.
- The state may require the managed care organizations 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.

e. 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;
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. 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 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:
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.
- 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 or support 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.
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).
• The training should assist the participant in attaining the knowledge required to operate technologies that facilitate successful virtual delivery of the service.

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.
• The state may require the managed care organizations 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.

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

Parent Support and Training is limited to 30 hours per calendar year.

Families may request more hours from their MCO if needed."

Services are subject to prior approval, and must be intended to achieve the goals or objectives identified in the child's person-centered service plan.

Group settings cannot consist of more than 3 families.

The group membership requirement for Parent Support is that members each have a family member with a diagnosis of ASD.

Families must agree to a group setting

Delivery of this service may occur via telemedicine, telehealth or other modes of video distance monitoring methods that adhere to all required HIPPA guidelines and meet the state standards for telemedicine delivery methods. This service delivery model is subject to state program manager approval. The state requires three years of experience working with a child diagnosed with ASD.

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	Community Service Providers, (CSP) and Community Mental Health Centers (CMHC)
Individual	Parent Support Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Parent Support and Training (peer to peer) Provider

Provider Category:

Agency

Provider Type:

Community Service Providers, (CSP) and Community Mental Health Centers (CMHC)

Provider Qualifications

License *(specify):*

Community Service Providers are licensed by KDADS
Community Mental Health Center will be licensed under K.A.R. 30-60-1

All licensed agencies that are on file with the Secretary of State's office that are or can become Medicaid enrolled, and employ individuals that meet the qualifications of a parent support and training provider. The types of licensed agencies that can enroll in Medicaid to provide HCBS services are listed here: https://www.kmap-state-ks.us/Documents/Content/Checklists/HCBS.PDF.

Certificate *(specify):*

Other Standard *(specify):*

Adherence to KDADS training and professional development requirements; maintenance of clear background as evidenced through background checks of; Kansas Bureau of Investigation (KBI), Adult Protective Services (APS), Child Protective Services (CPS), Nurse Aide Registry, and Motor Vehicle screen.

The motor vehicle screen can be waived for positions which DO NOT require driving as a function of the position.

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.

*High School Diploma or equivalent

*Twenty-one years of age or older

*Completion of parent support training or other approved training curriculum.

*Must have three years of direct care experience with a child with an autism spectrum disorder,
Or be the parent of a child with an autism spectrum disorder.

*Medicaid Enrolled provider and MCO contracted provider

Verification of Provider Qualifications

Entity Responsible for Verification:

Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.

Frequency of Verification:

Kansas provides monitoring and oversight of MCO's verification of HCBS-Autism provider qualifications. This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Parent Support and Training (peer to peer) Provider

Provider Category:

Individual

Provider Type:

Parent Support Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Adherence to KDADS training and professional development requirements; maintenance of clear background as evidenced through background checks of; Kansas Bureau of Investigation (KBI), Adult Protective Services (APS), Child Protective Services (CPS), Nurse Aide Registry, and Motor Vehicle screen.

The motor vehicle screen can be waived for positions which DO NOT require driving as a function of the position.

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.

The motor vehicle screen can be waived for positions which DO NOT require driving as a function of the position.

*High School Diploma or equivalent

*Twenty-one years of age or older

*Completion of parent support training or other approved training curriculum.

*Must have three years of direct care experience with a child with an autism spectrum disorder,
Or be the parent of a child with an autism spectrum disorder

*Medicaid Enrolled Provider

* MCO contracted provider

Verification of Provider Qualifications

Entity Responsible for Verification:

Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.

Frequency of Verification:

Kansas provides monitoring and oversight of MCO's verification of HCBS-Autism provider qualifications. This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

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):

The contactor / sub contactor and /or provider must complete a Kansas Bureau of Investigation (KBI), Adult Protective Services (APS), Child Protective Services (CPS), Nurse Aide Registry, and motor vehicle screen upon the hiring of the following providers of services:

-Eligibility Determination (Functional Eligibility Specialist)
-Respite Care Provider
-Parent Support Specialist Provider
-Family Adjustment Counseling Provider

The contactor / sub contactor and /or provider must provide evidence that required standards have been met at the time of renewing their license. This standard can be reviewed by KDADS regional field staff at the time of their reviews and sooner if a potential problem is identified. At any time deemed appropriate by KDADS, a certification may be formally resurveyed by KDADS to determine whether the licensee continues to be in compliance with the requirements, per K.A.R. 30-60-6

A single provider must provide the above documentation along with qualifications to the MCO and receive prior authorization before the delivery of services.

The completion of all required background checks and screenings are the responsibility of the potential waiver provider. All background checks/screens must be completed and submitted with provider enrollment applications. If a provider is identified to have an offense on the Prohibited Offenses list, there is no exception. Any potential service provider found to be convicted of a Prohibited Offense will not be enrolled or credentialed as a waiver provider.

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):

The contractor / sub contactor and /or provider must check all individuals against the Kansas Department for Children and Families (DCF) child abuse, adult abuse and nurses aid registries. DCF Children and Adults Services maintain the registries for all confirmed perpetrators.

-Functional Eligibility Determination (Eligibility Specialist)
-Respite Care Provider
-Parent Support Specialist Provider
-Family Adjustment Counseling Provider

The contractor / sub contactors and /or providers must provide evidence that required standards have been met at the time of renewing their license. This standard can be reviewed by KDADS regional field staff at the time of their reviews and sooner if a potential problem is identified. At any time deemed appropriate by KDADS, a certification may be formally resurveyed by KDADS to determine whether the licensee continues to be in compliance with the requirements, per K.A.R. 30-60-6

All background checks/screens are the responsibility of the potential waiver provider. All results must be submitted with all other required documentation at the time the application is submitted. There are no exceptions for those who have been identified with an offense listed on the Prohibited Offenses list. Any potential service provider found to be convicted of a Prohibited Offense will not be enrolled or credentialed as a waiver provider.

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.*

☐ **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.*

○ **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:

Participants of HCBS-Autism waiver services have the right to choose who provides their services, within established guidelines regarding provider qualifications. Any qualified provider of those services may enroll through the Medicaid agency, Kansas Department of Health and Environment, (KDHE), for the Kansas Medical Assistance Program; and also must contract with, and meet the contracting terms of, the KanCare MCOs.

In addition to broad scale information and outreach by the State and the KanCare MCOs for all Medicaid providers, the providers that support HCBS waiver members have received additional outreach, information, transition planning and education regarding the KanCare program, to ensure an effective and smooth transition. In addition to the broader KanCare provider outreach the providers that support HCBS waiver members have had focused discussions with State staff and MCO staff about operationalizing the KanCare program; about transition planning (and specific flexibility to support this) for the shift of targeted case management into MCO care management; and about member support in selecting their KanCare plan. The requirements, procedures and timeframes to quality have been clearly communicated via state and MCO information development and outreach as described above, and also via standardized credentialing applications and state-approved contracts which MCOs offered to each existing provider; and related information, including provider manuals has been made available via State and MCO websites.

All providers submit the required application, background check/screening, and required program specific documentation to the Kansas Medical Assistance Program (KMAP) at the time of enrollment. All applications are reviewed and processed in the order that they are received, usually within forty-five (45) days of application submission date provided a complete application is received.

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 enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards
N=Number of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards
D=Number of enrolled licensed/certified waiver 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 *(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 = 95%
☒ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☒ **Annually**	☒ **Stratified** Describe Group: Proportionate by MCO
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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**	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number/percent of new licensed/certified waiver provider applicants that initially met licensure requirements, certification requirements, and other waiver standards prior to furnishing waiver services N=Number of new licensed/certified waiver provider applicants that initially met licensure requirements, etc.prior to furnishing waiver services D=Number of all new licensed/certified providers

Data Source (Select one):
Other
If 'Other' is selected, specify:
KanCare Managed Care Organization (MCO) reports and record reviews

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 = 95%
☒ **Other** Specify:	☒ **Annually**	☒ **Stratified** Describe Group:

KanCare Managed Care Organizations (MCOs)		Proportionate by MCO
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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 enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements N=Number and percent of 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 *(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 = 95%
☒ **Other** Specify: KanCare Manged Care Organizations (MCOs)	☒ **Annually**	☒ **Stratified** Describe Group: Proportionate by MCOs
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services
N=Number of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing wavier services D=Number of all new 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 *(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 =

		95%
☒ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☐ **Annually**	☒ **Stratified** Describe Group: Proportionate by MCO
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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 of providers that meet training requirements Denominator: Number of active providers

Data Source (Select one):
Record reviews, off-site
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 = 95/5
☒ **Other** Specify: MCO and contracted entity	☒ **Annually**	☒ **Stratified** Describe Group: proportioned by MCO
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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: MCOs contracted entity	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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.
KanCare MCOs are required to complete ongoing monitoring to ensure that their contracted providers meet all MCO credentialing and State Medicaid enrollments standards. The State completes MCO record reviews at least annually to ensure that all providers meet MCO credentialing and State enrollment standards.

The State completes record reviews with the MCOs to ensure that all MCO credentialed waiver providers meet the state Medicaid enrollment requirements. The State currently requires all Medicaid enrolled/MCO contracted providers to complete state approved training modules prior to delivering services. In the event that the training is not accessible at the time of enrollment providers are required to complete the state approved training modules within six (6) months of becoming an enrolled Medicaid approved provider. If the required training is not completed Medicaid enrollment/MCO contract is terminated.

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 and the operating protocols of the interagency monitoring team.

Data analysis is completed and remediated for any assurance or sub-assurance less than 100%. KDADS staff will notify the MCO of areas below 100% with details of each finding. KDADS staff will notify the MCO if a any findings are below 87%, those that fall below 87% are required to also include a quality improvement project. The MCO 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 Quality Management System (QMS) will be entered in Quality Review Tracker (QRT). Once entered, the QRT system will send an alert to the Assessor and/or MCO, and copy to the applicable Program Manager.

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: KanCare Managed Care Organizations (MCOs)	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

The purpose of the Kansas Autism Waiver is to provide eligible Kansans the option to receive parental support in their home and community in a cost-efficient manner. Therefore, based on the type and scope of services, the Autism Waiver services is limited to four

The four year limit applies to all services offered under this program. Autism waiver service limits have changed as they were once limited to three years with a request for a 1 yr extension. Waiver limits were designed based on research available at the time of program inception, stakeholder input and available funding for overall program administration.

Participants are provided information about the program at the time of initial program eligibility determination and notified of limitations by the MCO at the first assessment. Following level of care determination, the MCO is responsible for informing the participant of the Autism waiver program and service limitations. Program and specific service limitations are provided in the Autism waiver manual and made available to the public on KDADS, KDHE, KanCare MCO and Kansas Medical Assistance Program (KMAP) websites.

The MCO may adjust the limitation based on the waiver participant's health or welfare needs or other factors documented in the participants Service Plan. Both, the State and the MCOs, have appeal processes in place to ensure that waiver participants may appeal adverse actions. Details on the appeals/grievances processes are captured in Appendix F of the waiver.

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.

The State submitted a proposed Statewide Transition Plan pending CMS approval. see Main section, attachment #2

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 (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:

☐ **Social Worker**
Specify qualifications:

☒ **Other**
Specify the individuals and their qualifications:

Kansas has contracted with three managed care organizations, to provide overall management of these services as one part of the comprehensive KanCare program. The Managed Care Organization assigns a Care Coordinator for each participant. The Care Coordinator is responsible for organizing the Person Centered Planning Team meetings and assuring the Service Plan includes input from the participant and their family.

The CONTRACTOR(S) service coordinators shall have experience that is appropriate to the Member's health care needs and shall perform activities within their scope of practice in accordance with applicable licensing/ credentialing rules. The CONTRACTOR(S) has the flexibility to determine the service coordinator qualifications for populations not specifically listed here. Service coordinators working with specific populations shall have specific qualifications. CONTRACTOR(S) and community service coordinators serving Members who are in multiple population groups, such as youth in foster care who are enrolled on a HCBS Waiver, shall be assigned service coordinator most appropriate for the Member's needs and have experience working with the populations to be served.
At minimum qualifications shall include:
A. For Members with a LTSS need, CONTRACTOR(S) and community service coordinators shall:
1. Have at least a bachelor's degree in social work, rehabilitation, nursing, psychology, special education, gerontology, or related health and human services area or be a Registered Nurse (RN).
2. Have at least one (1) year of experience working with individuals with long-term care needs, and if working with a specific Waiver population (e.g. IDD, TBI or Frail Elderly [FE]), at least one (1) years' experience working directly with that population. Fulltime experience in the field of developmental disabilities services may be substituted for the degree at the rate of six (6) months of full-time experience for each missing semester of college for service coordinators working with individuals with IDD. Additionally, community service coordinators providing services to individuals with IDD must meets qualifications described in K.A.R. 30-63-32-Article 63.
3. Comply with additional qualifications as described in the State's HCBS Waivers included in Attachment C of this RFP.
B. For Members with a Behavioral Health need, CONTRACTOR(S) and community service coordinators shall:
1. Have at least a bachelor's degree in social work, nursing, rehabilitation, psychology or related health and human services area, or be a RN.
2. Have at least one (1) year of experience working with individuals with Behavioral Health needs and receive training in trauma informed care.

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.

When the Functional Eligibility Specialist has determined a child likely to require the level of care provided in inpatient psychiatric facility for individuals under 21 years of age, the child/family or his/her legal representative will be (1) informed of any feasible alternative available under the waiver, and (2) given the choice of either institutional or home and community based services [42 CFR 441.302 (d), and permitted to choose between them.

Child/family has access to the following:

-A copy of the forms(s) used to document freedom of choice and to offer a fair hearing
-The HCBS/Autism Waiver Participant Rights and Responsibilities which, among other Rights and Responsibilities, lists the right to services which are provided to persons in their category of eligibility in accordance with the Medicaid State Plan, based on the availability of services and fiscal limitations.

b. Once the child/family has received the above mention information and would like to receive HCBS/Autism waiver services the child/family is then given a provider list in which the family chooses their provider(s). The child/family, unless a guardian is in place, have the right to determine who is included in the process, and which service providers to use.

The Managed Care Organization assigns a Care Coordinator for each participant. The Care Coordinator is responsible for organizing the Person Centered Planning Team meetings and assuring the Service Plan includes input from the participant and their family.

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 have primary responsibility for Service Plan development and accountability to deliver all Medicaid covered services included in a participant's Service Plan. The initial and annual Service Plans are developed during a face-to-face meeting with the participant, legal representative (if applicable), the MCO and selected representatives that the participant chooses to be involved. 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 participant has the authority to determine the parties that he/she chooses to be involved in the development of their Service Plan. The KDADS' Person-Centered Service Plan policy outlines who the required participants are in the development of the Service Plan. MCOs, or their designee, are required to invite known HCBS providers for the individual to the Service Plan meeting unless otherwise specified by the individual. 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 has a court appointed guardian/conservator or an activated durable power of attorney for health care decisions, the guardian/conservator or the holder of the activated durable power of attorney for health care decisions must be included and all necessary signatures documented on the Service Plan.

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.

State Response: Needs Assessment(s) completed by the MCO within 6 months, which must address:
a. Physical, and
b. Behavioral, and
c. Functional
Each of these areas must be addressed in the Person-Centered Service Plan.

b) All applicants for program services must undergo a Vineland 3 to determine functional eligibility for the Autism waiver. The Vineland 3 is utilized to determine the level of care (LOC) eligibility for the Autism waiver. The State's functional eligibility contractor conducts an assessment of the individual within the time frame specified in the contract, unless a different time frame is requested by the applicant or his/her legal representative, if appropriate. The MCO, or their designee, will complete a needs assessment for the participant within six months and must address physical, behavioral and functional needs in the Person-Centered Service Plan that identify the services the participant needs in order to allow them to safely remain in the community and to help them achieve their preferred lifestyle. The participant will complete a Participant Interest Inventory (PII). The PII is a Service Plan related document which allows the participant to identify their preferred lifestyle, their strengths, their passions and values, what is important to them, their goals, areas in which they feel they need support and how they would like that support to be provided to them. The MCO, or their designee, will review the PII with the individual and their legal representative during the Service Plan meeting and will use the PII to help design the Service Plan. The Service Plan includes the scope, duration and amount of the authorized services for the HCBS participant.

c) Each participant found eligible for Autism waiver services can choose whether they would like to receive services through the waiver program. The MCO, or their designee, is responsible for providing information about the waiver service that are 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 included in the Person-Centered Service Plan (Service Plan). The MCO, or their designee, assists the participant with accessing information and supports from the participant's chosen provider.

d) Through the various assessments and Service Plan related documents described in b) above, the participant's goals, needs and preferences are at the forefront of developing their Service Plan. The Person-Centered Service Plan meeting refers to, at a minimum, the annual (once every 365 calendar days or less), face-to-face meeting where a participant develops their Person-Centered Service Plan with the support of any designated legal representatives, guardians, informal supports, or service providers requested by the participant.

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. A Person-Centered Service Plan meeting shall be held, subject to the convenience of the individual, upon MCO notification or awareness of necessitating circumstances. Responsibilities are designated by the MCO Care Coordinator during the Person Centered Service Plan meeting. These assignments are documented in the Service Plan. 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. Each service provider who will participate in the delivery of services shall sign a statement of understanding and consent to deliver the applicable services included in the Person-Centered Service Plan. The MCO Care Coordinator would need to include all services the child needs to access on the Person Centered Service Plan. This will include State plan services as well as waiver services.

1. The MCO shall coordinate obtaining provider signatures.
b) Provider signature does not constitute approval or denial of the Person-Centered Service Plan. Provider signatures indicate an understanding of the Person-Centered Service Plan contents, and denotes a willingness and ability to deliver services within the scope, amount and duration established in the Person-Centered Service Plan.
2. The participant may request that their primary or specialty care providers sign their plan, if this request is made, the MCO Care Coordinator is responsible to obtain signature from these providers.
a) In the event the provider originally selected refuses to sign a statement of agreement, the MCO Care Coordinator shall provide education to the participant that services on the plan cannot be provided by a Provider who is unwilling to sign the plan.
b) The MCO Care Coordinator shall obtain another provider choice from the individual.
3. In the event the only willing provider of HCBS services refuses to sign the Person-Centered Service Plan, the MCO must obtain signed documentation from the party that they refuse to sign the plan and the MCO Care Coordinator shall notify the applicable HCBS Program Manager, in writing, of this refusal. MCOs shall proceed with services for providers who have signed the Person-Centered Service Plan.
4. When interim changes are made to a participant's Person-Centered Service Plan that
MCO Care Coordinator must also obtain a signature from the impacted service providers.
5. Providers who fail to sign a statement of agreement will not be paid for services provided prior to MCO receipt of a signed statement from the provider.

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. MCOs shall conduct one face-to-face or telephonic visit with the participant within 30 days of transitions from any alternate setting of care, after which the MCO must follow up with quarterly telephone calls and face-to-face visits every six months.

g) The requirements for how and when the Service Plan are updated are specified in the KDADS' Person-Centered Service Plan policy. The MCOs conduct periodic reviews, as specified by the KanCare MCO contracts, 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. Additional Person-Centered Service Plan meetings may be necessary due to changes in condition or circumstance that require updates to the participant's plan, which would impact the scope, amount or duration of services included in the Person-Centered Service Plan. The following changes in condition or circumstance necessitate a Person-Centered Service Plan meeting to ensure the plan meets the participant's wishes and needs:
a) Change in functional ability to perform two or more Activities of Daily Living (ADLs) or three or more Instrumental Activities of Daily Living (IADLs) compared to the most recently assessed functional ability;
b) Significant change in informal support availability, including death or long-term absence of a primary caregiver, and/or any participant identified changes in informal caregiver availability that results in persistent unmet needs that are not addressed in the most recently developed Person-Centered Service Plan;
c) Post-transition from any alternate setting of care (i.e.: state hospital, nursing home, etc.), when the participant was not residing in a community-based setting for thirty days or greater;
d) Upon the request of any waiver participant, guardian or legal representative;
e) Any health and/or safety concern;
f) Any change in needs for an HCBS recipient not listed above.
coverage

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

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, which identifies 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 Person-Centered Service Plan is subject to periodic review and update as required by the KanCare contract. 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.

A 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 a 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 MCO qualified providers of each service included in his/her written Person-Centered Service Plan. The MCO provides each eligible participant with a list of providers from which the participant can choose a service provider. The MCO assists the participant with accessing information and supports from the participant's preferred provider. These service access agencies have, and make available to the participant, the names and contact information of qualified providers for waiver services identified in their Person-Centered Service Plan.

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):

The MCO and the child/family develop a Person Centered Service Plan. This plan is then submitted to the contracted MCO of choice for the plan's approval.

The MCO is responsible for maintaining a copy of an electronic or paper Person Centered Service Plan in the child's file.

Engagement of the interagency monitoring team, brings together leadership, program management, contract management, fiscal management and other staff/resources of the SSMA and the Operating Agency to collectively monitor the extensive reporting, review results and other quality information and data related to the KanCare program and services on a quarterly basis.

The State Operating Agency Quality Management Staff (QMS) conducts routine oversight of service plans including: On-site reviews are conducted, at a minimum, annually. The State Operating Agency QMS conduct ongoing reviews based upon a statistically valid random sample of service plans, at a minimum quarterly. Critical components of the SSMA and Operating Agency's role in service plan development include:

1. Engagement of the interagency monitoring team, which meets quarterly and brings together agency leadership, program management, contract management, fiscal management and other staff/resources of the SSMA and the Operating Agency to collectively monitor the extensive reporting, review results and other quality information and data related to the KanCare program and services.
2. Continuance of the Long Term Committee where the Operating Agency reports quality assurance and programmatic activities to SSMA for oversight and collaboration.

KDADS conducts quarterly reviews of the MCO service plans by the KDADS Quality Assurance team. KDADS Quality Assurance Team follows a protocol to evaluate each service plan. The KDADS Program Manager reviews these results as well as the KDHE Waiver Managers. The MCO's are assigned to implement approved Quality Improvement Plans to address any and all deficiencies. We are looking at a sample that meets specifications as indicated in the waiver.

The sample review using a 95% confidence level review. These reviews are conducted quarterly. KDADS Quality Assurance Team follows the protocol established for performance measure reviews. KDADS Program Manager and KDHE Waiver Managers review for accuracy. KDADS assigns approved Quality Improvement Plans to the MCO's in cases where they do not meet the threshold for the performance measures.

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:

The Eligibility Specialist maintains copies of the original FEI, freedom of choice forms, and the Rights and Responsibilities forms.

The KanCare MCOs maintain the copies of the above mentioned information as well as any additional forms such as; the child/family strengthens and needs assessment, individualized behavioral program and Service Plan, detail progress notes, etc., In the child's case file.

Copies are maintained for a minimum period of 3 years as required by 45 CFR 74.53

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 three KanCare contracting managed care organizations are responsible for monitoring the implementation of Service Plans that were developed as a partnership between the participant and the MCO and for ensuring the health and welfare of the participant with input from the Autism 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).

On an ongoing basis, the MCOs monitor the Service Plans and participant needs to ensure:

- Services are delivered according to the Service Plan: ;
- Participants have access to the waiver services indicated on the Service Plan
- Participants have free choice of providers;
- Services meet participant's needs;
- Liabilities with self-direction (if applicable)/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 Service Planis 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 Service Plan is modified to meet change in needs, eligibility, or preferences, or at least annually.

In addition, the 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 requiring remediation are reported to the MCO and waiver provider for prompt follow-up and feedback. Related information is reported to the Autism 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

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.

The monitoring methods are a desk review of the Service Plans provided by the MCO's as assigned during quarterly reviews. The sample is statistically significant based off of approved waiver standards. Currently there is one performance measure where data is collected based off returned member survey results. The survey includes questions regarding current services and the individuals/guardians experience with HCBS services and the waiver. KDADS assigns remediation to each MCO in the form of a request for a Quality Improvement Plan for each performance measure they do not meet the 87% threshold. KDADS staff follows up with a QIP meeting for each MCO to approve or amend QIP's submitted by the MCO's. KDADS then follows up to review progress by each MCO's quarterly review scores to evaluate improvement or adjust the QIP as necessary to meet the performance measure.

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 service plans address all of each participant's health and safety risk factors N=Number of waiver participants whose service plans address all of each participant's 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 reviews

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 = 95%
☒ **Other** Specify:	☐ **Annually**	☒ **Stratified** Describe Group:

KanCare Managed Care Organizations (MCOs)		Proportionate by MCO
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver participants whose service plans address participants' goals Numerator: Number of waiver participants whose service plans address participants' goals Denominator: Number of service plans due to be updated for annual redetermination that were reviewed.

Data Source (Select one):
Other

If 'Other' is selected, specify:

Record reviews

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 = 95%
☒ **Other** Specify: KanCare Managed Care Organizations	☐ **Annually**	☒ **Stratified** Describe Group: Proportionate by MCO
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment Numerator: Number of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment Denominator: Number of waiver participants whose service plans were reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews

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 = 95%
☒ **Other** Specify:	☒ **Annually**	☒ **Stratified** Describe Group: Proportionate by MCO

KanCare Managed Care Organizations (MCOs)		
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

Performance Measure:
Number and percent of waiver participants (or their representatives) who were present and involved in the development of their service plan N=Number of waiver participants (or their representatives) who were present and involved in the development of their service plan D=Number of waiver participants whose service plans were reviewed

Data Source (Select one):
Record reviews, off-site
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 = 95/5
☒ **Other** Specify: MCOs	☐ **Annually**	☒ **Stratified** Describe Group: proportioned by MCO
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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: contracted MCO	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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 waiver participants with documented change in needs whose service plan was revised, as needed, to address the change N=Number of waiver participants with documented change in needs whose service plan was revised, as needed, to address the change D=Number of waiver participants whose service plans were reviewed.

Data Source (Select one):
Record reviews, off-site
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**	☐ **Weekly**	☐ **100% Review**

Agency		
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95/5
☒ **Other** Specify: MCOs	☐ **Annually**	☒ **Stratified** Describe Group: Proportioned by MCO
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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: contracted MCO	☒ **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 service plans reviewed before the waiver participant's annual redetermination date N=Number of service plans reviewed before the waiver participant's annual redetermination date D=Number of waiver participants whose service plans were reviewed

Data Source (Select one):
Record reviews, on-site
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 = 95/5
☐ **Other** Specify:	☐ **Annually**	☒ **Stratified** Describe Group: Proportionate by MCO.
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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: contracted MCOs	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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:
Number and percent of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan N=Number of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan D=Number of waiver participants whose service plans were reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews and Electronic Visit Verification (EVV) reports, if applicable

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 = 95%
☒ **Other** Specify: contracted MCOs	☒ **Annually**	☒ **Stratified** Describe Group: Proportionate by MCO
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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 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 for documentation indicating a choice of waiver services

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews

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 = 95%
☒ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☒ **Annually**	☒ **Stratified** Describe Group: Proportionate by MCO
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver participants whose record contains documentation indicating a choice of community-based services v. an institutional alternative N=Number of waiver participants whose record contains documentation indicating a choice of community-based services D=Number of waiver participants whose files are reviewed for the documentation

Data Source (Select one):
Record reviews, off-site
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 = 95/5
☒ **Other** Specify: MCOs	☐ **Annually**	☒ **Stratified** Describe Group: proportioned by MCO
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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: contracted MCOs	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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 files are reviewed for the documentation indicating a choice of waiver service providers

Data Source (Select one):
Record reviews, off-site
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 = 95/5
☒ **Other** Specify:	☐ **Annually**	☒ **Stratified** Describe Group:

MCOs		proportioned by MCO
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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: MCOs	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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 priority identification regarding all waiver assurances and minimum standards and 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 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 trended to identify areas for improvement. Upon completion of identified areas of improvement this information is compiled into reports and shared both internally and externallyThese 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.

KDADS Quality Assurance field staff have file review protocol questions to assess whether service plans include waiver processes, such as:

- Providing Choice;
- Rights & Responsibilities;
- Notice Of Action for adverse actions, terminations, denials or change in service plans;

Service plan include goals;

- Addresses health and safety risks and needs; and
- Participant involvement

: If a case is found to have errors, the State would note that measure as not being met. An example of an error or non-compliant measure could include but may not limited to:

- Doesn't appear the service plan adequately addressed the needs, or health or safety risks; or goals.
- No evidence (i.e…signature/date of consumer) the participant participated and was involved in the development of their service plan.

MCOs are required to monitor service plan development of contracted providers as part of their ongoing quality process. The State completes, at a minimum, annual record reviews for the Autism Waiver oversight to overall service plan development of MCOs and contracted providers.

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 of waiver performance standards as detected through on-site monitoring, survey results and other performance monitoring

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*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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

E-1: Overview (1 of 13)

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.

) All participants of Autism waiver services have the opportunity to choose the MCO that will support them in overall service access and care management. The opportunity for participant direction (self-direction) is made known to the participant by the MCO, which is available to all waiver participants (Kansas Statute 39-7,100). Respite is the only service that can be participant directed on this wavier. This opportunity includes specific responsibilities required of the participant, including:

- Recruitment and selection of 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 the worker, 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 Respite services attendants 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) 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 respite attendants, managing workers, and providing effective communication and problem-solving.

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*:

- [x] **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

The participant must have a legal guardian to direct some or all of the services offered under participant-direction. Participant-direction is offered for the following services:

- Respite

Self-direction is not an option when the 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 services provided by direct service workers, 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 direct service workers;
•the benefits of self-direction;
•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 Autism Program Manager, KDADS Regional Field Staff, and is also available through waiver policies and procedure manuals.

c)Information regarding self-directed services is initially provided by the MCO during the 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 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.

Information regarding participant direction of services is shared with each person at least annually during the eligibility redetermination (with the state assessing agency), and person-centered planning meetings.

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:

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
Respite 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 Agency with Choice provider 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 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.

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.

All standards, certifications and licenses that are required for the specific field through which service is provided including: professional license / certification if required and adherence to KDADS' training and professional development requirements. 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.

In addition, organizations are required to submit the following documents with the signed agreement:

FMS organizations are required to submit the following documents with the signed FMS provider agreement as a part of the readiness review:
•Community Mental Health Center (CMHC) or Community Developmental Disabilities Organization (CDDO)
•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

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).

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 member per month. The per member per month payment is estimated based upon a formula that includes all direct and indirect costs to payroll agents and an average hourly rate for direct service workers. 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).

Requirements include agreements between the FMS provider and the participant, Direct Service Worker and the State Medicaid Agency and verification of processes to ensure the submission of Direct Service 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 Service Worker satisfaction; maintain a grievance process for Direct Service 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 the 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. The Kansas Department of Health and Environment 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)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.

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
Parent Support and Training (peer to peer) Provider	☒
Financial Management Services	☒
Family Adjustment Counseling	☒
Respite Care	☒

☒ **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:

The Department for Aging and Disabilities Services contracts with the Self-Advocate Coalition of Kansas (SACK) to provide training to participants regarding the self-directed option for service delivery. Each person is given contact information for SACK upon request.

Services in support of participant-direction are offered whenever a waiver affords participants the opportunity to direct some or all of their waiver services. Two core service definitions are provided: (1) information and assistance in support of participant direction and (2) financial management services.
FMS providers assist the participant or participant's representative by providing two distinct types of tasks: (1) administrative tasks and (2) information and assistance (I&A) tasks.
When a participant or participant's representative chooses an FMS provider, he or she must be fully informed by the FMS provider of his or her rights and responsibilities to:
• Choose and direct support services
• Choose and direct the workers who provide the services
• Perform the roles and responsibilities as employer
• Understand the roles and responsibilities of the FMS provider
• Receive initial and ongoing skills training as requested

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:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. 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. 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) entity. The participant is to maintain continuous Respite coverage, as previously documented on the participant’s Service Plan, with the authorization for service;

The duties of the consumer's case manager and the KanCare MCO in collaboration, are to:
•Explore other service options and receive a copy of the completed new Choice form from the CDDO/CMHC; and
•Advocate for participants by arranging for services with individuals, businesses, and agencies for the best available service within limited resources.

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 participant's chosen MCO may discontinue self-direction and offer agency-directed services when, in the MCO's professional judgment as observed and documented in the participant's case file, one or more of the following occurs:
1. if the participant/representative does not fulfill the responsibilities and functions required;
2. if 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 for the participant have been exhausted;
3. if the direct support worker has not adequately performed the services as outlined in the Peron-Centered Service Plan (Service Plan);
4. if the direct support worker has not adequately performed the necessary tasks and procedures; or
5. if the participant/representative or service provider has abused or misused self-direction including:
• the participant/representative has directed the direct support worker to provide, and the direct support worker has in fact provided, paid attendant care services beyond the scope of the needs assessment and/or POC;
• the participant/representative has directed the service providers to provide, and the service providers has in fact provided paid comprehensive support or Enhanced Care Services beyond the scope of the service definition;
• the participant/representative has submitted signed time sheets for services beyond the scope of the needs assessment and/or the Service Plan;
• the participant/representative has continually directed the direct support worker to provide care and services beyond the limitations of their training, or the training of the service providers for health maintenance activities in a manner that has a continuing adverse effect on the health and welfare of the participant.

The following warrant termination of the self-directed care option without the requirement to document an attempt to remedy:
1. the participant/representative has falsified records that result in claims for services not rendered;
2. the participant has Health Maintenance Activities or medication setup and the participants attending physician or RN no longer authorizes the participant to self-direct his/her care; or 3. the participant/representative has committed a fraudulent act.

A timely Notice of Action (NOA) shall be sent to the participant prior to the effective date for termination of the participant's participation in the Self-Directed Care Option. The MCO coordinates to ensure there is not a lapse in service delivery.

The MCO works with the participant to maintain continuous attendant coverage as outlined and authorized on the participant's Service Plan. The MCO, though their care management and monitoring activities, works with the participant's choice of a non-self-directed agency to assure participant health and welfare during the transition period and beyond by communicating with both the participant and the non-self-directed agency, by monitoring the services provided, and by gathering continual input from the participant as to satisfaction with services.

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	75	
Year 2	75	
Year 3	75	
Year 4	75	
Year 5	75	

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:

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 K.S.A. 39-2009 is not eligible for reimbursement of services under Medicaid funding.

☒ **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.

Request for Fair Hearing Regarding a Functional Eligibility Determination:

Kansas has contracted with independent assessors to conduct level of care determinations (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 determination/redetermination.

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.

Applicants/beneficiaries may file a fair hearing for an ineligible determination made by the contracting assessor agency.

KanCare Managed Care Organizations (MCOs) are required to have grievance and appeal processes that meet all relevant federal and state standards, including state fair hearings and expedited appeals. 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 processes and Fair Hearing processes can also be found at the KanCare website.

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 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. The assessing entity provides the Consumer Rights and Responsibilities form to each family which outlines the appeal rights.

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.
- Members will receive a Notice of Action in the mail if an Action has occurred.
- An Appeal is a request for a review of any of the above actions.
- To file an Appeal: Members or (a friend, an attorney, or anyone else on the member's behalf can file an appeal).
- An appeal can be filed verbally, but it must be followed by a written request. The Customer Service Center for your health plan can also help you with an appeal.
- An appeal must be filed within 60 days calendar days plus 3 calendar days after the participant has received a Notice of Action.
- The 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 resolve in 45 calendar days.

Fair Hearings

A member may request a Fair Hearing upon receiving a Notice of Action.

A Fair Hearing is a formal meeting 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, conduct 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 the appeal, the participant or their representative may ask for a fair hearing. The letter or fax must be received within 120 plus 3 calendar days of the date of the appeal decision.
The request be submitted in writing and mailed or faxed to:
Office of Administrative Hearings 1020 S. Kansas Ave.
Topeka, KS 66612-1327
Fax: 785-296-4848

• 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.

Participants have the right to benefits continuation of previously authorized services while a hearing is pending and can request such benefits as a part of their fair hearing request. 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. The MCOs have the information regarding continuation of waiver services pending a hearing decision in their notices of adverse benefit determination. In Kansas, waiver beneficiaries are not required to request continuation. Following an MCO's adverse benefit determination that reduces, suspends or terminates waiver services, the MCOs continue the waiver services during the 60-day appeal time period to give the beneficiary the opportunity to request an MCO appeal. If the waiver beneficiary requests an MCO appeal timely, the waiver services continued during the appeal time period are continued another 120 days. The beneficiary must request a hearing within the 120-day time period in order to have their services continued until the hearing decision.

For all KanCare MCOs:
In addition to the education provided by the State, members receive information about the Fair Hearing process in the member handbook they receive at the time of enrollment. The member handbook is included in the
welcome packet provided to each member. It will also be posted online at the MCOs' member 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 member can call the MCO to get information and assistance with the Fair Hearing process.

The State requires that all MCOs define an "action" pursuant to the KanCare contract and 42 CFR §438.400. While 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 their Medicaid application is denied, 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).

Reporting KDADS defined adverse incident requirements:

Other adverse incidents to be reported by KDADS staff into AIRS include, Death, Elopement, Emergency Medical Care, Law Enforcement Involvement, Misuse of Medications, Natural Disaster, Neglect, Serious Injury, Suicide, Suicide Attempt, and use of Restraints, Seclusion, and Restrictive interventions. See KDADS HCBS Adverse Incident Reporting and Management policy 2017-110 for definitions of all adverse incidents that are required to be reported by KDADS staff.

Additionally, incidents shall be classified as adverse incidents when the event brings harm or creates the potential for harm to any individual being served by KDADS HCBS waiver program, the Older Americans Act, the Senior Care Act, or Behavioral Health Services programs, according to KDADS HCBS Adverse Incident Reporting and Management Standard policy 2017-110. These acts include all use of restraints, seclusion and restrictive intervention.

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: (a) 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 thereto 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: 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:

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 work days, 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.

Reporting entities/individuals may include (but are not limited to):
All KDADS licensed providers

Community Developmental Disability Organization (CDDO)
Aging and Disability Resource Center (ADRC)
Financial Management Services Providers (FMS)
Community Mental Health Center (CMHC)
Psychiatric Residential Treatment Facilities (PRTF)
Substance Abuse Treatment Facilities
Targeted Case Managers (TCM)
Concerned community members (have the ability)

KDADS Program Integrity staff members provide interactive trainings to entities that could potentially report incidents in the AIR System such as assessing entities, HCBS providers and the MCO's.

The MCO's are required to review the following steps and take the appropriate actions to ensure health and welfare of the waiver participant. 1. Back-up Plan
2. Behavior Support Plan
3. Behavioral Health Follow-up
4. Community Resource Referral
5. Complex Case Round
6. Corrective Action Plan
7. DPOA/Guardian Contact
8. Face-to-face visits
9. Increase Participant Engagement
10. Performance Improvement Plan
11. Integrated Person Centered Service Plan Change
12. Policy/Procedure Request
13. Potential Quality of care issue identified
14. Removal of Self-direction to Agency Directed Services
15. Safeguard Planning
16. TCM Contact

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.

The participant's chosen KanCare MCO provides information and resources to all participants and caregivers regarding strategies to identify, prevent, report, and correct any instances of potential Abuse, Neglect or Exploitation. Information and training on these subjects is provided by the MCOs to members in the member handbook, is available for review at any time on the MCO member website, and is reviewed with each member, by the care management staff responsible for service plan development, during the annual process of service plan development. Depending upon the individual needs of each member, additional training or information is made available and related needs are addressed in the individual's service plan. The information provided by the MCOs is consistent with the State's abuse, neglect and exploitation incident reporting and management process (although the MCOs also have additional incident management information and processes beyond those regarding reporting/management of member abuse, neglect and exploitation).

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.

• The entity that receives reports of each type of critical event or incident:
For reportable events involving suspected Abuse, Neglect, Exploitation or Fiduciary Abuse of children, the State of Kansas per K.S.A. 38-2223 requires when persons mandated to report suspicion that a child has been harmed as a result of physical, mental or emotional abuse or neglect or sexual abuse, the reporter shall report the matter promptly. Reports can be made to the Kansas Protection Report Center or when an emergency exists the report should be made to the appropriate law enforcement agency.
The reporting of all KDADS defined adverse incidents, as defined in the HCBS Adverse Incident Reporting and Management Standard Policy, shall be reported within 24 hours of the reporter becoming aware of the adverse incident by direct entry into the KDADS web-based AIRS in accordance with the KDADS HCBS Adverse Incident Monitoring SOP.
The entity that is responsible for evaluating reports and how reports are evaluated:
All reports of Abuse, Neglect, Exploitation and Fiduciary Abuse are reported to and investigated by DCF. Following the DCF Prevention and Protective Services (PPS) Policy and Procedure Manual 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 is statutorily responsible for all Abuse, Neglect, Exploitation, and Fiduciary Abuse investigation and follow-up in accordance with, K.S.A. 38-2223 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. 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, which is entered into AIRS and reviewed by KDADS staff.
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, PICS will determine the level of severity for each screened in adverse incident reported in AIRS,and will assign a level of severity. PICS will assign each incident with a Level 1 or Level 2 scoring. All abuse, neglect and exploitation reports are given a Level 2 priority. 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. All use of restraint, seclusion or restrictive interventions shall be reviewed by the MCO to ensure adherence to policy and appropriate follow-up. 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.
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. Per PPS policy number 1521, reports assigned for Abuse/Neglect concerns shall be assigned with either a same day or 72-hour response time. Reports assigned as Non-Abuse/Neglect Family in Need of Assessment (NAN FINA) are assigned a response time per PPS policy number 1670.
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. Per DCF PPS Policy and Procedure Manual 2500: The purpose of the case finding is to inform when abuse/neglect has occurred; and whether the identified perpetrator should be permitted to reside, work, or regularly volunteer in a child care facility. A case finding shall be completed for each assigned allegation associated with a child alleged or suspected to have been abused or neglected. The CPS specialist, in consultation with the PPS supervisor or designee, (See PPM 0140), shall make the finding decision based on information gathered by the CPS specialist or CPS investigator during investigatory activities. The decision is made by weighing the facts and circumstances learned during the investigation and assessment and applying the definition of abuse/neglect. The standard of evidence applied to all case finding decisions regarding abuse and neglect is preponderance of the evidence.
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:

Notice of Department Finding per DCF PPS Policy Number 2540:
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.

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.

KDADS has primary responsibility for ensuring that all adverse incidents are reviewed and addressed as outlined in the MOU with KDHE 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.

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 as outlined in the inter-agency cooperative agreement. Kansas Department for Children and Families, Division of Child Protective Services is responsible for overseeing the reporting of and response to all critical incidents and events related to abuse, neglect and exploitation. Child 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 Child Protective Services Program Manager gather, trend and evaluate data from both sources and report the data to KDADS 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.

- The frequency of oversight activities.

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. KDADS quality team reviews the MCO process, investigation and outcome of the AIR report. The quality team makes a determination if the MCO outcome is satisfactory and if not, will assign a corrective action plan and remediation as necessary.

MCO investigations shall be concluded in one of the following three findings:
Finding #1 - Doesn’t meet adverse incident definition – report reviewed by MCO and does not meet the Adverse Incident definitions as defined.
Finding #2 - MCO action required - Report was reviewed and MCO action is required. (Select all that apply)
1. Back-up Plan
2. Behavior Support Plan
3. Behavioral Health Follow-up
4. Community Resource Referral
5. Complex Case Round
6. Corrective Action Plan
7. DPOA/Guardian Contact
8. Face-to-face visits
9. Increase Participant Engagement
10. Performance Improvement Plan
11. Integrated Person Centered Service Plan Change
12. Policy/Procedure Request
13. Potential Quality of care issue identified
14. Removal of Self-direction to Agency Directed Services
15. Safeguard Planning
16. TCM Contact

Finding #3 - No MCO action required – Report was reviewed and no MCO action is required (e.g. death by natural causes, law enforcement/emergency medical involvement where no suspected ANE documented, etc.).

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:

The State has added 2 sub-assurances under the QIS sub-section of Appendix G to ensure ongoing monitoring and oversight of unauthorized uses of restrictive interventions. The sub-assurances added were developed to be consistent with global reporting measures that the State developed with the assistance of CMS and Truven through technical assistance to bring quality reporting into the managed care environment in 2014.

The State will be utilizing the AIR system to monitor all restrictive interventions as well as any adverse incidents.

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.

○ **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:

The State has added 2 sub-assurances under the QIS sub-section of Appendix G to ensure ongoing monitoring and oversight of unauthorized uses of restrictive interventions. The sub-assurances added were developed to be consistent with global reporting measures that the State developed with the assistance of CMS and Truven through technical assistance to bring quality reporting into the managed care environment in 2014.

The State will be utilizing the AIR system to monitor all restrictive interventions as well as any adverse incidents.

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.

○ **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 is utilizing the AIR system to monitor all restrictive interventions as well as any adverse incidents.

The Kansas Department for Aging and Disability Services (KDADS-CSP) 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. Information and findings are reported to KDHE waiver managers quarterly/annual reports.

Methods for detecting unauthorized use, overuse or inappropriate, ineffective use of restrictive interventions and ensuring that all applicable state requirements are followed.

MCO as well as CMHC conducts on-going education through the Person Center Planning Process to educate and assess the participant's knowledge, ability, and freedom from the use of restraints. If it is determined that there is suspected un-authorized use, the KDADS Licensing Staff instructs the CMHC to report to the appropriate hotline and enter an adverse incident report to KDADS PIC team. Immediate remediation would follow the reporting. KDADS staff will be responsible for ensuring these issues are effectively in place for waiver participants, as part of the overall KanCare quality improvement strategy.

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 re-occurrence.

KDADS PIC Team refers any reports of unauthorized restraints to the MCO for appropriate follow up. MCO outreach to the Person-Centered planning team and providers to investigate the safety of participant and minimize the reoccurrence. MCO manages additional meetings to update Service Plan to ensure safety of the participant on the waiver. KDADS Integrity team reviews the MCO follow up to ensure proper policy and procedures were followed and safety needs of participate are meet.
KDADS Licensing will follow up with the CMHC staff to ensure appropriate supports and services are in place to eliminate the need for restraints.

The following Performance Improvement Analysis Process occurs on an annual basis.

1. Data Aggregation is completed by the data analysis staff.

2. Quality Assurance Process including:

a. Quality Assurance Team including the Program Manager, Quality, data analysis staff and QMS staff reviews the data for trends and determines the necessity of changes to the tool, training or program might be necessary.

3. Quality Assurance Report provided to KDHE via the KDHE Waiver Managers, for review by the State Medicaid Agency (SSMA).

- The methods for overseeing the operation of the incident management system including how data are collected, compiled, and used to prevent re-occurrence.

Oversight for compliance to assure the protection of children through critical incident reviews, regulatory standards, and statute is conducted by KDADS- Licensing through on-going and on-site record review. KDADS Quality Assurance teams interviews of individuals served, guardians if applicable, review of compliance of the Person Center Service Plan. KDADS-Licensing are responsible for addressing all unauthorized restraint with the CMHC to ensure preventative action is taken for the protection of children.

○ **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 instancesof 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:
Number and percent of unexpected deaths for which review/investigation followed the appropriate policies and procedures N=Number of unexpected deaths for which review/investigation followed the appropriate policies and procedures as in the approved waiver D=Number of unexpected deaths

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 =
☒ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

Managed Care Organizations (MCOs)		
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of unexpected deaths for which review/investigation resulted in the identification of preventable causes N=Number of unexpected deaths for which review/investigation resulted in the identification of non-preventable causes D=Number of unexpected deaths

Data Source (Select one):
Other

If 'Other' is selected, specify:

Record reviews

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 =
☒ **Other** Specify: Managed Care Organizations (MCOs)	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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**	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
PM 3: Number and percent of unexpected deaths for which the appropriate follow-up measures were taken Numerator: Number of unexpected deaths for which the appropriate follow-up measures were taken as in the approved waiver Denominator: number of unexpected deaths.

Data Source (Select one):
Record reviews, off-site
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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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:
Number and percent of reported critical incidents requiring review/investigation where the State adhered to its follow-up measures N=Number of reported critical incidents requiring review/investigation where the State adhered to the follow-up methods as specified in the approved waiver D=Number of reported critical incidents

Data Source (Select one):
Other
If 'Other' is selected, specify:
Critical incident management 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 =
☒ **Other** Specify: Managed Care Organizations (MCOs)	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participants' reported critical incidents that were initiated and reviewed within required time frames N=Number of participants' reported critical incidents that were initiated and reviewed within required time frames as specified in the approved waiver D=Number of participants' reported critical incidents

Data Source (Select one):
Other
If 'Other' is selected, specify:
Critical incident management 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 =

☒ **Other** Specify: Managed Care Organizations (MCOs)	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

Number and percent of waiver participants who received information on how to report suspected abuse, neglect, or exploitation Numerator: Number of waiver participants who received information on how to report suspected abuse, neglect, or exploitation Denominator: Number of waiver participants interviewed by QMS staff or whose records are reviewed

Data Source (Select one):
Record reviews, off-site
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 = 95/5
☒ **Other** Specify: MCOs	☐ **Annually**	☒ **Stratified** Describe Group: proportioned by MCO
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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: MCOs	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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:
Number and percent of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver
Denominator: Number of restraint applications, seclusion or other restrictive interventions

Data Source (Select one):
Record reviews, on-site
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**	☐ **Weekly**	☒ **100% Review**

Agency		
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

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

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):
Record reviews, off-site
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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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 received physical exams in accordance with State policies Numerator: Number of HCBS participants who received physical exams in accordance with State policies Denominator: Number of HCBS participants whose service plans were reviewed

Data Source (Select one):
Record reviews, off-site
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 = 95/5
☐ **Other** Specify:	☐ **Annually**	☒ **Stratified** Describe Group: proportioned by MCO
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
MCO's	
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
PM 10: Number and percent of waiver participants who have a disaster red flag designation with a related disaster backup plan Numerator: Number of waiver participants who have a disaster red flag designation with a related disaster backup plan Denominator: Number of waiver participants with a red flag designation

Data Source (Select one):
Record reviews, off-site
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 = 95/5
☒ **Other** Specify: MCOs	☐ **Annually**	☒ **Stratified** Describe Group: proportioned by MCOs
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **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:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

DCF’s Division of Child Protective Services is responsible for overseeing the reporting of and response to all critical incidents and events.

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.

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: KanCare Managed Care Organizations (MCOs)	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

KDHE operates as the SSMA and KDADS serves as the operating agency. The two agencies collaborate in developing operating agency priorities to meet established HCBS assurances and minimum standards of service.

Through KDADS's Quality Review (QR) process, a statistically significant random sample of HCBS participants is interviewed and data collected for meaningful participant feedback on the HCBS program. KDADS reviews a statistically significant sample of participants for the Autism (KS.0476) population and the other affected waiver populations under the Quality Improvement Strategy. The QR process includes review of participant case files against a standard protocol to ensure policy compliance. KDADS Program Managers regularly communicate with Managed Care Organizations, the functional eligibility contractor and HCBS service providers, thereby ensuring continual guidance on the HCBS service delivery system.

KDADS Quality Review staff collects data based on participant interviews and case file reviews. KDADS Program Evaluation staff reviews, compiles, and analyzes the data obtained as part of the Quality Review process at both the statewide and MCO levels to initiate the HCBS Quality Improvement process. This information is provided quarterly and annually to KDADS management, KDHE's Long-Term Care Committee and the interagency monitoring team and the KanCare Managed Care Organizations and contracted assessor organizations. De-identified results, to exclude any personally-identifying information, are available upon request to other interested parties. In addition to data captured through the QR process, other data is captured within the various State systems, the functional eligibility contractor's systems as well as the Managed Care Organizations' systems. On a routine basis, KDADS' Program Evaluation staff extracts or obtains data from the various systems and aggregates it, evaluating it for any trends or discrepancies as well as any systemic issues. Examples include, but are not limited to, reports focusing on qualified assessors and claims data.

A third major area of data collection and aggregation focuses on the agency's critical incident management system. KDADS worked with CPS, a division within the Kansas DCF and the MCO's and established a formal process for oversight of critical incidents and events, including reports generated for trending, the frequency of those reports, as well as how this information is communicated to DHCF-KDHE, the single state Medicaid agency. The system allows for uniform reporting and prevents any possible duplication of reporting to both the MCOs and the State. The Adverse Incident Reporting System, also known as AIR, facilitates ongoing quality improvement to ensure the health and safety of individuals receiving services by agencies or organizations licensed or funded by KDADS and provides information to improve policies, procedures and practices. Incidents are reported within 24 hours of providers becoming aware of the occurrence of the adverse incident. Examples of adverse incidents reported in the system include, but are not limited to, unexpected deaths, medication misuse, abuse, neglect and exploitation.

For all three main areas of data collection and aggregation, KDADS Program Evaluation staff collects data, aggregates it, analyzes it and provides information regarding discrepancies and trends to Program staff, Quality Review staff 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, training of the QR staff to ensure the protocols are utilized correctly, protocol revisions to capture the appropriate data and policy clarifications to MCOs to ensure adherence to policy. Additionally, any remediation efforts might be MCO-specific or provider-specific, again depending on the nature, scope and severity of the issue(s).

KDADS Quality Assurance Team reviews quarterly submissions from the contracted assessor to ensure accurate information is being obtained and the Vineland-3 assessments are being completed correctly within the appropriate timeframe. KDADS Quality Assurance Team requires the contracted assessor to provide the following documents for each child assessed:

1. Vineland-3 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 waiver children, to ensure adequacy of qualified providers and to ensure financial accuracy in billing. KDADS Quality Assurance Team requires the Managed Care Organizations to provide the following documents for each child on the Autism Waiver:

1. Person Centered Service Plans (PCSP) (aka: POC/ISP)
2. All PCSP's for the review period (include documentation of any changes made during the review period)
3. All PCSP's require individual's representative/guardian's, and provider's signatures; and dates signed.
4. PCSP components include, but not limited to:
 a. Developed according to the process (face to face interview and is signed and dated by the individual and/or their representative/guardian; and
 b. Identified individual's services in type, scope, amount, duration, frequency as noted in the assessment, to include effective dates; and
 c. Addresses, Needs and Capabilities; Health and Safety Risk Factors; and
 d. Includes individual's goal(s).
 e. Be understandable to the individual receiving services and persons important to the individual. It must be written in plain language and in a manner that is
 accessible to the individuals with disabilities and persons with limited English proficient.
 f. Identify the individual and/or entity responsible for monitoring the plan
 g. Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation
 h. Be distributed to the individual and others involved in the plan
 i. Include those services the purpose or control of which the individual elects to self-direct
 j. Prevent the provisions of unnecessary or inappropriate services and supports
 k. Identify specific individualized assessed need
 l. Document the positive interventions and supports used prior to any modifications to the PCP
 m. Document less intrusive methods of meeting the need that had been tried but did not work
 n. Include a clear description of the condition that is directly proportionate to the specified assessed need
 o. Include regular collection and review of data to measure the ongoing effectiveness of the modification
 p. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated
 q. Include informed consent of the individual
 r. Include an assurance that interventions and supports will cause no harm to the individual
 s. The plan must be reviewed, and revised upon reassessment of functional need at least every 12 months or when the individual's needs or circumstances change
 significantly, or at the request of the individual
5. Needs Assessment(s) completed by the MCO within 6 months, which must address:
 a. Physical, and
 b. Behavioral, and
 c. Functional
6. Choice Form/Documentation:
 a. Choice of Waiver services v. Institutional placement
 b. Choice of Self-Direct or Agency-Directed services
 c. Choice of Provider (Provide documentation of individual being shown how to access the list of providers, and noting choice with valid signature and date of
 individual or their representative/guardian.
 d. Choice of Services (Provide documentation of choice being offered for eligible services, with valid signature and date of individual or their
 representative/guardian.
7. Case log documentation for the review period, to include contacts with individual such as telephone calls, individual visits, etc.….
8. All Notices of Actions to the individual, relevant to the review period. (Inclusive of adverse actions and POC updates.)
9. Documentation of notifications to the individuals made through the 3160 and/or 3161(s) and the 834 report (*Evidence of MCO notification of eligibility by providing
 copy or screen shot of eligibility) including but not limited to:
 a. Notification of Eligibility
 b. Change of address
 c. Change in POC cost
 d. Change in Client Obligation
 e. Death of Individual
 f. HCBS service termination

g. Individual enters institution, for planned brief stay
10. Evidence of Rights and Responsibilities, discussed with the individual's representative/guardian. Must be signed and dated by individual's representative/guardian.
11. Evidence of Appeal and Grievance rights/processes, discussed with the individual's representative/guardian. Must be signed and dated by individual's representative/guardian.
12. Back Up Plan for individual and has individual's representative/guardian's signature and date
13. Notification of eligibility (documentation of MCOs notice of individual's eligibility)
14. Evidence of start date of Personal Service Worker
15. Evidence that the individual / family received information on how to report abuse, neglect and exploitation
16. Documentation on "reported use" of restraint application, seclusion or other restrictive interventions
17. Documentation on use of restraint application, seclusion or other restrictive interventions where "appropriate procedures were followed"
18. Documentation on "Critical Incidents" reporting "unauthorized" use of restraint application, seclusion or other restrictive interventions

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. Data analysis is completed and remediated for any assurance or sub-assurance less than 87%. KDADS Program Manager will notify the provider of areas below 87% 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 the KDADS Program Manager 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, the KDADS Program Manager 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 KDADS Program Manager.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Quality Improvement Committee**	☒ **Annually**
☒ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☐ **Other** Specify:

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 the state fiscal agent 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 state fiscal agent staff to generate recommended systems changes, which are then monitored and analyzed by the state fiscal agent staff 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:

WORK PLAN:
The Operating Agency has convened an internal HCBS Quality Improvement Committee, comprised of Program, Quality Review, and Program Evaluation Staff as of 1/18/2017. The group will meet quarterly to evaluate trends reflected in the HCBS Quality Review Reports and identify areas for improvement. KDADS compiles a quarterly report containing data for all of the HCBS Performance Measures in all 7 1915 c waivers. Results of these reports are distributed and reviewed internally at KDADS and KDHE, in addition to being posted publicly on the KanCare website

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. Because of other business relationships with the State, 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.

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 MCOs make payments 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.

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 key component of that collaboration will be through the interagency monitoring team, an important part of the overall state's KanCare Quality Improvement Strategy, which will provide 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.

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 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 functions 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.

The State operating agency Quality Assurance conduct annual MCO reviews and audits which are inclusive of HCBS services.

All providers are subject to 100% review annually by the State operating agency Quality Assurance staff.

100% of Autism waiver providers are audited annually. There is no random sample drawn for this population.

For the Autism waiver, 100% of providers are audited annually by the State operating agency Quality Assurance staff.

Waiver providers are contracted and credentialed by the MCO and bill the MCO directly for services rendered.

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

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
DSS/DAI encounter data

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 =*
☒ ***Other*** *Specify:* *KanCare Managed Care Organizations (MCOs)*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***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***	☒ ***Annually***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
Specify: *KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency*	
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

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 N=number of payment rates that were certified to be actuarially sound by the State' actuary and approved by CMS D=Total number of capitation (payment) rates

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Rate Setting 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 =
☒ ***Other*** *Specify:* *KanCare Managed Care Organizations (MCOs)*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***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:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

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 work will be governed by the comprehensive state Quality Improvement Strategy for the KanCare program. The Quality Improvement Strategy engages program management, contract management and financial management staff of both KDHE and KDADS.

The MCOs are responsible for monitoring for ensuring that service plans are rendered appropriately as well as responsible for the payment to the provider.

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 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:* *KanCare Managed Care Organizations (MCOs)*	☐ ***Annually***
	☒ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

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.

The State is receiving TA assistance to ensure all Waiver quality measures appropriately meet the intent of each assurance. The State is currently targeting 1/1/23 to have new/revised measures implemented.

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 Autism 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 Autism 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.

The FMS administrative payments are paid on a monthly basis. While a participant is temporarily hospitalized, the monthly payment would not need to be cancelled or changed as long as the participant is using participant-directed services during the month.

FMS in Kansas works under an employer agent model. Funds received on behalf of the participant, and within the scope of the FMS responsibilities, shall be deposited in accordance with the FMS provider agreement in which such deposits shall be individually accounted by participant. As required by 42 CFR 443.300 et seq, residual funds not dispersed to a participant's DSW in accordance with federal and state laws, rules and regulations shall be returned in accordance with the FMS provider agreement. Kansas does not require FMS providers to perform the required background checks. This requirement may be taken on by the FMS provider, waiver participant or DSW.

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 Autism 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:*

A capitated payment is made to the MCOs for each month of Waiver eligibility. This is identified through KAECES, the State's eligibility system.

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 and participant interviews to verify that services on the Service Plan were rendered.

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:

○ ***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:

The MMIS Managed Care system assigns beneficiaries to one of the three KanCare Plans. Each assignment generates an assignment record, which is shared with the plans via an electronic record. At the end of each month, the MMIS Managed Care System creates a capitation payment, paid in arrears, for each beneficiary who was assigned to one of the plans. Each payment is associated to a rate cell. The rate cells, defined by KDHE as part of the actuarial rate development process which is certified to and approved by CMS, each have a specific dollar amount established by actuarial data for a specific cohort and an effective time period for the rate.

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:

☒ ***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.

Not applicable.

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

I-3: Payment (7 of 7)

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 ?1115/?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 ?1115 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 are 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	548.75	12500.00	13048.75	33458.67	8541.33	42000.00	28951.25
2	699.97	12500.00	13199.97	33458.67	8541.33	42000.00	28800.03
3	861.60	12500.00	13361.60	33458.67	8541.33	42000.00	28638.40

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)
4	1000.48	12500.00	13500.48	33458.67	8541.33	42000.00	28499.52
5	1143.30	12500.00	13643.30	33458.67	8541.33	42000.00	28356.70

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	82	82
Year 2	82	82
Year 3	82	82
Year 4	82	82
Year 5	82	82

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.*

Average Length of Stay is 289 days for each year of the renewal.

The ALOS is calculated based off of the turnover rate, which is the total number of unduplicated persons per year divided by the number of persons served at any point in time: 82/65 = 1.26. The average length of stay is 365 days divided by the turnover rate of 1.26, which equals = 289 days. Since the point-in-time limit is the same for all 5 years, the ALOS is 289 days for each year of the renewal.

The unduplicated persons served is based upon the approved CMS 372 report for Year 5 (01/01/2015 to 12/31/2015) of the previous waiver. The unduplicated number of participants could not be changed/updated during the current renewal due to Section 9817 ARP MOE requirements.

The point-in-time limit was established during the last waiver renewal to manage waiver expenditures due to legislative appropriation.

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 Information System and analyzing trends of annual utilization from April 2017 through March 2020. This will only be a projection of MCO encounters and not be reflective of the State's Capitation payments made to the MCO.

The State assumed increased participation in Family Adjustment Counseling based on a waiver change based on allowing telehealth as an option in the renewal. Additionally, the State adjusted utilization by participants by increasing the unit limit to 60 and estimating that 75% of the limit will be utilized on average.

For Parent Support and Training, the State estimated growth in the first three years of the renewal period based on allowing for telehealth and as place of service. The State also assumed growth in units per participant based on increased availability of services with the telehealth option.

The State has added Self-Directed respite as a new service to this Waiver. The State reviewed Managed Care encounter data from the Kansas Medicaid Information System and evaluated trends of utilization from April 2017 through March 2020 for the existing waiver services. Then, based upon programmatic knowledge and assumptions, the State made its best estimate to project utilization for the new waiver service over the 5 years of the Waiver. The State assumed that approximately 30% of the Waiver participants would utilize this service by Year 5 and assumed growth would occur over that 5-year period in order to reach that target.

For Financial Management Services (FMS), the state is aligning with the utilization of the new self-directed service. FMS will be billed each month for every beneficiary utilizing the self-directed respite service.

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' was projected by subtracting the Factor D cost estimates from the estimated MCO encounter payments that will be made to the State's Managed Care Organizations over the period of the Waiver.

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:*

In Kansas, Factor G represents hospitalization costs for KanCare beneficiaries receiving services through an Inpatient Psychiatric facility for individuals aged 21 and younger.

These costs are paid by the state through managed care capitated payments which cover all Medicaid costs. The average all-inclusive capitated costs for these beneficiaries while admitted to the institutional setting averaged approximately $1,700 annually prior to the COVID pandemic which was derived on data from the State's Medicaid data system based on data from April 2017 through March 2020. Given the length of stay difference between the Waiver and the institutional stay, the State extrapolated the institutional capitated cost based on the Waiver length of stay to determine an historical Factor G cost of approximately $35,000.

Based on the actual state expended capitated rate payment data, the state projects costs of $42,000 annually in the new Waiver period assuming a 20% cost growth along with similar lengths of stay experienced prior to the COVID-19 pandemic. The state assumed cost growth is directly related to the state's current processes in expansion of the provider network for these inpatient services.

In order to breakout the total capitated cost of $42,000 between Factor G and G', the state analyzed MCO encounter claims for Waiver Years 1-3 (04/01/2017-03/31/2020) to proportionally split the cost between hospital and other state plan share of cost. This resulted in a Factor G of $33,458 and a Factor G' of $8,541.

At this point, the state does not currently project substantial increases in utilization or costs during the 5-year Waiver period.

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:*

In Kansas, Factor G' represents non-hospitalization costs for KanCare beneficiaries receiving services through an Inpatient Psychiatric facility for individuals aged 21 and younger.

These costs are paid by the state through managed care capitated payments which cover all Medicaid costs. The average all-inclusive capitated costs for these beneficiaries while admitted to the institutional setting averaged approximately $1,700 annually prior to the COVID pandemic which was derived on data from the State's Medicaid data system based on data from April 2017 through March 2020. Given the length of stay difference between the Waiver and the institutional stay, the State extrapolated the institutional capitated cost based on the Waiver length of stay to determine an historical Factor G cost of approximately $35,000.

Based on the actual state expended capitated rate payment data, the state projects costs of $42,000 annually in the new Waiver period assuming a 20% cost growth along with similar lengths of stay experienced prior to the COVID-19 pandemic. The state assumed cost growth is directly related to the state's current processes in expansion of the provider network for these inpatient services.

In order to breakout the total capitated cost of $42,000 between Factor G and G', the state analyzed MCO encounter claims for Waiver Years 1-3 (04/01/2017-03/31/2020) to proportionally split the cost between hospital and other state plan share of cost. This resulted in a Factor G of $33,458 and a Factor G' of $8,541.

At this point, the state does not currently project substantial increases in utilization or costs during the 5-year Waiver period.

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	
Respite Care	
Financial Management Services	
Family Adjustment Counseling	
Parent Support and Training (peer to peer) Provider	

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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Care Total:							**16316.80**
Agency Directed	☒	15 minutes	5	160.00	3.26	**2608.00**	
Self Directed	☒	15 minutes	15	272.00	3.36	**13708.80**	
Financial Management Services Total:							**18756.00**
Financial Management Services	☒	1 month	15	10.00	125.04	**18756.00**	
Family Adjustment Counseling Total:							**4158.45**
Group	☒	15 minutes	3	45.00	5.44	**734.40**	
Individual	☒	15 minutes	7	45.00	10.87	**3424.05**	
Parent Support and Training (peer to peer) Provider Total:							**5766.36**
Group	☒	15 minutes	18	58.00	3.26	**3403.44**	
Individual	☒	15 minutes	6	58.00	6.79	**2362.92**	

GRAND TOTAL:	**44997.61**
Total: Services included in capitation:	44997.61
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**82**
Factor D (Divide total by number of participants):	**548.75**
Services included in capitation:	548.75
Services not included in capitation:	
Average Length of Stay on the Waiver:	289

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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Care Total:							**20026.24**
Agency Directed	☒	15 minutes	5	160.00	3.26	**2608.00**	
Self Directed	☒	15 minutes	18	288.00	3.36	**17418.24**	
Financial Management Services Total:							**22507.20**
Financial Management Services	☒	1 month	18	10.00	125.04	**22507.20**	
Family Adjustment Counseling Total:							**6115.50**
Group	☒	15 minutes	5	45.00	5.44	**1224.00**	
Individual	☒	15 minutes	10	45.00	10.87	**4891.50**	
Parent Support and Training (peer to peer) Provider Total:							**8748.96**
Group	☒	15 minutes	24	66.00	3.26	**5163.84**	
Individual	☒	15 minutes	8	66.00	6.79	**3585.12**	

GRAND TOTAL:	**57397.90**
Total: Services included in capitation:	57397.90
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**82**
Factor D (Divide total by number of participants):	**699.97**
Services included in capitation:	699.97
Services not included in capitation:	
Average Length of Stay on the Waiver:	289

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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Care Total:							**24058.24**
Agency Directed	☒	15 minutes	5	160.00	3.26	**2608.00**	
Self Directed	☒	15 minutes	21	304.00	3.36	**21450.24**	
Financial Management Services Total:							**26258.40**
Financial Management Services	☒	1 month	21	10.00	125.04	**26258.40**	
Family Adjustment Counseling Total:							**8072.55**
Group	☒	15 minutes	7	45.00	5.44	**1713.60**	
Individual	☒	15 minutes	13	45.00	10.87	**6358.95**	
Parent Support and Training (peer to peer) Provider Total:							**12261.80**
Group	☒	15 minutes	30	74.00	3.26	**7237.20**	
Individual	☒	15 minutes	10	74.00	6.79	**5024.60**	

GRAND TOTAL:	**70650.99**
Total: Services included in capitation:	70650.99
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**82**
Factor D (Divide total by number of participants):	**861.60**
Services included in capitation:	861.60
Services not included in capitation:	
Average Length of Stay on the Waiver:	289

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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Care Total:							**28412.80**
Agency Directed	☒	15 minutes	5	160.00	3.26	**2608.00**	
Self Directed	☒	15 minutes	24	320.00	3.36	**25804.80**	
Financial Management Services Total:							**30009.60**
Financial Management Services	☒	1 month	24	10.00	125.04	**30009.60**	
Family Adjustment Counseling Total:							**10029.60**
Group	☒	15 minutes	9	45.00	5.44	**2203.20**	
Individual	☒	15 minutes	16	45.00	10.87	**7826.40**	
Parent Support and Training (peer to peer) Provider Total:							**13587.40**
Group	☒	15 minutes	30	82.00	3.26	**8019.60**	
Individual	☒	15 minutes	10	82.00	6.79	**5567.80**	

GRAND TOTAL:	**82039.40**
Total: Services included in capitation:	82039.40
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**82**
Factor D (Divide total by number of participants):	**1000.48**
Services included in capitation:	1000.48
Services not included in capitation:	
Average Length of Stay on the Waiver:	289

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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Care Total:							**33089.92**
Agency Directed	☒	15 minutes	5	160.00	3.26	**2608.00**	
Self Directed	☒	15 minutes	27	336.00	3.36	**30481.92**	
Financial Management Services Total:							**33760.80**
Financial Management Services	☒	1 month	27	10.00	125.04	**33760.80**	
Family Adjustment Counseling Total:							**11986.65**
Group	☒	15 minutes	11	45.00	5.44	**2692.80**	
Individual	☒	15 minutes	19	45.00	10.87	**9293.85**	
Parent Support and Training (peer to peer) Provider Total:							**14913.00**
Group	☒	15 minutes	30	90.00	3.26	**8802.00**	
Individual	☒	15 minutes	10	90.00	6.79	**6111.00**	

GRAND TOTAL:	**93750.37**
Total: Services included in capitation:	93750.37
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**82**
Factor D (Divide total by number of participants):	**1143.30**
Services included in capitation:	1143.30
Services not included in capitation:	
Average Length of Stay on the Waiver:	289