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.Adding a telehealth delivery option of Parent Support and Training Service and Wrap-Around Facilitation. The State does not expect an increase in utilization for Wraparound Facilitation due to the addition of the telehealth delivery option. Due to Appendix K flexibilities during the pandemic, telehealth is currently being utilized for this service and has not had a great impact on the average users or units when analyzing the state's encounter data. The State assumes that Wraparound Facilitation levels of utilization will resume pre-COVID levels of utilization over the five years of the renewal period.
2.Lowering the age of eligibility to 14 for Independent Living/Skills Building
3.Removal of Performance Review Team.
4.Removing the third party eligibility review. KDADS Program Manager reviews each initial eligibility packet for LOC evaluation and determines functional eligibility before KDHE determines financial eligibility.
5.Future PM amendments will be submitted on 8/1/2023 and/or after the renewal is approved.

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*):

Serious Emotional Disturbance (SED) Waiver

C. Type of Request: renewal

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: KS.0320
Waiver Number:KS.0320.R05.00
Draft ID: KS.009.05.00

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 Serious Emotional Disturbance (SED) Waiver is designed as a hospitalization diversion program. The goal of the SED waiver is to divert psychiatric hospitalization through the provision of intensive home and community based support services in an effort to maintain children and participant in their homes and communities.

The Kansas SED waiver provides six services to participants and their families that are not available to other Medicaid participant. These services are: wraparound facilitation, short term respite care, attendant care, independent living/skills building, parent support and training, and professional resource family care. Participants eligible for the waiver are between the ages of 4 and 18.
An age exception for clinical eligibility may be requested for participants under the age of 4 and over the age of 18 through age 21 who are experiencing a serious emotional disturbance and are at risk for inpatient psychiatric hospitalization. Foster Care children on the SED waiver will not be able to access short term respite care or professional resource family care. The foster care contractor is able to arrange for the foster care participant/to access those two services through their contract with the state .

Both clinical and financial criteria must be met to be eligible for the waiver. The clinical assessment is a multi-step process. A participant must have a mental health diagnosis determined by a Qualified Mental Health Professional (QMHP) and qualifying scores on two standardized assessment tools. These tools are the Child and Adolescent Functional Assessment Scale (CAFAS) and the Child Behavior Checklist(CBCL). Financial eligibility is determined by the Kansas Department of Health and Environment(KDHE).

The SED waiver is managed by the Operating Agency, the Kansas Department for Aging and Disability Services. SED Waiver services are provided by 25 Community Mental Health Centers (CMHCs) and two affiliated organizations.

Each waiver participant will have a Person Centered Service Plan, (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.

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 Input was October 1, 2021 through November 15,2021. SED Waiver Renewal Public Comment hosted by Wichita State University and lead by KDADS staff were held three different times:
Tuesday October 26, Wednesday, October 27, October 28 in the evening. All public comments can be found at https://kdads.ks.gov/kdads-commissions/long-term-services-supports/ltss-public-comment-section. There were a total of 17 public comments, below is a sample.

Commenter: HCBS Provider - Can we change the language for the TCM and WAF at the same time to the "same person can not bill TCM and wraparound facilitation at the same time"? That would apply to the last sentence of the WAF definition (first paragraph) and the comment about the TCM and WAF should not be the same person. I think that would be much clearer for the point you are trying to make IF I am clearly understanding that correctly. The way it is currently written the TCM and WAF can not be working on different tasks at the same time (WAF contacting families to reschedule the wraparound meeting and TCM working on helping the family find resources they need) nor can a WAF in Western Kansas where they have fewer staff deliver timely service to a client because they have to wait on someone else to get the information and complete the task (instead WAF could finish their phone calls to set up wraparound meeting and then switch to billing TCM to call and find out who has food resources this month since family expressed that need when on the phone with the WAF). When you say that it cannot be the same person at the same time, that very clearly says the same person is not billing two codes at the same time. It says that those of two very different services with very different purposes that can not be done at the same time by one person.
KDADS Response: KDADS revised the waiver language to make a clearer delineation on how to conduct billing for WAF and TCM.

Commenter: Other Stakeholder - I am assuming then also that the wraparound facilitator and targeted case manager not being the same person is actually not the same person at the same time.
KDADS Response: Correct. If they're not the same person. It just can't be the same person billing both codes at same time, they need to be separate people.

Commenter: Other Stakeholder - When we are getting a client onto Medicaid, but they aren't on the waiver yet, sometimes this takes time and we can't bill for TCM since we are going to end up being the wraparound facilitator. Should we continue to provide this service as a no-bill, or should we provide this service as targeted case management since they aren't on the waiver yet?
KDADS Response: Bill TCM if they have a Medicaid card and not yet on the waiver. If they do not yet have a Medical care it is a no-bill situation.

Commenter: Other Stakeholder - What if is the parent's preference to meet via telehealth for wraparound facilitation meetings?
KDADS Response: They can certainly do that. They are required to meet face-to-face once a year when we are outside of the pandemic. Telehealth is fine now, but out of a public health emergency there is a requirement for the coordinators to meet face-to-face once a year.

Commenter: Other Stakeholder - It would be great if that waiver medical card could be put on pause should a waiver participant have a residential stay so that services can start up in a timely matter. I have had so many more transfers recently. I don't know why more people are moving around but it is something we've noticed as an agency. It gets difficult sometimes to navigate all of the transfers. Even though it's a draft the manual that speaks to the transfers has been helpful. It's hard because sometimes the notification comes from the MCO, sometimes the family, sometimes the previous CMHC. Sometimes the previous CMHC doesn't have a release, just verbal consent. It feels like there needs to be more help with the transfer section Maybe create a 3161 specifically for transfers. Sometimes I don't have any information except the client's name and I have to contact multiple people to get updated contact information. If we can create a new document that shows their contact information that can be transmitted through agency mailboxes. KMIS is helpful but there would need to be a way to get all of those documents submitted. Anything to streamline transfer cases would be helpful.
KDADS Response: KDHE does not need a 3161 with someone who is within the state.If you could work with other CMHCs and come up with a proposal on inter-state transfers we would want to hear about it and see if we can help you with that.

Commenter: Other Stakeholder- The Provisional Plan of Care is not effective now until financial eligibility but that would be awesome. Problem will be if the process starts in one month but is approved in the following month.
KDADS Response: It's a difficult challenge. Until they're actually eligible for the waiver,they aren't eligible for services.

We are trying to close this gap as much as we can. There have been improvements in the last year or so getting eligibility determined much more quickly. We'll continue to work through this.

Commenter: Other Stakeholder - Does the MCO have to be face-to-face at wraparound facilitation meetings? Does everyone involved have to be present face-to-face? And as the CMHC, we usually lead meetings because we provide direct services and have the rapport. But we know the MCOs are now responsible for Person Center Service Plans and PIIs. Who should be leading the meeting. How should that work?
KDADS Response: The MCO care coordinator and the wraparound facilitator must meet in-person at least once a year with members. And we hold the MCOs accountable for having the meetings and making sure paperwork is submitted. I think it depends on each meeting who leads.

Notice to Tribal Governments: We received no 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 Manager

Agency: Kansas Department of Health and Environment.

Address: 900 SW Jackson, Room 900 N

Address 2:

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:
Heller-Workman, LBSW

First Name:
Angela

Title:
SED Waiver Program Manager

Agency:
Kansas Department for Aging and Disability Services Community Supports and Services

Address:
503 S Kansas Ave

Address 2:

City:
Topeka

State: **Kansas**

Zip:
66603

Phone:
(785) 296-6843 **Ext:** ☐ **TTY**

Fax:
(785) 296-0256

E-mail:
Angela.HellerWorkman@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: Jun 15, 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:

Lowered eligibility for independent Living and Skills Building to age 14

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 amendment or renewal will be subject to any provisions or requirements included in the state's 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.

Kansas is committed to an HCBS services environment that reflects the characteristics of ensuring choice of services and providers, privacy, autonomy, community access and integration for our waiver participants in compliance with the Final Settings Rule.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Not applicable

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

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 MCO's 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 SED 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:

KS has 26 Community Mental Health Centers (CMHCs) established under the provisions of the following state statute 2020 KS Statute, KSA 19 4001, and approved by the Secretary for Aging and Disability Services.
The 26 CMHC's hold yearly contracts through the KDADS Behavior Health Department which is mandated by the State Legislators through Kansas Statutes. CMHCs are responsible for the provision of mental health services in Kansas. The Centers are responsible for specific geographic areas throughout the state and are procured through the state's contracting process. Two of the CMHC's are local public governmental agencies. Twenty-four of the CMHC's are non-governmental state entities.
The CMHCs first complete a general intake/assessment on all participants to determine if the participant has a Serious Emotional Disturbance. Next, therapists would administer additional assessment tools to establish waiver eligibility. KDADS delegated the assessment functions to the CMHCs for SED potential participants and current participants via K.S.A. 39-1610, which states that each mental health center entering a contract with the secretary shall provide screening, treatment and evaluation, court ordered evaluation and other treatment services pursuant to the care and treatment act for mentally ill persons. KDADS contracts with the Community Mental Health Centers on a yearly basis. The CMHC's assist in waiver enrollment by providing the assessment function to start the waiver enrollment process. Once SED waiver level of care assessment is administered the CMHC's submits the LOC assessment to KDADS to determine program eligibility. The CMHC's Qualified Mental Health Practitioner conducts the initial LOC assessments which the SED waiver potential participant to determine waiver eligibility. KDADS Program Manager approves waiver access and sends to Kansas Department for Health and Environment (KDHE) to determine financial eligibility. KDADS Program reviews the CAFAS, CBCL and ICE packet, and any additional documents for program eligibility criteria. Program Manager signs off on those approved and met LOC criteria. The 3160 designated program eligibility form is complete and sent on to the KDHE eligibility department for the financial determination. KDHE then notifies the MCO and CMHC of the final eligibility and if approved, the start date of waiver services. KDHE sends completed eligibility packet to the chosen Managed Care Organization (MCO) and back to KDADS. KDHE Waiver Managers review monthly reports from the Program Manager which notes the current numbers for the SED Waiver participant.
The CMHCs and MCO's are both responsible for quality assurance and quality improvement activities.
The state's contracted MCOs conduct Service Plan development and related service authorizations, develop and review service plans, assist with utilization management, conduct provider credentialing, provider manuals, and other provider guidance; and participate in the comprehensive state quality improvement strategy. The state's Community Mental Health Centers (CMHC) conduct waiver assessment for current and potential participants. The MCO and CMHC meet with the participant and participant's family at initially and then every 90 days to review the Person-Centered Service Plan. The Person-Centered Service Plan Team meet with the participant to review goals and the need for continued waiver services to meet their defined goals. These is determined through the CMHC's conducing a Level of care assessment annually. The annual level of care continues to require a QMHP as the assessor and is based on current diagnosis and level of functioning. The participant's Annual LOC documents are uploaded by the CMHCs into KDADS KAMIS reporting system for KDADS review. The KDADS Quality Review Team reviews a sample of the CMHC's reassessments quarterly to assure all documents reflect the ongoing LOC for continuation on the waiver.
KDADS reviews and approves documentation for functional eligibility and the Single State Medicaid Agency (KDHE) approves financial eligibility. KDHE holds the contract for the Managed Care Organizations. KDHE hold regular quality assurance and oversight activities for the MCOs'. KDHE contracts with KFMC to perform EQRO functions. KDADS completes quarterly Performance Measure reviews for both the assessing entities and the MCOs.

☒ **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:

KS has 26 Community Mental Health Centers (CMHCs) established under the provisions of the following state statute 2020 KS Statute, KSA 19 4001, and approved by the Secretary for Aging and Disability Services.
The 26 CMHC's hold yearly contracts through the KDADS Behavior Health Department which is mandated by the State Legislators through Kansas Statutes. CMHCs are responsible for the provision of mental health services in Kansas. The Centers are responsible for specific geographic areas throughout the state and are procured through the state's contracting process. Two of the CMHC's are local public governmental agencies. Twenty-four of the CMHC's are non-governmental state entities.
The CMHCs first complete a general intake/assessment on all participants to determine if the participant has a Serious Emotional Disturbance. Next, therapists would administer additional assessment tools to establish waiver eligibility. KDADS delegated the assessment functions to the CMHCs for SED potential participants and current participants via K.S.A. 39-1610, which states that each mental health center entering a contract with the secretary shall provide screening, treatment and evaluation, court ordered evaluation and other treatment services pursuant to the care and treatment act for mentally ill persons. KDADS contracts with the Community Mental Health Centers on a yearly basis. The CMHC's assist in waiver enrollment by providing the assessment function to start the waiver enrollment process. Once SED waiver level of care assessment is administered the CMHC's submits the LOC assessment to KDADS to determine program eligibility. The CMHC's Qualified Mental Health Practitioner conducts the initial LOC assessments which the SED waiver potential participant to determine waiver eligibility. KDADS Program Manager approves waiver access and sends to Kansas Department for Health and Environment (KDHE) to determine financial eligibility. KDADS Program reviews the CAFAS, CBCL and ICE packet, and any additional documents for program eligibility criteria. Program Manager signs off on those approved and met LOC criteria. The 3160 designated program eligibility form is complete and sent on to the KDHE eligibility department for the financial determination. KDHE then notifies the MCO and CMHC of the final eligibility and if approved, the start date of waiver services. KDHE sends completed eligibility packet to the chosen Managed Care Organization (MCO) and back to KDADS. KDHE Waiver Managers review monthly reports from the Program Manager which notes the current numbers for the SED Waiver participant.
The CMHCs and MCO's are both responsible for quality assurance and quality improvement activities.
The state's contracted MCOs conduct Service Plan development and related service authorizations, develop and review service plans, assist with utilization management, conduct provider credentialing, provider manuals, and other provider guidance; and participate in the comprehensive state quality improvement strategy. The state's Community Mental Health Centers (CMHC) conduct waiver assessment for current and potential participants. The MCO and CMHC meet with the participant and participant's family at initially and then every 90 days to review the Person-Centered Service Plan. The Person-Centered Service Plan Team meet with the participant to review goals and the need for continued waiver services to meet their defined goals. These is determined through the CMHC's conducing a Level of care assessment annually. The annual level of care continues to require a QMHP as the assessor and is based on current diagnosis and level of functioning. The participant's Annual LOC documents are uploaded by the CMHCs into KDADS KAMIS reporting system for KDADS review. The KDADS Quality Review Team reviews a sample of the CMHC's reassessments quarterly to assure all documents reflect the ongoing LOC for continuation on the waiver.
KDADS reviews and approves documentation for functional eligibility and the Single State Medicaid Agency (KDHE) approves financial eligibility. KDHE holds the contract for the Managed Care Organizations. KDHE hold regular quality assurance and oversight activities for the MCOs'. KDHE contracts with KFMC to perform EQRO functions. KDADS completes quarterly Performance Measure reviews for both the assessing entities and the MCOs.

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:

KDHE holds the contract for the Managed Care Organizations. They hold regular quality assurance and oversight activities for the MCOs'. KDHE contro perform EQRO functions. The CMHCs first complete a general intake/assessment on all participants to determine if the participant has a Sacts with KFMC terious Emotional Disturbance. Next, therapists would administer additional assessment tools to establish waiver eligibility.
KDHE is responsible for the financial eligibility before the participants are granted access to the waiver. KDHE issues eligibility determination letters and appeal rights if not found eligible.

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

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

Appendix A: Waiver Administration and Operation

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

The state's Community Mental Health Centers (CMHC) conduct waiver assessment for current and potential participants. Initial and annual assessments are completed by the CMHC.

KDADS Program Manager reviews each initial eligibility packet for LOC evaluation and determines program eligibility before KDHE determines financial eligibility and submits through KDADS official operating system (KAMIS). KDADS Program reviews the CAFAS, CBCL and ICE packet, and any additional documents for program eligibility criteria. Program Manager signs off on those approved and met LOC criteria. The 3160 designated program eligibility form is complete and sent on to the KDHE eligibility department for the financial determination. KDHE then notifies the MCO and CMHC of the final eligibility and if approved, the start date of waiver services.

The MCO and CMHC meet with the participant and participant's family at initially and then every 90 days to review the Person Centered Service Plan. The Person Centered Service Plan Team meet with the participant to review goals and the need for continued waiver services to meet their defined goals. These is determined through the CMHC's conducing a Level of care assessment annually. The annual level of care continues to require a QMHP as the assessor and is based on current diagnosis and level of functioning. The participant's Annual LOC documents are uploaded by the CMHCs into KDADS KAMIS reporting system for KDADS review. The KDADS Quality Review Team reviews a sample of the CMHC's reassessments quarterly to assure all documents reflect the ongoing LOC for continuation on the waiver.

KDADS reviews and approves documentation for functional eligibility and the Single State Medicaid Agency (KDHE) approves financial eligibility. KDHE holds the contract for the Managed Care Organizations. KDHE hold regular quality assurance and oversight activities for the MCOs'. KDHE contracts with KFMC to perform EQRO functions. KDADS oversees assessing entities in quarterly quality reviews.

KDADS Program Manager reviews each initial eligibility packet for LOC evaluation and determines program eligibility before KDHE determines financial eligibility. KDADS Program Manager reviews the CAFAS, CBCL and ICE packet, and any additional documents for program eligibility criteria. Program Manager signs off on the designated form for approval and sends it on to the KDHE eligibility department for the financial determination. Reevaluations: The CMHC's upload the participant's Annual LOC documents into KAMIS for KDADS review. If the participant no longer qualifies, the CMHC submits a 3161 to KDHE. KDHE sends a formal notice to participant that they are no longer eligible for the waiver.

KDADS Quality Review Team reviews a sample of the CMHC's reassessments quarterly to assure all documents reflect the ongoing LOC for continuation on the waiver. These documents include the Annual Evaluation of Level of Care Form.

The CMHCs have quarterly reviews by the KDADS QA reviewers. A sample is pulled for each performance measure and reviews are conducted. The annual level of care continues to require a QMHP as the assessor and is based on current diagnosis and level of functioning. Each quarter the KDADS QA reviewers review a sample of members to determine whether functional eligibility was completed according to the waiver requirements. When issues are found related to the member's functional eligibility determination follow up and remediation is taken with the SED program manager and CMHC assessor.
KDHE Waiver Managers review and approve all quarterly reviews Performance Measure reports, 372s and Evidence Packages before submitting these reports to CMS.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	☒	☒	☒	☒
Waiver enrollment managed against approved limits	☒	☒	☐	☐
Waiver expenditures managed against approved levels	☒	☒	☐	☐
Level of care evaluation	☒	☒	☒	☒
Review of Participant service plans	☒	☒	☒	☐
Prior authorization of waiver services	☐	☐	☒	☐
Utilization management	☒	☒	☒	☐
Qualified provider enrollment	☒	☐	☒	☐
Execution of Medicaid provider agreements	☒	☒	☒	☐
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:
PM 1: Number and percent of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency Numerator: Number of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the

State Medicaid Agency Denominator: Number of Quality Review reports

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
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**	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify:	
	☐ **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 Numerator: Number of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS Denominator: Total number of waiver amendments and renewals

Data Source (Select one):
Other
If 'Other' is selected, specify:
Presentation 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 Numerator: Number of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency Number of waiver policy changes implemented by the Operating Agency

Data Source (Select one):
Other
If 'Other' is selected, specify:
Presentation of policy changes to KDHE

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** 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 Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports Numerator: Number of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports Denominator: Number of Long-Term Care meetings

Data Source (Select one):
Other
If 'Other' is selected, specify:
LTC meeting attendance record

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:

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. Staff of all three MCOs engage with state staff to ensure strong understanding of Kansas' waiver programs and the quality measures associated with each waiver program. The MCOs have begun to collect data regarding the waiver performance measures and reporting options. 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.

b. Methods for Remediation/Fixing Individual Problems

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

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

Monitoring and survey results are compiled, trended, reviewed, and disseminated consistent with protocols identified in the statewide quality improvement strategy. Each provider receives annual data trending which identifies provider specific performance levels related to statewide performance standards and statewide averages. Corrective Action Plan requests, technical assistance and/or follow-up to remediate negative trending are included in annual 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**
☒ **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.

The State is planning the waiver amendment Summer 2022 to address performance measures across waivers. The State has been working with New Editions to develop these performance measures.

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**			☐
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☒ **Mental Illness**					
	☐	**Mental Illness**			☐
	☒	**Serious Emotional Disturbance**	4	18	

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

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:

The MCO Care Coordinator in the person-centered planning process will help to identify community resources and services that are in line with the participant's goals. The participant's Service Plan is reviewed every 90 days or when the child's needs change, wraparound services are provided on an as needed basis throughout this process. A review of the participant's needs, goals, objectives, resources, preferences, participant's desired outcomes, and strengths are identified. At any time, the participant, their family, or the therapist may identify a need for a change in supportive services for the participant. As the participant approaches desired outcomes or is nearing the age limit of 22, a continuum of services will be identified by the participant, MCO and participants of the wraparound team. The MCO in collaboration with the local CMHC staff will link and access those identified services to the participant to achieve a successful transition.
Coordination between the CMHC's programs for child/participant and community Behavior Health Services at large will occur to aid in the transition. When the participant is transitioning out of the SED Waiver due to maximum age the MCO in collaboration with the CMHC evaluates the participant for adult community based services and mental health supports. Transition planning for a participant may begin as early as necessary but should start at least by the annual review that occurs in the year prior to turning age 22. An individual who remains clinically eligible will continue to receive services until his/her 22nd birthday. If the participant meets the applicable criteria for another waiver then transition to that program will be supported by the MCO/CMHC using the approved methods in the waiver or program that is determined to best meet the participants needs.

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	4900
Year 2	4900
Year 3	4900
Year 4	4900
Year 5	4900

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

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

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

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

○ **Not applicable. The state does not reserve capacity.**

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

Purpose(s) the state reserves capacity for:

Purposes	
Military exception	

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 exception

Purpose *(describe):*

The State reserves capacity for military participants and their immediate dependent family members who have been determined program eligible may bypass waitlist upon approval by KDADS. In the event Kansas instituted a waitlist, individuals who have been determined to meet the established SED waiver criteria will be allowed to bypass the waitlist and access services.

The Operating Agency does not have a waiting list for the SED waiver. A waiting list is not anticipated to be put in place. If a waiting list should occur, entrance parameters would be defined at that time with input from stakeholders and providers. Entrance to the waiver is determined by clinical (functional) and financial eligibility with the State of Kansas currently enrolling all eligible participants. The State of Kansas has legislative authority to request increased capacity if the number of applicants exceeds the approved number of eligible.

Describe how the amount of reserved capacity was determined:

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

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

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

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (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:

The waiver provides for the entrance of all eligible persons. This is spelled out in KDADS Serious Emotionally Disturbance Policy.

Entry to the waiver is offered to individuals to the waiver as they apply for the waiver. Kansas has no waiting list.

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:

  Reasonable classification group of individuals up to age 22 who meet the income and resource requirements of AFDC covered under 42 CFR 435.222 defined as children up to age 22 who if not for the provision of HCBS waiver services would otherwise be institutionalized.

  Parents and other caretaker relatives (42 CFR 435.110) and children (CFR 435.118).

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

- ○ **No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*
- ◉ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

  Select one and complete Appendix B-5.

  - ○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**
  - ◉ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

    Check each that applies:

☒ **A special income level equal to:**

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

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

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

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

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

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

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

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

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

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

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

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

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

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

◉ **The following standard included under the state plan**

Select one:

○ **SSI standard**
○ **Optional state supplement standard**
○ **Medically needy income standard**
◉ **The special income level for institutionalized persons**

(*select one*):

◉ **300% of the SSI Federal Benefit Rate (FBR)**
○ **A percentage of the FBR, which is less than 300%**

Specify the percentage:

○ **A dollar amount which is less than 300%.**

Specify dollar amount:

○ **A percentage of the Federal poverty level**

Specify percentage:

○ **Other standard included under the state Plan**

Specify:

○ **The following dollar amount**

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

○ **The following formula is used to determine the needs allowance:**

Specify:

○ **Other**

Specify:

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

◉ **Not Applicable**

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

Specify:

Specify the amount of the allowance (*select one*):

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

○ **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

○ **Not Applicable (see instructions)**

○ **AFDC need standard**

◉ **Medically needy income standard**

○ **The following dollar amount:**

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

○ **The amount is determined using the following formula:**

Specify:

○ **Other**

Specify:

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

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

Select one:

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

◉ **The state does not establish reasonable limits.**

○ **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ○ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

  Specify percentage:
- ○ **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised
- ○ **The following formula is used to determine the needs allowance:**

  Specify formula:
- ◉ **Other**

  Specify:

  300% of SSI

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

Select one:

- ◉ **Allowance is the same**
- ○ **Allowance is different.**

  Explanation of difference:

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

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

Select one:

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

◉ **The state does not establish reasonable limits.**

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

Appendix B: Participant Access and Eligibility

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:

According K.S.A.(j) Qualified Mental Health Professional means a physician or psychologist who is employed by a participating mental health center or who is providing services as a physician or psychologist under a contract with a participating mental health center, a licensed masters level psychologist, a licensed clinical psychotherapist, a licensed marriage and family therapist, a licensed clinical marriage and family therapist, a licensed professional counselor, a licensed clinical professional counselor, a licensed specialist social worker or a licensed master social worker or a registered nurse who has a specialty in psychiatric nursing, who is employed by a participating mental health center and who is acting under the direction of a physician or psychologist who is employed by, or under contract with, a participating mental health center.

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.

II. The applicant must have a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the most current Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnostic criteria. Disorders include, those listed in the most current DSM or the International Classification of Diseases (ICD) equivalent; Disorders do not include DSM-V "V" codes; Disorders do not include substance abuse or dependence and developmental disorders unless such co-occurs with a diagnosable condition such as mental, behavioral, or emotional disorder of sufficient duration to meet the most current DSM diagnostic criteria.

The applicant must meet standard thresholds on the following assessments:

1. Child Behavior Checklist (CBCL) or the Adult Behavior Checklist (ABCL); AND

2. Child and Adolescent Functional Assessment Scale (CAFAS) or the Preschool and Early Childhood Functional Assessment Scale (PECFAS) for children under five (5) years of age.

1. Qualifying on the CBCL/ABCL is completed by parent/guardian to assess behavioral and emotional problems:
(a) A qualifying score of 70 on any subscale of the Child Behavior Checklist (CBCL) for applicants less than 18 years of age,
i. A CBCL exception may be granted by the State -if a score of 63-69 on any subscale, and based on other supporting forms by a qualified mental health practitioner with a clinical judgement of that child/youth's impending risk of Inpatient Psychiatric Hospitalization within the next month which that the guardians account doesn't reflect.
(b) A qualifying score of 70 on any subscale of the Adult Behavior Checklist (ABCL) for applicants older than 18 years of age.
(c) The CBCL or ABCL must be current. I. The assessment must provide information concerning the applicant's behavior during the previous six months from the date of clinical judgement.

2. Qualifying on the CAFAS:
a. The qualifying score for the CAFAS is a total score of 100 or a score of 30 on two subscales,
b. The CAFAS must be completed by a Qualified Mental Health Professional (QMHP),
c. The Preschool and Early Childhood Functional Assessment Scale (PECFAS) may be substituted for the CAFAS for children under five (5) years of age. The range of clinical scores on the PECFAS is the same as the CAFAS.
d. There is no exception to the CAFAS requirement.
e. The CAFAS must have been completed less than three months prior to the clinical eligibility date.

III. Risk of Inpatient Psychiatric Hospitalization
(a) As part of an applicant's initial clinical eligibility packet, a Qualified Mental Health Professional (QMHP) with a Community Mental Health Centers (CMHC) must include:
i. An attestation/narrative of the applicant's risk of inpatient psychiatric hospitalization.
ii. The attestation must be signed and dated by the QMHP, with their credential included.
iii. The applicant's medical record must also include the completed initial clinical level of care packet containing the attestation/narrative of the applicant's risk of inpatient psychiatric hospitalization to demonstrate the need for a inpatient Psychiatric Hospitalization stay.

Annual Level of Care Criteria is assessed through re-administering the CAFAS or PECFAS assessment tool, as well as the clinical judgment of a qualified mental health provider that the child/youth are at risk of Inpatient Psychiatric Hospitalization and then KDADS SED Program manager or Program Eligibility Specialist reviews findings for continued program eligibility.
The Child & Adolescent Functional Assessment Scale (CAFAS) is a rating scale, which assesses a participant’s degree of impairment in day-to-day functioning due to emotional, behavioral, psychological, psychiatric, or substance use problems. One of its primary purposes is to assign cases to the appropriate level of care. The CAFAS is organized into eight scales for rating the child: school/work, home, community, behavior towards others, moods and emotions, substance abuse, self-harm, and thinking. A total score is derived for which there are general interpretive guidelines.

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 Community Mental Health Center 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 family and the clinical judgment of qualified mental health practitioner. The Community Mental Health Center Screening Form is the instrument used to assess for institutional level of care.

Kansas uses the initial clinical eligibility packet to determine level of care for the SED waiver. The initial clinical eligibility packet includes assessment information and the clinical impression of the qualified mental health professional, specifically a narrative summary of the clinical assessment and a narrative summary of the current evidence supporting the participants need for the level of care provided in an inpatient psychiatric hospital. In addition, the initial clinical eligibility packet includes the utilization of two normed and validated clinical assessments, the Child Behavior Checklist (CBCL) and the Child and Adolescent Functional Assessment Scale (CAFAS).

Kansas's initial clinical eligibility packet is a more stringent instrument based on nationally normed and validated clinical assessments. All participants receiving SED waiver services meet minimum scores in the clinical range on these standardized assessments (CBCL and CAFAS) and all participants receiving SED waiver services have a clinical need comparable to those served within inpatient psychiatric hospitals.

The State uses the Community Mental Health Center Screening Form to determine admission to a child’s state hospital alternative. These settings are inpatient, institutional alternatives to the state mental health hospitals. These institutional state hospital alternatives are used because of the age requirement for admission into state mental hospitals. The CMHC Screening Form reviews three criteria levels for admission in the state hospital alternative setting. These criteria include: Self-care failure/self-injury, diagnosis, and clinical needs. These criteria directly corelate to the measures used for the SED functional eligibility instrument. Given these co-relations the institutional instrument and functional eligibility instrument are directly comparable.

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

KDADS Program staff members review each individual needs-assessment packet submitted by the assessing entity. Program staff review the individual needs assessment results on both the CAFAS and CBCL assessment and determine that the individual meets the LOC eligibility thresholds scores. The assessing entity enters the results of the from CAFAS and CBCL assessments which are uploaded and entered into the KDADS tracking system of record, for KDADS review and confirmation of accuracy. Program staff also review age, contact information of parents/guardians, DSM V diagnosis, and narrative of presenting factors that warrant the need for hospitalization without SED waiver services in order to confirm the assessor's clinical judgement from the face-to-face presentation of symptoms of the child/youth. KDADS program staff also verify the assessment was performed by a QMHP who is credentialed by the CMHC. After the KDADS Program Manager reviews all the information listed above, they determine program eligibility. KDADS then submits the program eligibility status to the KDHE Eligibility Unit for KanCare Medicaid application financial consideration and final determination of eligibility for waiver services. KDHE sends the eligibility determination notice to the responsible party of the applicant of the child/youth's eligibility status for the SED waiver. If not found eligible, the notice contains appeal rights. When an applicant is eligible, KDHE sends the completed ES-3160 form back to KDADS, the designated Managed Care Organization, and the CMHC.

The Reevaluation Process:
Individual needs assessments are determined by the QMHP through the CMHC. This consists of re-administering the CAFAS or PECFAS assessment tool, which also includes a face-to-face interview as well as the clinical judgement of a qualified mental health provider that the child/youth continue to be at risk of Inpatient Psychiatric Hospitalization. The QMHP uploads the reassessment of needs package into KDAD' tracking system of record for review. This KAMIS based assessment will have all the required reassessment modules to capture program eligibility status, including the services utilized to avoid inpatient hospitalization. The KDADS Program Manager or Program Eligibility Specialist reviews findings to determine eligibility status. If the waiver participant is found ineligible, KDADS notifies the KDHE Eligibility Unit via an ES-3161, and KDHE notifies the individual with the same appeal rights as a new applicant who is denied wavier services.

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 provider that is responsible for performing annual assessments must upload assessment information into the State's database. This ensures that all reevaluations are done in a timely manner and allows KDADS to identify and remediate any outstanding reevaluations.

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 at the CMHC per K.A.R 30-60-57(c):

(c)Records demonstrating the center's compliance with this regulation shall be centrally maintained for at least five years. (Authorized by K.S.A. 75-3307b; implementing K.S.A. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f), and 75-3304a; effective July 7, 2003.)"

Records are maintained by the provider responsible for performing the initial eligibility determination and annual reevaluation. 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.

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:
Other-Operating Agency's data systems/State Data System application and Managed Care Organizations (MCOs) encounter data

Responsible Party for data	**Frequency of data collection/generation**	**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*	*(check each that applies):*	
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%/5
☒ **Other** Specify: Contracted Assessors	☐ **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):*
Contracted assessors participate in analysis of this measure's results as determined by the State Operating Agency	
	☐ **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 12 months of the previous Level of Care determination Numerator: Number of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination Denominator: 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 waiver participants whose Level of Care (LOC) determinations used the state's approved screening tool N = Number of waiver participants whose Level of Care determinations used the approved screening tool D = Number of waiver participants who had a Level of Care determination

Data Source (Select one):
Operating agency performance monitoring
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: Contracted assessors	☐ **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 assessors 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 initial Level of Care (LOC) determinations made by a qualified assessor Numerator: Number of initial Level of Care (LOC) determinations made by a qualified assessor Denominator: Number of initial Level of Care determinations

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: Contracted assessors	☐ **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 assessors participate in analysis of this measure's results as determined by the State Operating Agency	☐ **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 initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied Numerator: Number of initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied Denominator: Number of initial 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: contracted Assessing agency	☐ **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 follow-up remediation as necessary. In addition, the performance of the functional contractor with Kansas will be monitored on an ongoing basis by the State and the MCOs to ensure compliance with the contract requirements. Additionally, KDADS Program Manager reviews the ICEP which includes the CAFAS and CBCL or Annual LOC for LOC evaluation for functional eligibility.

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

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: KanCare MCOs 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.

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. The State has included this timeline in the Waiver.

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).

Before the functional eligibility evaluation is conducted, as a part of the referral process the CMHC educates the individual on their choices of community-based programs as well as the institutional equivalent. The CMHC assessor documents the individuals' choice of Home and Community-based services on the eligibility communication form (E-3160) used by the state. In addition, during the Person-Centered Service Plan development process, the KanCare MCO selected by the participant informs eligible participants, or their legal representatives, of feasible alternatives for long-term care, and documents their choice of either institutional or home and community-based waiver services utilizing the Person-Centered Plan document to note the choice.

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 MCO maintains all Service planning documentation in their records. The forms are maintained a minimum of three years.

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	**Attendant Care**		
Statutory Service	**Independent Living/Skills Building**		
Statutory Service	**Short-Term Respite Care**		

Service Type	Service		
Other Service	Parent Support and Training		
Other Service	Professional Resource Family Care		
Other Service	Wraparound Facilitation		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Attendant Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Attendant care for the SED waiver is provided to a child whose mental health disorder affects their activities of daily living. It is specialized in the way it is provided based on how the child's therapist is working with the child. SED attendant care is designed to reinforce techniques from the child's primary therapist. SED attendant care is designed to help the child cope with their mental illness and provide them with someone to help work through emotional disturbances caused by the mental health disorder. Attendant care on the SED waiver is designed to continue working on skills set by the QMHP or LMHP to help the child with their mental health diagnosis. The clinical supervision is necessary to ensure the correct skills are being utilized. The SED waiver allows children to continue to receive therapy services from providers other than therapists at the CMHC. The Contractor-Designated LMHP is a licensed mental health professional that is providing therapy services to a child on the SED waiver. The LMHP in these cases is not directly associated with the CMHC." Attendant care for the SED waiver is provided to a child whose mental health disorder affects their activities of daily living. It is specialized in the way it is provided based on how the child's therapist is working with the child. SED attendant care is designed to reinforce techniques from the child's primary therapist. SED attendant care is designed to help the child cope with their mental illness and provide them with someone to help work through emotional disturbances caused by the mental health disorder. Attendant care on the SED waiver is designed to continue working on skills set by the QMHP or LMHP to help the child with their mental health diagnosis. The clinical supervision is necessary to ensure the correct skills are being utilized. The SED waiver allows children to continue to receive therapy services from providers other than therapists at the CMHC.The service enables the waiver participant to accomplish tasks or engage in activities that whey would normally do themselves if they did not have a mental illness. Assistance is in the form of direct support, supervision and/or cueing so the participant performs task by him/herself. Such assistance most often relates to performance of Activities of Daily Living and Instrument Activities for Daily Living and includes assistance with maintaining daily routines and/or engaging in activities critical to residing in their home and community. Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. Services must be recommended by a wraparound team and must be intended to achieve the goals or objectives identified in the participant's Person-Centered Service Plan. All coordination must be documented in the waiver participant's medical record.
Transportation is provided between the participant's place or residence and other services sites or places in the community, and the cost of transportation is included in the rate paid to providers of this services. Kancare MCO's will be responsible for all other transportation needs for the waiver participant.

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

These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.
There are no limits on Attendant Care hours. Services must be prior authorized. Participants must receive ongoing and regular clinical supervision by a person meeting the qualification of a Qualified Mental Health Professional and supervision shall be available at all times.

Services provided at a work site must not be job tasks oriented. Waiver funding may not be used to pay for special education and related services that are required to be included in a child's Individualized Educational Plan (IEP) under the provisions of Individuals with Disabilities Education Improvement Act of 2004 (IDEA).
Excludes services to waiver participants who is in an inpatient or resident of a hospital, nursing facility, intermediate care facility for persons with intellectual or developments disabilities, or institution for mental disease.

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Attendant Care

Provider Category:

Agency

Provider Type:

Community Mental Health Center

Provider Qualifications

License *(specify):*

Attendant Care worker must have a high school diploma or equivalent and are supervised by the QMHP as defined by KSA 19-400. Attendant Care workers have additional training that is located on KS Train.

Certificate *(specify):*

Attendant Care workers have additional training that is located on KS Train up to 2 hours before providing direct care. The hours of training cover the Basics of Community Support Services for Youth.

Other Standard *(specify):*

Must be 18 years of age and at least 3 years older then the youth. Completion of state approved training according to the curriculum approved by the Operating Agency prior to providing the service.

Pass a Kansas Bureau of Investigation background check, the Department of Children and Families child and adult abuse registry checks, and motor vehicle screens.

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

A Qualified Mental Health Professional and/or Licensed Mental Health Professional provides supervision and guidance to the attendant care worker who is providing direct services to the child or youth utilizing the service.

Verification of Provider Qualifications

Entity Responsible for Verification:

The CMHC, as an agency provider, verifies the qualifications of the attendant care performing the assigned task. The MCOs conduct an annual provider review via a shared contractor. KDADS verifies the MCO contractor reviews annually and these finding are also reviewed and verified by KDHE.

Frequency of Verification:

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:

Statutory Service

Service:

Habilitation

Alternate Service Title (if any):

Independent Living/Skills Building

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
04 Day Services	04020 day habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Independent Living/Skills Building services are designed to assist participants who are or will be transitioning to adulthood with support in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to be successful in the domains of employment, housing, education, and community life and to reside successfully in home and community settings. Independent Living/Skills Building activities are provided in partnership with participants to help them arrange for the services they need to become employed, find transportation and housing, and continue their education. Services are individualized according to each participant's strengths, interests, skills, and goals as specified in the service pan. Independent Living/Skills Building activities should take place in the community. This service can be utilized to train and cue normal activities of daily living. Housekeeping, homemaking, or basic services solely for the convenience of the participant receiving Independent Living/Skills Building are not covered. These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization

The following are examples of appropriate community settings rather than an all-inclusive list: a grocery store to teach the participant how to shop for food, a clothing store to teach the participant what type of clothing is appropriate for job interviews, an unemployment office to assist in seeking jobs or assist the participant in completing applications for jobs, apartment complexes to seek out housing opportunities, and laundromats to teach the participant how to wash clothing. This is not an all inclusive list. Other appropriate activities can be provided in any other community setting as identified through the service plan process.

Transportation is provided between the participants place of residence and other services sites or places in the community. The cost of transportation is included in the rate paid to providers of this service. Children may begin accessing this service at age 14.

Independent Living/Skills Building does not duplicate any other Medicaid state plan service or service otherwise available to participants at no cost.

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

These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. There are no limits on Independent Living/Skills Building. Independent Living/Skills Building cannot be used to replace, supplement, an/or supplant education and related services that are included in a child’s Individualized Educational Plan (IEP) under the provisions of Individuals with Disabilities Education Improvement Act of 2004 (IDEA).

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Independent Living/Skills Building

Provider Category:

Agency

Provider Type:

Community Mental Health Center

Provider Qualifications

License *(specify):*

The Transition Coordinator must have a high school diploma or equivalent. Must be 21 years of age. Completion of Independent Living/Skills Building training according to a curriculum approved by the Operating Agency prior to providing the service. Receive ongoing supervision by a person meeting the qualifications of a qualified mental health professional. The State requires that all providers of SED waiver services undergo and pass a criminal background check with the Kansas Bureau of Investigation and Department of Children and Family Services child and adult registry as well as a motor vehicle check.

Certificate *(specify):*

Not applicable.

Other Standard *(specify):*

Individual provider must have a high school diploma or equivalent.

Must be 21 years of age.

Pass a Kansas Bureau of Investigation background check, the Department of Children and Family Services child and adult abuse registry checks, and motor vehicle screens.

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

Completion of Independent Living/Skills Building training according to a curriculum approved by the Operating Agency prior to providing the service.

Receive ongoing supervision by a person meeting the qualifications of a qualified mental health professional. A qualified mental health professional shall be available at all times to provide back up, support, and/or consultation.

Verification of Provider Qualifications

Entity Responsible for Verification:

The CMHC, as an agency provider, verifies the qualifications of the individual performing the assigned task. The MCO contractor takes a sampling of the individuals providing the service to verify compliance outlined by provider qualifications. KDADS reviews the MCO Contractor's reviews and verifies the review was done correctly. This review is then verified by KDHE.

Frequency of Verification:

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:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Short-Term 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):*

Short-Term Respite Care provides temporary direct care and supervision for the participant. The primary purpose is to provide relief to the parents or caregivers of a participant with a serious emotional disturbance. The service is designed to help meet the needs of the primary caregiver, as well as the identified participant. Normal activities of daily living are considered content of the service when providing respite care. These include support in the home, after school, or at night; transportation to and from school, medical appointments, or other community-based activities, or any combination of the above. The cost of transportation is included in the rate paid to providers of this services. Short-Term Respite Care can be provided in the participant's home or place of residence or provided in other community settings. Other community settings include Licensed Family Foster Homes, Licensed Emergency Shelters, and Out-Of-Home Crisis Stabilization Houses/Units/Beds. Short-Term Respite Services provided by or in an IMD are not covered. The service cannot be provided in a Youth Residential Center 1 or a Youth Residential Center 2. The participant must be present when providing Short-Term Respite Care.

Short-Term Respite Care may not be provided simultaneously with Professional Resource Family Care services and does not duplicate any other Medicaid state plan service, or service otherwise available to participants at no cost.

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

Foster care children and youth on the SED waiver will not be able to access short term respite care. This service is available to children and youth in foster care under the foster care contract.

This service cannot be provided in a Youth Residential Center 1 or a Youth Residential Center 2.
Short term respite care is time limited and may not exceed 30 consecutive days. FFP may not be claimed for room and board when respite is provided in the participant's home or place of residence.

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Short-Term Respite Care

Provider Category:

Agency

Provider Type:

Community Mental Health Center

Provider Qualifications

License *(specify):*

Respite Care worker must have a high school diploma or equivalent and be supervised by the QMHP as defined by KSA 19-4001.
The home or facility must meet applicable Kansas Department of Children and Families licensure requirements in an overnight setting outside the family or relative's home.

Certificate *(specify):*

CPR.

Crisis Prevention/Management (example: CPI, Mandt, etc.).

Other Standard *(specify):*

Individual providers must have a high school diploma or equivalent.

Must be 21 years of age.

Completion of Short-Term Respite Training according to the curriculum approved by the Operating Agency prior to providing the service.

First Aid.

Pass a Kansas Bureau of Investigation background check, the Department of Children and Families child and adult abuse registry checks, and motor vehicle screens.

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

Receive ongoing supervision by a person meeting the qualifications of a qualified mental health professional. A qualified mental health professional shall be available at all times to provide back up, support, and/or consultation.

Verification of Provider Qualifications

Entity Responsible for Verification:

The CMHC, as an agency provider, verifies the qualifications of the individual performing the assigned task. The MCO contractor takes a sampling of the individuals providing the service to verify compliance outlined by provider qualifications. KDADS reviews the MCO Contractor's reviews and verifies the review was done correctly. This review is then verified by KDHE.

Frequency of Verification:

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:

Parent Support and Training

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10090 other mental health and behavioral services

Category 2:	**Sub-Category 2:**
09 Caregiver Support	09020 caregiver counseling and/or training
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 families of children who have been identified to have a serious emotional disturbance and in need of or at risk of more intensive level of care such as a state psychiatric hospitalization, psychiatric residential treatment facility treatment (PRTF), or brief hospitalization or crisis services the training and support necessary to ensure engagement and active participation of the family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. Parent Support and Training can be provided anywhere in the community that is agreeable to the individual.

This is a training and support service necessary to ensure engagement and active participation of the family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. Training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the participant.

For the purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver , and may include a parent, spouse, children, relatives, grandparents, or foster parents. Services may be provided individually or in a group setting.

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 service plan 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 Service Plan.

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.
o The virtual delivery of the service shall be provided in the participant's preferred setting.
• The participant's choice for virtual delivery of a service shall be documented and included in their service plan.
o The participant shall be able to rescind their choice of virtual delivery of a service at any time.
When this occurs, the MCO shall ensure service continuity via a non-virtual delivery method and confirm that the participant's service plan reflects the participant's choice change.
o The managed care organization shall be responsible for ensuring that the provider is educating and informing the

participant on the scope of the virtual delivery of the service prior to documenting the choice of the individual.
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).
o 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.
o 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.

Parent Support and Training does not duplicate any other Medicaid state plan service or service otherwise available to recipients at no cost.

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

There are no limits on Parent Support and Training. Operationally, individuals receiving Parent Support Training do not simultaneously receive Professional Resource Family Care.

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Parent Support and Training

Provider Category:

Agency

Provider Type:

Community Mental Health Center

Provider Qualifications

License *(specify):*

Parent Support Specialist must have a high school diploma or equivalent and are supervised by the QMHP as defined by KSA 19-4001. Must be 21 years of age. Kansas Train provides an online Parent Support and Training in addition to the individual CMHC training that is provided for all Parent Support Specialists.

Certificate *(specify):*

Not applicable.

Other Standard *(specify):*

Individual providers must have a high school diploma or equivalent.

Must be 21 years of age. Preference is given to Parents or caregivers of children with SED.

Completion of Parent Support Training according to a curriculum approved by the Operating Agency within one year of hire. Preference is given to Parents or caregivers of children with SED.

Pass a Kansas Bureau of Investigation background check, the Department of Children and Families child and adult abuse registry checks, and motor vehicle screens.

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

Peer to Peer provider must be associated with the CMHC.

Verification of Provider Qualifications

Entity Responsible for Verification:

The CMHC, as an agency provider, verifies the qualifications of the individual performing the assigned task. The MCO contractor takes a sampling of the individuals providing the service to verify compliance outlined by provider qualifications. KDADS reviews the MCO Contractor's reviews and verifies the review was done correctly. This review is then verified by KDHE.

Frequency of Verification:

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:

Professional Resource Family Care

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
10 Other Mental Health and Behavioral Services	10090 other mental health and behavioral services
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):*

Professional Resource Family Care is intended to provide intensive supportive resources for the participant and his or her family. This service offers intensive family-based support for the participant's family through the utilization of a co-parenting approach provided to the participant in a surrogate family setting. The goal is to support the participant and family in ways that will address current acute and/or chronic mental health needs and coordinate a successful return to the family setting at the earliest possible time. This service is provided in a licensed foster care home outside of the family home.
During the time the professional resource family is supporting the participant, there is regular contact with the family to prepare for the participant's return and his or her ongoing needs as part of the family. It is expected that the participant, family, and the professional resource family are integral members of the participants individual treatment team.
Transportation is provided between the participant's place of residence and other services sites or places in the community and the cost of transportation is included in the rate paid to providers of this services.

Professional Resource Family Care can be provided anywhere in the community that is agreeable to the individual.

Professional Resource Family Care may not be provided simultaneously with Short-Term Respite Care and does not duplicate any other Medicaid state plan service or service otherwise available to participants at no cost.

FFP is not claimed for the cost of room & board.Waiver funds are not available to pay for maintenance (including room and board) and supervision of children who are under the state’s custody, regardless of whether the child is eligible for funding under Title IV-E of the Act. The costs associated with maintenance and supervision of these children are considered a state obligation.

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

Service must be delivered in a licensed foster home.
Foster care children and youth on the SED waiver will not be able to access Professional Resource Family Care. This service is available to foster care children and is named "Therapeutic Foster Care" under the foster care contract.

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Professional Resource Family Care

Provider Category:

Agency

Provider Type:

Community Mental Health Center

Provider Qualifications

License *(specify):*

Professional Resource Family care must have a high school diploma or equivalent and are supervised by the QMHP as defined by KSA 19-4001. Must be 21 years of age.

Family Home Setting licensed by Kansas Department of Children and Families. Kansas Train provides additional online training in addition to individual CMHC training provided to Professional Resource Family Care Staff. CMHC orientation training includes, CPR, First Aid and nationally recognized CI training.

Certificate *(specify):*

First Aid.

Crisis Prevention/Management (Example: CPI, Mandt, etc.).

Other Standard *(specify):*

Pass a Kansas Bureau of Investigation background check, the Department of Children and Families child and adult abuse registry checks, and motor vehicle screens.

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

Receive ongoing supervision by a person meeting the qualifications of a qualified mental health professional and are supervised by the QMHP as defined by KSA 19-4001. A qualified mental health professional shall be available at all times to provide back up, support, and/or consultation.

Verification of Provider Qualifications

Entity Responsible for Verification:

The CMHC, as an agency provider, verifies the qualifications of the individual performing the assigned task. The MCO contractor takes a sampling of the individuals providing the service to verify compliance outlined by provider qualifications. KDADS reviews the MCO Contractor's reviews and verifies the review was done correctly. This review is then verified by KDHE.

Frequency of Verification:

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:

Wraparound Facilitation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management
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):*

Wraparound facilitation is a mental health professional employed by the CMHC. Facilitators will be certified after completion of the specialized training on Kansas Train in the wraparound facilitation. The training is over twelve hours and 80 percent comprehension of the course objectives would have to be met before certification is awarded. Wraparound facilitation is used to bring the managed care organization, participant, family and community participants together to discuss community-based services and develop an individualized Person-Centered Service Plan.

The function of the wraparound facilitator is to form the wraparound team consisting of the participant's family, extended family, other community members involved with the participant's daily life, and the participant's chosen MCO, for the purpose of updating the community-based person-centered Service Plan. This includes working with the participant's family to identify who should be involved in the wraparound team and assembly of the wraparound team when subsequent Service Plan review and revision is needed, at minimum yearly to review the Service Plan and more frequently when changes in the participant's circumstances warrant changes in the Service Plan. The wraparound facilitator will emphasize building collaboration and ongoing coordination among the parents or caregivers, family participants, service providers, MCO care coordinator, and other formal and informal community resources identified by the family. The wraparound facilitator will promote flexibility to ensure appropriate and effective service delivery to the participant and parents or caregivers. The wraparound facilitator provides ongoing wraparound services through the participants time on the SED waiver. Facilitators will be certified after completion of specialized training on Kansas Train in the wraparound philosophy, waiver rules and processes, waiver eligibility and associated paperwork, structure of the wraparound team, and wraparound meeting facilitation. While they may not be part of the team, wraparound facilitators are supervised by the CMHC agency's QMHP. The WAF follows waiver language as specified.

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.

o 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:

There are no limits on wraparound facilitation. The wraparound facilitator follows waiver language as specified.

Wraparound facilitation cannot duplicate any services provided by targeted case management. TCM and Wrap Around Facilitator can play dual roles as both positions due to the rural nature of the State of Kansas.

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Wraparound Facilitation

Provider Category:

Agency

Provider Type:

Community Mental Health Center

Provider Qualifications

License *(specify):*

The wraparound facilitator must have at least a bachelor's degree or be equivalently qualified by work experience or a combination of work experience in the human services filed and education with one year of experience substituting for one year of education. This includes a licensure requirement of a community mental health center as defined by KSA 19-4001.

Certificate *(specify):*

Not applicable.

Other Standard *(specify):*

Individual providers must have at least a bachelor's degree or be equivalently qualified by work experience or a combination of work experience in the human services filed and education with one year of experience substituting for one year of education.

Completion of Wraparound Facilitation training curriculum as approved by the Operating Agency prior to the delivery of service.

Pass a Kansas Bureau of Investigation background check, the DCF child and adult abuse registry checks, and motor vehicle Pass a Kansas Bureau of Investigation background check, the Department of Children and Families child and adult abuse registry checks, and motor vehicle screens.

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

Receive ongoing supervision by a person meeting the qualifications of a qualified mental health professional. A qualified mental health professional shall be available at all times to provide back up, support, and/or consultation.

Verification of Provider Qualifications

Entity Responsible for Verification:

The CMHC, as an agency provider, verifies the qualifications of the individual performing the assigned task. The MCO contractor takes a sampling of the individuals providing the service to verify compliance outlined by provider qualifications. KDADS reviews the MCO Contractor's reviews and verifies the review was done correctly. This review is then verified by KDHE.

Frequency of Verification:

Annually

Appendix C: Participant Services

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

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☒ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*
- ☒ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Case management services for this waiver will continue to be provided by the community mental health centers (CMHC) across Kansas, who have clinical and programmatic expertise and experience regarding the needs of people who use this waiver, in collaboration with the care managers at the KanCare MCOs to address the needs of each waiver participant. CMHC Target Case Manager (TCM) assist individuals with access to medical, social, educational and other services outside the waiver. Wraparound Facilitation through a waiver service is provided in addition to targeted case management to address the unique mental health needs of a participant living in the community. Wraparound facilitation cannot duplicate any services provided by targeted case management. TCM and Wrap Around Facilitator can play dual roles as both positions due to the rural nature of the State of Kansas, but are not allowed to bill for TCM when providing wrap around facilitation services. The MCO's must approve all service plans and services listed in the person-centered service plan prior to a CMHC providing services to a youth and are present at the wrap around facilitation meetings.

The Health Action Plan (HAP) is the center piece of the One Care Kansas (OCK) program and for all OCK services delivered in the program. The HAP coordinates and integrates all clinical and non-clinical health care related to the member's needs and services. The HAP does not replace any specific treatment plans or person-centered plans already required, such as HCBS person-centered service plans. It is designed to capture information that can be shared with all providers involved in serving the member. The HAP assigns specific responsibilities to the OCK provider and the OCK member related to the member's health goals. The HAP captures whether there is a HCBS waiver service plan in place, and the type of waiver service plan. The waiver participant would not receive TCM through the Mental Health Center if they were enrolled in OneCare Kansas, who provides the Health Action Plan.
All OCK providers must employ sufficient and qualified staff to meet the member's needs. In most cases, the MCO Care Coordinator will coordinate and write the HCBS person-centered support plan, and other TCM functions. The OCK Care Coordinator facilitates the development and maintenance of the HAP.

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):

In accordance with the Background check policy, background checks will be completed every two years. The State requires that all providers of SED waiver services undergo a criminal background check with the Kansas Bureau of Investigation and motor vehicle check. The Operating Agency interviews the Human Resources Director at the CMHC to determine whether the mandatory investigations have been conducted. The Operating Agency reviews the CMHC personnel files to ensure the results of the mandatory investigations are on file with the CMHC. eProvider files are reviewed by a joint MCO contractor annually. KDADS completes a sample of the MCO's Contractor's files annually. KDHE reviews KDADS review of the provider files annually. This is review is completed by the joint MCO contractor who pulls a sample of each provider's employees for review annually.

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):

In accordance with the Background check policy, background checks will be completed every two years. The State requires that all providers of SED waiver services undergo a criminal background check with the Kansas Bureau of Investigation and motor vehicle check. The MCO contractor completes the sample review annually for each CMCH contactor to assure compliance with the background check policy.

Each provider is responsible for conducting the screening against the registry in accordance with HCBS Background Check Policy. Per the policy, these background checks are completed every two years. The MCO contractor conducts a sample pull annually to review of compliance for background check policy. KDADS quality assurance team reviews the contractors review to be sure the contractor's review is in compliance with the HCBS Background Check Policy.

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:

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.
Providers have a portal at https://portal.kmap-state-ks.us/PublicPage/Public/ProviderManualsto gather information regarding requirements and procedures to qualify. KMAP processes a clean and accurate application in 5 business days. As soon as the application is approved, the MCOS will be able to access the enrollment application and all associated attachments in their portals.

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 new licensed waiver provider applicants that initially met licensure requirements and other waiver standards prior to furnishing waiver services N = Number of new licensed waiver provider applicants that initially met licensure requirements and other waiver standards prior to furnishing waiver services D = Number of all new licensed/certified waiver 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:

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**

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

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 enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements N = Number enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements D = Number of enrolled non-licensed/non-certified providers

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

Responsible Party for data collection/generation *(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: 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 =
☐ **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:

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.

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.
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**

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

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.

KDADS has proposed a statewide transition plan for residental and non-residental settings in compliance with federal HCBS requirments, upon approval from CMS.

Please see attachment 2 for the HCBS-SED Transition and statewide Transition plan.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Person Centered Service Plan

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

☐ **Registered nurse, licensed to practice in the state**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**

☐ **Licensed physician (M.D. or D.O)**

☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

☐ **Social Worker**
Specify qualifications:

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

The MCO 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 MCO 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. MCOS 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, MCO 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:*

The below safeguards to mitigate and addresses the potential problems that may arise when the individual's HCBS provider, or an entity with an interest in or employed by a provider of HCBS, performs service plan development/case management was performed by the CMHC. The only organizations developing Person Center Service Plan are the Managed Care Organizations, even in rural areas of Kansas. The State agency is aware that the safeguards are addressed to be sure the following are met.

a. Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;

b. Direct oversight of the process or periodic evaluation by a state agency;

c. Restricting the entity that develops the person-centered service plan from providing services without the direct approval of the state; and

d. Requiring the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.

An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;

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.

The MCO providers 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 person center service plan development process. The MCO provides both the choice regarding services and services in the community vs. institutional based services as well as a choice of services. The Wraparound Facilitator forms the wraparound team consisting of the participant's family or extended family or legal representative, other community members involved with the participant's daily life, and the MCO service coordinator for the purpose of developing the community-based, Person Centered Service Plan. This includes the MCO and wrap around facilitator working with the participant's family to identify who should be involved in the wraparound team. The responsibility of notifying all parties authorized by the participant of the date/time/ location of the PCSP meeting. Wrap around facilitator will assemble the wraparound team when subsequent Person Centered Service Plan review and revision is needed by the family and MCO or CMHC. There are ongoing 90 day reviews with families and at minimum, a yearly review the Person Centered Service Plan and more frequently when changes in the participant's circumstances warrant changes in such plan.

The State has developed a Provisional Plan of Care process. It is a provisional plan of care which is developed at the time of care by the level of care assessor. The assessor uses the PPOC form to determine at least one waiver service a month that will qualify them for wavier needed services. The PPOC will be valid up to the point where the Person Center Support Plans are in place. On average, a PPOC may be into effect up to 30 days.

Then the PII is gathered by the MCO's with the potential waiver participant and their parent(s) and legal guardian. The MCO and the CMHC meet together with the participant and parent(s)to develop the Person Centered Service Plan. The Person Center Service plan process is discussed in the section above more in depth.

In addition to the initial plan, the State conducts a quarterly review of HCBS Person Centered Service Plans and other related documents, to collect data for the HCBS Performance Measures in the waiver. The Service Plan audit review is based off of statistically significant sample of the waiver population. The State has a continual quality review process for the HCBS Performance Measures, which includes a review of the participant Service Plan. Continuous feedback is given to the Medicaid Agency and Operating Agency, in addition to the MCOs regarding compliance related to the HCBS Performance Measures. KDHE performs MCO contract reviews annually and samples service plans in the contract review.
The State utilizes a statistically significant sampling methodology, that is specified in the HCBS waiver. The KDADS Quality Management Specialists conduct a quarterly review of HCBS Person Centered Service Plans and other related documents, to collect data for the Performance Measures listed in the waiver.

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 Wraparound Facilitator coordinates a Wraparound Meeting that is comprised of all identified parties of the participant's choosing to develop the Person-Centered Service Plan. The waiver participant and family and/or legal guardian presence is required at the wrap around facilitation meeting. This meeting includes the participant's chosen MCO. The MCO Service Coordinator, and the CMHC Wraparound Facilitator are responsible for providing information about the all waiver and community based services 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. The MCO, or their designee, will complete a needs assessment for the participant within 14 days 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 Person Centered 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 Person Centered Service Plan meeting and will use the PII to help design the Person Centered Service Plan. The PSCP includes the scope, duration and amount of the authorized services for the HCBS 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 Service Coordinator assists the participant with accessing information and supports from the participant's chosen provider. The MCO Service Coordinator is ultimately responsible for the Person Center Service Plan developments and updates.

The Person Centered Service Plan will be updated at the minimum of yearly and more frequently when changes in the participant’s circumstances warrant changes in the Service Plan or requested by the participant and/or family. The individual’s preference and choice of location is the primary determinant of meeting times. The MCO care coordinator provides a list of services that includes explanation of those services to the family at the time of Person Centered Service Plan development. CMHC is present at the times as part of the team to assist families and provide additional information to them regarding services in their specific county and surrounding area that can be of accessed quickly to aid in the situation immediately and long term. The MCO informs the participant about available services under the waiver at the Wraparound Meeting. All participants, including the legal guardian shall sign and date the Person-Centered Service Plan document signature page. All participants in the meeting, including the providers and the participant/guardian must sign off on the Person Center Service Plan.

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 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.

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.

Each MCO completes a health risk assessment and a needs assessment, annually,to determine needed services for the pariticpant. Each MCO also trains their staff on the person-center planning progress using the Lifecourse Model. Each Person-Centered Service Plan includes a Back-up Plan which outlines how the participant's needs will be addressed should there be an emergency or absence of a caregiver.

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.

Participants will have free choice of providers within the KanCare structure and may change providers as often as desired. Participants on the SED waiver may receive waiver services at the CMHC, but are not required to utilize a CMHC in an identified geographical area. When a participant becomes eligible for the SED Waiver and is already established with a therapist who is not a member of the network, the CMHC is required to make every effort to arrange for the participant to continue with the same provider if the participant so desires. The provider would be requested to meet the same qualifications as other providers in the network. In addition, if a participant needs a specialized service that is not available through the network, the assigned managed care organization will arrange for the service to be provided outside the network if a qualified provider is available. Finally, except in certain situations, participants will be given the choice between at least two providers. Exceptions would involve highly specialized services which are usually available through only one agency in the geographic area. This information is provided in the KanCare health plan's member handbooks which are given to participants upon enrollment in the waiver. Member handbooks are also available on the KanCare health plan websites.
KanCare health plans lists all providers in their immediate area and surrounding counties that are accessible when carrying out their individualized Person Center Service Plan. MCOs' integrate all the behavioral and physical health services into the Service Plan. It is the MCO's responsibility to coordinate all State Plan and waiver services for their members.

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 State has developed a Provisional Plan of Care process. It is a provisional plan of care which is developed at the time of care by the level of care assessor. The assessor uses the PPOC form to determine at least one waiver service a month that will qualify them for wavier needed services. Then the PII is gathered by the MCO's with the potential waiver participant and their parent(s) and legal guardian.
Next the MCO and the CMHC meet together with the participant and parent(s)to develop the Person Centered Service Plan. The Person Center Service plan process is discussed in a different section in depth.

In addition to the initial plan, the State conducts a quarterly review of HCBS Person Centered Service Plans and other related documents, to collect data for the HCBS Performance Measures in the waiver. The Service Plan audit review is based off of statistically significant sample of the waiver population. The State has a continual quality review process for the HCBS Performance Measures, which includes a review of the participant Service Plan. Continuous feedback is given to the Medicaid Agency and Operating Agency, in addition to the MCOs regarding compliance related to the HCBS Performance Measures. KDHE performs MCO contract reviews annually and samples service plans in the contract review.

The State utilizes a statistically significant sampling methodology, that is specified in the HCBS waiver. The KDADS Quality Management Specialists conduct a quarterly review of HCBS Person Centered Service Plans and other related documents, to collect data for the Performance Measures listed in the waiver.

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**
- [x] **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 SED 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 Plan is the fundamental tool by which the State will ensure the health and welfare of participants served under this waiver. The KanCare MCOs, who deliver no direct waiver services to waiver participants, are responsible for both the initial and updated plans of care. CMHC are providing information and performing the initial level of care assessments and send their findings to KDADS for program eligibility determination.

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 SED 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. KDADS Quality Review Team reviews service plans as part of the quarterly performance measure review, and possible insistences of ANE as part of the review process, and KDADS has a system in place to report that to appropriate personnel. 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. 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

KDHE has MOC's annual contract reviews; reviewing a sample of service plans.

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 participants' goals Numerator: Number of waiver participants whose service plans address participants' goals 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: 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:
PM 2: 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 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: KanCare 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 service plans address health and safety risk factors Numerator: Number of waiver participants whose service plans address health and safety risk factors Denominator: 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: 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:

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 whose service plans were developed according to the processes in the approved waiver Numerator: Number of waiver participants whose service plans were developed according to the processes in the approved waiver Denominator: 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: 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:

Performance Measure:
Number and percent of waiver participants (or their representatives) who were present and involved in the development of their service plan KDADS HCBS Quality Review Report Numerator: Number of waiver participants (or their representatives) who were present and involved in the development of their service plan Denominator: 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:	☐ **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**
	☐ **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:
Numerator: Number of service plans reviewed before the waiver participant's annual redetermination date 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: 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 with documented change in needs whose service plan was revised, as needed, to address the change Numerator: Number of waiver participants with documented change in needs whose service plan was revised, as needed, to address the change Denominator: 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: MCOs	☒ **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 at least every 90 days Numerator: Number of service plans reviewed at least every 90 days Denominator: 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:	☐ **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 Numerator:Number and percent of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan Denominator: 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: MCOs	☒ **Annually**
	☒ **Continuously and Ongoing**

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

Performance Measure:
Number and percent of survey respondents who reported receiving all services as specified in their service plan Numerator: Number of survey respondents who reported receiving all services as specified in their service plan Denominator: Number of waiver participants interviewed by QMS staff

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:

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 the documentation

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:	☒ **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 record contains documentation indicating a choice of waiver service providers Numerator: Number of waiver participants whose record contains documentation indicating a choice of waiver service providers Denominator: 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:	☐ **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**
	☐ **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 Numerator:Number and percent of waiver participants whose record contains documentation indicating a choice of community-based services Denominator: 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	**Frequency of data collection/generation**	**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*	*(check each that applies):*	
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 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):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care Numerator: Number of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care Denominator: 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:	☐ **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**
	☐ **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, and data provided by the KanCare MCOs, is compiled quarterly for evaluation and trending to identify areas for improvement. Upon completion of identified areas of improvement this information is compiled into reports and shared both internally and externally, including with KDHE. As the KanCare program has been operationalized, staff of the three plans have been engaged with state staff to ensure strong understanding of Kansas' waiver programs and the quality measures associated with each waiver program. The role of the MCOs is collecting and reporting data regarding the waiver performance measures has evolved, with increasing responsibility as the MCOs have had greater understanding of the Kansas programs. These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through a state interagency monitoring team, which includes program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

b. Methods for Remediation/Fixing Individual Problems

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

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

Monitoring and survey results are compiled, trended, reviewed, and disseminated consistent with protocols identified in the statewide quality improvement strategy. Each provider receives annual data trending which identifies Provider specific performance levels related to statewide performance standards and statewide averages. Corrective Action Plan requests, technical assistance and/or follow-up to remediate negative trending are included in annual provider reports where negative trending is evidenced.

ii. Remediation Data Aggregation

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

Responsible Party*(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	☐ **Annually**

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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.

Kansas Community Mental Health Centers (CMHC) conduct level of of care determination. KDADS provides the program eligibility review. KDHE provides the financial eligibility review. Decisions made by the state are subject to state fair hearing review, and notice of the right and related process is provided at the time of the assessment.

• HCBS eligibility decision: Department of Health Care Finance (DHCF) makes decisions regarding HCBS waiver eligibility. If an HCBS participant loses eligibility for HCBS waiver services, KDHE 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.

Each MCO provides a Member Handbook to each member which includes Fair Hearing Rights. The State reviews and approves the MCO Member Manuals to assure all information complies with the Fair Hearing process. HCBS eligibility decision: KDHE 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. The participant is informed via a Notice of Action from the MCO for an adverse action such as a service reduction. For an adverse action notice by the MCO there is a 60 plus window to appeal the decision before services are reduced or discontinued. KDHE will send a notice of action for closure of a participants services. 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 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 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.

As part of its regulatory role to educate participants regarding their rights and responsibilities.

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:

AIR reports are required to be submitted to KDADS w/in 24 hours of the individual becoming aware of the adverse incident. The incident is reported to 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.
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.

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 plan of care/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 state has formal agreements for sharing information between agencies, MCO and providers. These include cooperative agreements between KDADS and KDHE, KDADS and KDCF, as well as contracts between KDHE and MCOs, the MCOs and providers. Since MCOs and providers are considered mandatory reporters of abuse, neglect and exploitation they are required to follow K.S.A. 39-1433 and K.S.A. 38-2223 and share information.

All adverse incidents, except those required to be reported to the Department of Children and Families (DCF) indicated below in General. III. A. 1., shall be reported no later than 24 hours of becoming aware of the adverse incident by direct entry into the KDADS web based Adverse Incident Reporting (AIR) system.

All reported incidents are assigned a level of severity when assigned to the appropriate MCO. An AIR report is only screened out and not investigated if it is a duplicate report or a report for a non-HCBS waiver participant.

Per KDADS HCBS Adverse Incident Reporting and Management Standard Policy, General III. A.1. All reports regarding abuse, neglect, exploitation, and fiduciary abuse shall be to the Department of Children and Families (DCF) as required by K.S.A. 39-1433, K.S.A. 38-2223.
All adverse incidents, except those required to be reported to the Department of Children and Families (DCF) indicated below in General. III. A. 1., shall be reported no later than 24 hours of becoming aware of the adverse incident by direct entry into the KDADS web based Adverse Incident Reporting (AIR) system.

The KDADS HCBS Adverse Incident Reporting and Management SOP indicates that CPS needs to be reported to first and then an AIR is filed. All incidents are reported into the AIR system even those that are reported to the State through APS. The MCO's have 30 days to follow up on any quality of care concerns. KDADS will collaborate with Medicaid Fraud as well as enter the data into the AIR system on all reported fraud cases. KDADS collaborates internally with licensing and program managers for all substantiated cases simultaneously with the AIR report being sent to the MCO for follow-up. Program management outreaches to the involved entities for information on the internal remediation plan.

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

The Managed Care Organization has a 30 day window to follow up with any quality of care concerns.
The MCO staff members are required to attend the KDADS PIC training to learn what constitutes an incident that requires reporting, how to submit a report and the subsequent process for investigating the report. See KDADS HCBS Adverse Incident Reporting and Management policy. Community report to MCO for waiver participants in the home to follow up on the concern as deemed necessary.

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 Kansas Department for Children and Families, Division of Children's Services and Division of Adult Services is responsible for obtaining and overseeing all reports of child and adult abuse and neglect involving participants as well as all non-abuse/neglect critical incidents involving waiver participants. Each quarter, a spreadsheet of the previous quarter's participants is compared to a list of all children who have been the subject of allegations of abuse and/or neglect by the Operating Agency's Division of Children and Family Services. The list of all waiver participants is then compared to a list of all children who have been part of an investigation to determine if contact with the alleged victim was made timely and whether a investigation finding was made timely.

KDADS oversees the Adverse Incident System as outlined in inter agency cooperative agreement. This information is sent to the KDADS Program Manager of the Waiver in our QRS System. The MCO reports Critical Incidents through the AIRS system. KDADS Program Integrity and Compliance (PIC) team reviews the MCO process, investigation and outcome of the AIR report. PICS makes a determination if the MCO outcome is satisfactory and if not, will assign a corrective action plan and remediation as necessary.
Adverse Incident Data, Trending, and Remediation A. Each MCO shall submit a monthly report to KDADS Program Integrity which captures the following: 1) Performance data on each health and welfare performance measure as identified in each HCBS waiver. 2) Trend analysis by each HCBS waiver health and welfare performance measure. 3) Trend analysis on each adverse incident as defined in this policy. 4) Remediation efforts by health and welfare performance measure as identified in each HCBS waiver. 5) Remediation efforts by each adverse incident as defined in Procedures. I. 3.
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 agency (or agencies) responsible for overseeing the use of restrictive interventions and ensuring that the state's safeguards are followed. The SED waiver does not allow for restraints. Each participant and their family are notified by the MCO during their Person-Centered Planning meeting of their rights and rights to appeal decisions.

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.

KAR 30-60-48. De-escalation techniques and emergency behavioral interventions. (a) Each center shall adopt and adhere to written policies and procedures that require the following:
(1) Each staff member, volunteer, and contractor shall utilize only de-escalation techniques or emergency behavioral interventions that the staff member, volunteer, or contractor has been appropriately trained in or is professionally qualified to utilize. Each use of these techniques and interventions shall be consistent with the rights of consumers as listed in K.A.R. 30-60-50.
(2) No practice utilized shall be intended to humiliate, frighten, or physically harm a consumer.
(3) No practice that becomes necessary to implement shall continue longer than necessary to resolve the behavior at issue.
(4) Physical restraint or seclusion shall be used as a method of intervention only when all other methods of de-escalation have failed and only when necessary for the protection of that consumer or others.
(5) Each instance of the utilization of a physical restraint or the use of seclusion shall be documented in the consumer's clinical record required by K.A.R. 30-60-46 and reviewed by supervising staff and the center's risk management program required by K.A.R. 30-60-56.
(6) Each instance in which the utilization of a de-escalation technique or emergency behavioral intervention results in serious injury to the consumer shall be reported to the division.
(b) Each center shall ensure that each affiliated provider with which the center has an affiliation agreement adheres to the center's policies and procedures adopted in compliance with subsection (a) of this regulation. (Authorized by K.S.A. 39-1603(d) and (t), 65-4434(f), and 75-3306b; implementing K.S.A. 39-1603, 39-1604(d), 65-4434(f), 75-3304a, and 75-3307b; effective July 7, 2003.)
As note in KAR 30-60-48 Each instance of the utilization of a physical restraint or the use of seclusion shall be documented in the consumer's clinical record required by K.A.R. 30-60-46 and reviewed by supervising staff and the center's risk management program required by K.A.R. 30-60-56.

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

If it is determined that there is suspected un-authorized use, the KDADS Field Staff report immediately. Any areas of vulnerability would be identified for additional training and assurance of non-aversive methods. KDADS Field Staff will be conducting a portion of these reviews with MCO staff, and over time the MCO staff will also 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 reviews concerns on an annual basis and as needed depending on how often concerns are reported to KDADS. Additionally, KDADS Field staff review planning for each individual to ensure appropriate supports and services are in place to eliminate the need for restrictive intervention. On the rare occurrence of detection, the incident is addressed immediately. Any areas of vulnerability would be identified for additional training and assurance of non-aversive methods. KDADS Field Staff will be conducting a portion of these reviews with MCO staff, and over time the MCO staff will also be responsible for ensuring these issues are effectively in place for waiver participants, as part of the overall KanCare quality improvement strategy.

○ **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 New Editions through technical assistance to bring quality reporting into the managed care environment in 2014.
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 State is utilizing the AIR system to monitor all restrictive interventions as well as any adverse incidents.

○ **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:

Methods for detecting unauthorized use of restrictive interventions and ensuring that all applicable state requirements are followed.
Data is 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 Field Staff conduct on-going, record review and on-site, in-person interviews with the participant and his/her informal supports and paid staff supports to ensure there is no use of unauthorized restraint. KDADS Field staff review planning for each individual 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. Performance Improvement Analysis Process including:
a. Performance Improvement 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. Performance Improvement Waiver Report provided to KDHE via the KDHE Long Term Care Committee, 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, regulatory standards, and statute is conducted by KDADS-CSP Field Staff (QMS) through on-going, on-site record review, observation, interviews of individuals served, guardians if applicable, and staff, review of compliance of the individual's plan of care (POC). KDADS-CSP (QMS) Field Staff are responsible for addressing all unauthorized restraint with the service provider to ensure preventative action is taken for the protection of children.
Data gathered by KDADS-CSP Field Staff during the Quality Review Process is provided quarterly to the KDADS-CSP Performance Improvement team chaired by the Quality Program Manager, for evaluation and trending to identify areas for improvement. Upon completion of identified areas of improvement this information is compiled into an executive report (quarterly and annually) which is submitted to the Performance Improvement Executive Committee Chaired by the Director of KDADS-CSP, staffed by HCBS Program Managers, QA Program Manager.
The Performance Improvement Committee generates corrective action planning and improvement planning which is submitted to the Director of KDADS-CSP, the Medicaid Operating Agency, for review and approval or denial and sent to the KDHE via the KDHE Long Term Care Committee for review by the State Medicaid Agency (SSMA).
The approval or denial from the Director of KDADS-CSP would be returned to the Performance Improvement team for corrective action or planning for implementation of improvement.
The frequency of oversight: Continuous and ongoing.
MCOs as well as CMHCs also conduct on-going education through the Person Center Planning Process to educate and assess the participant and guardian's knowledge, ability, and freedom from the use of restraints. KDADS staff ensure MCOs and CMHCs educate participants about the unauthorized use of restraint throughout service to the participant. 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 that will be received by the KDADS PIC team. After receipt of the report, immediate remediation would occur. KDADS staff will be responsible for ensuring these protocols are effectively in place for waiver participants, as part of the overall KanCare quality improvement strategy.

○ **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.

KDADS licensing ensures that each CMHC's critical incident reporting policy and procedures adhere to the State current guidance and are being implemented as written. Licensing staff instruct CMHC to notify the appropriate hotline and enter the adverse incident report via KDADS website. Program Integrity submits all reported uses of medications to the appropriate MCO. MCO must complete the follow up process on all submitted AIR report within 30 days of assignment.
KDADS licensing conducts a full review of each CMHC every two years. In the off years, a compliance review is conducted which includes review of a sample of open and closed cases at each CMHC.
KDADS and the MCO complete separate reviews. Once KDADS licensing completes review, the information is tracked internally. Findings of he review are shared with the CMHC. At the conclusion of the MCO's review the MCO provides a follow up to the incident. This includes review of authorized/unauthorized use of chemical restraint. The appropriate documentation is outlined in person centered plans, and the measure was the least restrictive for the participant. If additional changes need to occur to any individualized care, the MCO facilitates a meeting with the member and their support circle to identify other strategies to support he member. New strategies are memorialized in the member's plan of care.
Any medication that is used to restrict the movement of a member or is used to manage agitation or aggression of a member in a time of crisis is considered a chemical restraint and needs to be reported through AIR system to allow appropriate follow-up procedures. KDADS licensure staff reviews all uses of any medication that is used to restrict the freedom of movement or to manage agitation or aggression of the participant. Medications are then reported via Critical Incident Reports to ensure proper usage of medication and proper medical documentation. One the report has been entered through the Adverse Incident Reporting system, KDADS program integrity staff assigned the report to the appropriate MCO to allow form additional follow-up.
KDADS licensing conducts a full review of each CMHC every two years. In the off-years, a compliance review is conducted which includes review of a sample of open and closed cases at each CMHC.,,
KDADS and the MCO complete separate reviews. Once KDADS licensing completes review, the information is tracked internally. Findings of the review are shared with the CMHC. At the conclusion of the MCO's review the MCO provides a follow up to the incident. This includes review of authorized/unauthorized use of chemical restraint. The appropriate documentation is outlined in person centered plans, and that the measure was the least restrictive in the for the participant. If additional changes need to occur to any individualized care, the MCO facilitates a meeting with the member and their support circle to identify other strategies to support the member. New strategies are memorialized in the member's plan of care.Any medication that is used to restrict the movement of a member or is used to manage agitation or aggression of a member in a time of crisis is considered a chemical restraint and needs to be reported through the AIR system to allow appropriate follow-up procedures. KDADS licensure staff reviews all uses of any medication that is used to restrict the freedom of movement or to manage agitation or aggression of the participant is considered a chemical restraint. Medications are then reported via Critical Incident Reports to ensure proper usage of medications and proper medical documentation. Once the report has been entered through the Adverse Incident Reporting system, KDADS program integrity staff assigns the report to the appropriate MCO to allow for additional follow-up.

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.

All medication errors need to be reported to KDADS. A critical incident is reported if it occurred while the individual was participating in a KDADS paid service or on any premises owned or operated by a KDADS licensed provider or facility. Providers must report all medication errors such as missed and mismanaged that result in emergency medical treatment or incident. Each incident shall be reported using the appropriate KDADS reporting tool within 24 hours of the provider becoming aware of the occurrence of the critical incident. Forms are completed and submitted through a secure web-based connection to KDADS. Medical errors must be reported as critical incidents to the state web-based critical incident reporting system. KDADS is responsible for oversight of this reporting system. Contracted MCOs are charged with the responsibility to oversee and monitor second line medication management. For Schedule I - V medications for children greater than 3 yrs old, the medication must be prescribed by or in consultation/collaboration with a child and adolescent psychiatrist, pediatric neurologist, or developmental-behavioral pediatrician. For use in adults 18 yrs of age or older, one of the following criteria must be met:
a. Patient must have a documented diagnosis within the previous 365 days of ADHD, binge eating disorder, hyper somnolence, narcolepsy, depression in accordance with DSM-V or cancer related fatigue, or
b. Prescription must be written by a psychiatrist. Patients with a documented substance abuse diagnosis within the previous 365 days will require a written peer-to-peer consult with health plan psychiatrist, medical director, or pharmacy director for approval, followed by a verbal peer-to-peer, if unable to approve written request.
• Controlled Substances: Prescriber has reviewed controlled substance prescriptions in the Prescription Drug Monitoring Program (PDMP) (aka K-TRACS) MCO's are tasked with following the prior authorization process and run medication adherence reports and outlier reports as well to identify patterns of use/misuse, contraindications and OVER THE MAX limits. Issues revolving incidences of misuse or prescribing are addressed with the individual and or their legal guardian as well as the pharmacy and prescribing physician. Additionally, technologies are available that measure health indicators of patients in their homes and transmit the data to an overseeing provider. The provider, who might be a physician, nurse, social worker, or even a non-clinical staff Member, can filter Member questions and report to a clinical team as necessary.

Upon receipt at KDADS, email notification is sent to the appropriate program staff as determined by the provider type. The individual MCO identified on the form is notified at the same time. Reporting parameters, including timeliness and content will be determined by contractual requirements.

All reportable critical incidents shall be documented and analyzed as part of the provider's quality assurance and improvement program. Incident reports are reviewed jointly by the KDADS designated quality manager and the MCO designee to determine whether further review or investigation is needed. Reviews or investigations shall be completed following relevant KDADS policies and procedures.

For community mental health centers, if it is determined that an investigation is warranted (including those events designated in K.A.R. 30-60-55 as requiring investigation), the incident will be referred to a Peer Review Committee who is designated and are deemed to be peer review officers and/or peer review committees duly constituted by the mental health center under peer review and risk management laws, including but not limited to K.S.A. 65-4915 et. seq. and 65-4922 through 4927.

As a result of an investigation, a CMHC may be asked to submit a written corrective action plan. If such program fails to submit a corrective action plan, or if the corrective action plan does not demonstrate compliance with provider standards, the program's license may be suspended, pending satisfactory resolution of the critical incident. If the critical incident is not resolved within 12 months from the date of the initial critical incident, the program's license may be revoked. Additionally, the KEESM manual [12230] requires copies of facility based reports be sent to the KDADS Regional Field Staff.

A critical incident is reported if it occurred while the individual was participating in a KDADS paid service or on any premises owned or operated by a KDADS licensed provider or facility. Providers must report all medication errors such as missed and mismanaged medications that result in emergency medical treatment or incident. Each incident shall be reported using the appropriate KDADS reporting tool within 24 hours of the provider becoming aware of the occurrence of the critical incident. Forms are completed and submitted through a secure web-based connection to KDADS. Medical errors must be reported as critical incidents to the state web-based critical

incident reporting system. KDADS is responsible for oversight of this reporting system.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

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).

The Kansas Department for Aging and Disability Services (KDADS-LTSS) has primary responsibility for overseeing unauthorized, restrictive interventions. KDADS-LTSS 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 via quarterly and annual reports as well as reported to KDHE through quarterly/annual reports during the Long-Term Care Committee Meeting.
Methods for detecting unauthorized use of restrictive interventions and ensuring that all applicable state requirements are followed.
Data is 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 Field Staff conduct on-going, record review and on-site, in-person interviews with the participant and his/her informal supports and paid staff supports to ensure there is no use of unauthorized restraint. KDADS Field staff review planning for each individual 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. Performance Improvement Analysis Process including:
a. Performance Improvement 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. Performance Improvement Waiver Report provided to KDHE via the KDHE Long Term Care Committee, 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, regulatory standards, and statute is conducted by KDADS-CSP Field Staff (QMS) through on-going, on-site record review, observation, interviews of individuals served, guardians if applicable, and staff, review of compliance of the individual's plan of care (POC). KDADS-CSP (QMS) Field Staff are responsible for addressing all unauthorized restraint with the service provider to ensure preventative action is taken for the protection of children.
Data gathered by KDADS-CSP Field Staff during the Quality Review Process is provided quarterly to the KDADS-CSP Performance Improvement team chaired by the Quality Program Manager, for evaluation and trending to identify areas for improvement. Upon completion of identified areas of improvement this information is compiled into an executive report (quarterly and annually) which is submitted to the Performance Improvement Executive Committee Chaired by the Director of KDADS-CSP, staffed by HCBS Program Managers, QA Program Manager. The Performance Improvement Committee generates corrective action planning and improvement planning which is submitted to the Director of KDADS-CSP, the Medicaid Operating Agency, for review and approval or denial and sent to the KDHE via the KDHE Long Term Care Committee for review by the State Medicaid Agency (SSMA). The approval or denial from the Director of KDADS-CSP would be returned to the Performance Improvement team for corrective action or planning for implementation of improvement.
The frequency of oversight: Continuous and ongoing.
MCOs as well as CMHCs also conduct on-going education through the Person Center Planning Process to educate and assess the participant and guardian's knowledge, ability, and freedom from the use of restraints. KDADS staff ensure MCOs and CMHCs educate participants about the unauthorized use of restraint throughout service to the participant. 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 that will be received by the KDADS PIC team. After receipt of the report, immediate remediation would occur. KDADS staff will be responsible for ensuring these protocols are effectively in place for waiver participants, as part of the overall KanCare quality improvement strategy.

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:

All medication errors need to be reported to KDADS. A critical incident is reported if it occurred while the individual was participating in a KDADS paid service or on any premises owned or operated by a KDADS licensed provider or facility. Providers must report all medication errors such as missed and mismanaged that result in emergency medical treatment or incident. Each incident shall be reported using the appropriate KDADS reporting tool within 24 hours of the provider becoming aware of the occurrence of the critical incident. Forms are completed and submitted through a secure web-based connection to KDADS. Medical errors must be reported as critical incidents to the state web-based critical incident reporting system. KDADS is responsible for oversight of this reporting system.

Upon receipt at KDADS, email notification is sent to the appropriate program staff as determined by the provider type. The individual MCO identified on the form is notified at the same time. Reporting parameters, including timeliness and content will be determined by contractual requirements.

All reportable critical incidents shall be documented and analyzed as part of the provider's quality assurance and improvement program. Incident reports are reviewed jointly by the KDADS designated quality manager and the MCO designee to determine whether further review or investigation is needed. Reviews or investigations shall be completed following relevant KDADS policies and procedures.

For community mental health centers, if it is determined that an investigation is warranted (including those events designated in K.A.R. 30-60-55 as requiring investigation), the incident will be referred to a Peer Review Committee who is designated and are deemed to be peer review officers and/or peer review committees duly constituted by the mental health center under peer review and risk management laws, including but not limited to K.S.A. 65-4915 et. seq. and 65-4922 through 4927.

As a result of an investigation, a CMHC may be asked to submit a written corrective action plan. If such program fails to submit a corrective action plan, or if the corrective action plan does not demonstrate compliance with provider standards, the program's license may be suspended, pending satisfactory resolution of the critical incident. If the critical incident is not resolved within 12 months from the date of the initial critical incident, the program's license may be revoked. Additionally, the KEESM manual [12230] requires copies of facility based reports be sent to the KDADS Regional Field Staff.

A critical incident is reported if it occurred while the individual was participating in a KDADS paid service or on any premises owned or operated by a KDADS licensed provider or facility. Providers must report all medication errors such as missed and mismanaged medications that result in emergency medical treatment or incident. Each incident shall be reported using the appropriate KDADS reporting tool within 24 hours of the provider becoming aware of the occurrence of the critical incident. Forms are completed and submitted through a secure web-based connection to KDADS. Medical errors must be reported as critical incidents to the state web-based critical incident reporting system. KDADS is responsible for oversight of this reporting system.

(b) Specify the types of medication errors that providers are required to *record:*

K.A.R. 28-4-818 (5) states the date and time that each medication is self-administered shall be recorded on the childs medication record. Any noted adverse reactions shall be documented. Each licensee shall review the record for accuracy and shall check the medication remaining in the container against the expected remaining doses.

According to the AIR system medication errors include: Misuse of Medications - The incorrect administration or mismanagement of medication, by someone providing a CSP service which result in or could result in serious injury or illness to a consumer.

(c) Specify the types of medication errors that providers must *report* to the state:

Providers are responsible for reporting to the State any medication errors that are determined by contracted health professionals to have an adverse effect including, but not limited to, hospitalization or calls to poison control.

○ **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.

All Medicaid providers, including all SED waiver providers, must immediately report all critical incidents to the State. KDADS is the state agency responsible for the on-going monitoring. Medication administration errors that result in a need for medical services are reportable critical incidents. State staff will analyze data from critical incident reporting to identify trends in medication administration errors. Providers with possible trends in medication administration errors will be required to submit a corrective action plan to the State. A critical incident report, including any possible trends, will be provided to the State Medicaid Agency via the KDHE waiver managers on quarterly basis.
Contracted MCOs are charged wit the responsibility to oversee and monitor second line medication management. For Schedule I - V medications
for children greater than 3 yrs old, the medication must be prescribed by or in consultation/collaboration with a child and adolescent psychiatrist,
pediatric neurologist, or developmental-behavioral pediatrician. For use in adults 18 yrs of age or older, one of the following criteria must be met:
a. Patient must have a documented diagnosis within the previous 365 days of ADHD, binge
eating disorder, hyper somnolence, narcolepsy, depression in accordance with DSM-V or
cancer related fatigue or
b. Prescription must be written by a psychiatrist. Patients with a documented substance abuse diagnosis within the previous 365 days will require
a written peer-to-peer consult with health plan psychiatrist, medical director, or pharmacy
director for approval, followed by a verbal peer-to-peer, if unable to approve written request.
• Controlled Substances: Prescriber has reviewed controlled substance prescriptions in the Prescription Drug Monitoring Program (PDMP) (aka K-TRACS) MCO's are tasked with following the prior authorization process and run medication adherence reports and outlier reports as well to identify patterns of use/misuse, contraindications and OVER THE MAX limits. Issues revolving incidences of misuse or prescribing are addressed with the individual and or their legal guardian as well as the pharmacy and prescribing physician. Additionally, technologies are available that measure health indicators of patients in their homes and transmit the data to an overseeing provider. The provider, who might be a physician, nurse, social worker, or even a non-clinical staff Member, can filter Member questions and report to a clinical team as necessary.

The Department of Children and Family oversight responsibility:
An onsite survey inspection shall be completed by the licensing division prior to issuance of a license and annually thereafter to ensure the applicant/permittee/licensee is in compliance with the laws and regulations. Onsite inspections shall occur during a regulatory complaint investigation and compliance surveys as needed, to verify compliance.
1. Onsite inspection of the facility is completed within policy timelines.
a. Timelines for completion of Initial Licensing Inspections by program type
i. Initial licensing survey Family Foster Home and Family Foster Home Military Base Approval
1. Onsite inspection shall be completed within 15 calendar days of assignment
2. Extension to exceed 15 days may be granted by the regional supervisor
3. Document of the extension shall be documented in the electronic licensing system facility narrative
ii. Initial licensing survey Family Foster Home Non-Related Kinship, Family Foster Home Relative Approval
1. Onsite inspection shall be completed within 30 calendar days of assignment
2. Extension to exceed 30 days may be granted by the regional supervisor
3. Document of the extension shall be documented in the electronic licensing system facility narrative
iii. Initial licensing survey Adoption Placement Agency, Attendant Care Center, Child Placement Agency, Detention Center, Foster Care Placement Agency, Group Boarding Home, Residential Center, Secure Care Center, Staff Secure Facility
1. Onsite inspection shall be completed within 30 calendar days of assignment
2. Extension to exceed 30 days may be granted by the regional supervisor
3. Document of the extension shall be documented in the electronic licensing system facility narrative
b. Timelines for completion of Annual Renewal Inspections by program type
i. Annual renew of Family Foster Home and Family Foster Home Military Base Approval, Family Foster Home Non-Related Kinship, Family Foster Home Relative Approval, Adoption Placement Agency, Attendant Care Center, Child Placement Agency, Detention Center, Foster Care Placement Agency, Group Boarding Home, Residential Center, Secure Care Center, Staff Secure Facility
1. Onsite inspection shall be completed within 30 calendar days of assignment
2. Extension to exceed 30 days may be granted by the regional supervisor

3. Document of the extension shall be documented in the electronic licensing system facility narrative.
2. Onsite inspection results are completed in the electronic licensing system at the time of the inspection
a. The applicable survey template is applied in the electronic licensing system.
b. The survey summary and recommendations. Section I is completed at the time of the onsite visit
c. A notice of survey findings is completed and provided to the licensee and sponsoring child placement agency, if applicable, following the onsite inspection.
d. Licensee was found to be in full compliance with the regulatory requirements
i. Survey summary section 11 is completed, noting full compliance, in the electronic licensing system
ii. Survey completion date is entered and workflow is closed
iii. Electronic licensing system notifies the assigned administrative assistant survey is completed
iv. Administrative assistant completes a review of the electronic background checks within 2 business days of survey completion
1. All required background checks are retuned and on file
a. Administrative assistant issues the license
b. Administrative assistant provides a copy of the license to the licensee and sponsoring child placement agency if applicable.
2. Required background checks are not on file
a. Administrative assistant sets a facility reminder alert in the electronic licensing system to check for results
b. Administrative assistant completes a follow up check within 7 business days
c. All required background checks are retuned and on file
d. Administrative assistant issues the license
e. Administrative assistant provides a copy of the license to the licensee and sponsoring child placement agency if applicable.
e. Licensee was found to be in non-compliance with the regulatory requirements, licensee is notified via notice of survey findings corrections are due within 5 calendar days
i. Survey Summary section II is completed in the electronic licensing system, noting areas of non-compliance identified
ii. Survey remains open for 5 calendar days
iii. A compliance action plan is received addressing areas of non-compliance within 5 days
1. Surveyor reviews the compliance action plan submitted verifying plan addresses violations cited.
2. Surveyor accepts or denies the compliance action plan
a. If accepted surveyor accepts compliance action plan, images compliance action plan and returns accepted copy to the licensee or CPA as appropriate and proceeds to step 3
b. If denied, surveyor returns Compliance Action Plan for corrections to the licensee or CPA as appropriate
3. All areas of non-compliance have been corrected and compliance action plan is completed
a. Surveyor completes Survey Summary and Recommendations Section III Corrections Received. No on-site compliance check is necessary. Licensure recommended
b. Survey completion date is entered and workflow is closed
c. Electronic Licensing System notifies administrative assistant survey is completed and administrative assistant completes step 2 d iv 1 and 2.
4. Areas of non-compliance are not corrected and compliance action plan target date exceeds 5 days.
a. Surveyor completes Survey Summary and Recommendations Section III Recommend ongoing compliance checks.
i. Survey completion date is entered and workflow closed
b. Surveyor will assign a compliance survey due the date of Completion on the Compliance Action Plan.
i. If the Compliance Action Plan was not completed by the target date, the licensee or sponsoring agency may submit an FCL Supplemental Form addressing the delayed completion, identify the continued regulatory non-compliance and establish a new completion date.
ii. The supplemental form shall be reviewed by the surveyor and either accepted or denied.
iii. The accepted or denied supplemental form shall be returned to the licensee or sponsoring agency and shall image the FCL Supplemental Form in facility images.
iv. If the supplemental plan is accepted, the compliance survey due date shall be updated to reflect the Compliance Action Plan due date.
v. If the FCL Supplemental Plan is denied, the compliance survey will be completed in accordance with step c.
c. Surveyor completes the compliance survey by completing Survey Summary Sections I and II.
i. The compliance survey may be completed by receiving corrections via emailed documents or pictures, or on-site confirmation. All received corrections, excluding protected health documents, fingerprints or other criminal

background checks, will be Imaged into CLARIS and labeled for clarity.
d. Compliance is found
i. Survey completion date is entered and workflow closed.
ii. Electronic Licensing System notifies administrative assistant survey is completed and completes step 2 d iv 1 and 2.
e. Licensee is not in compliance.
i. Survey Summary Section I and II are completed, not in compliance
ii. Survey completion date in entered and workflow closed
iii. A facility narrative is added noting what areas of non-compliance are unresolved.
iv. Surveyor shall email the regional supervisor the FCL 025 Recommendation for Enforcement
v. The FCL 025 Recommendation for Enforcement is uploaded to the facility images tab in the electronic licensing system.

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 resulted in the identification of non-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: KanCare Managed Care Organizations; Community Mental Health Centers	☐ **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):*
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 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 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: KanCare Managed Care Organizations; Community Mental Health Centers	☐ **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:	☐ **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):*
	☐ **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 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: KanCare Managed Care Organizations; Community Mental Health Centers	☐ **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:

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 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: KanCare MCOs; Community Mental Health Centers	☐ **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:

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

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**

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 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**

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

Performance Measure:
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:	☐ **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**
	☐ **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.

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-LTSS 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. KDADS utilizes the Adverse Incident Reporting System (AIR) to track all adverse/critical incidents.

DCF-Child Protective Services (CPS) and DCF-Adult Protective Services (APS) maintain data bases of all critical incidents and events. CPS and APS maintain data bases of all critical incidents and events and make available the contents of the data base to KDADS and KDHE through quarterly reporting.

KDADS and DCF-Child Protective Services (CPS) and DCF-Adult Protective Services (APS) meet on a quarterly basis to trend data, develop evidence-based decisions, and identify opportunities for provider improvement and/or training.

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

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; Community Mental Health Centers	☒ **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.

The Kansas Department of Health and Environment (KDHE), specifically the Division of Health Care Finance, operates as the single State Medicaid Agency, and the Kansas Department for Aging and Disability Services (KDADS) serve as the operating agency. The two agencies collaborate in developing operating agency priorities to meet established HCBS assurances and minimum standards of service.

The sample for the quarterly desk review is based off of waiver standards and is statistically significant. As part of one of the performance measures in this waiver, a survey is mailed to each individual on the quarterly sample. The survey includes questions regarding current services and the individuals/guardians experience with HCBS services and the waiver. Results of this survey, if returned to the State, are logged into our Quality Review Tracking system and made available to HCBS KDADS staff. If there are concerns relayed in the returned survey, HCBS Quality Management Staff, will send an alert to the Program Manager. This alert contains information documented on the survey, so the Program Manger can follow up accordingly.
KDADS has a continual quality review process for the HCBS Performance Measures. This cycle is completed on a quarterly basis, giving continuous feedback to appropriate staff and stakeholders. The KDADS HCBS Quality Management Staff are responsible for desk reviews, for the various Performance Measures located in the waiver. Participants are selected for review based off of a statistically significant sample, pulled by KDADS, according to standards in the waiver.
KDADS Quality Assurance Team reviews quarterly submissions from the contracted assessor to ensure accurate information is being obtained and the Level of Care assessments are being completed correctly within the appropriate timeframe. KDADS Quality Assurance Team reviews quarterly submissions from the Managed Care Organizations to ensure accuracy and appropriateness of the Person-Centered Service Plan, to ensure health and welfare of the waiver children, to ensure adequacy of qualified providers and to ensure financial accuracy in billing. A representative sample of HCBS Waiver individual's case files, to include National Core Indicators (NCI surveys), will be selected quarterly by KDADS Financial and Information Services Commission (FISC), and assigned to the appropriate KDADS Quality Management Specialist (QMS) for review. The selected cases will include both Primary (P) and Secondary (S) listing of cases. Record cases open for 30 days or less, from MMIS eligibility date, are considered a "non-review" and will not be reviewed by QMS. A secondary case will be substituted when the case is deemed a "non-review."

FISC will generate and provide a report regarding findings to the KDADS Program Manager to review and to remediate as necessary.

KDADS Program Evaluation staff collect data, aggregate it, analyze it and provide information regarding discrepancies and trends to Program staff, Quality Review staff, KDHE staff, MCOs and other management staff. If systemic issues are found, several different remediation strategies are utilized, depending upon the nature, scope and severity of the issues. Strategies include but are not limited to;
-assign remediation plans and/or Quality Improvement Plan(s)
-re-education of best practices
-training of the QR staff to ensure the protocols are utilized correctly
-protocol revisions to capture the appropriate data
-policy clarifications to MCOs to ensure adherence to policy
-Meet with MCO LTSS Directors
-Interagency collaboration with KDHE and DCF.
KDADS compiles a quarterly report containing data for all of the HCBS Performance Measures. Results of these reports are distributed and reviewed internally at KDADS and KDHE, in addition to being posted publicly on the KanCare website. Also submitted by KDHE in KanCare Special Terms and Conditions quarterly and annual reports. KDADS compiles a quarterly report containing data for all of the HCBS Performance Measures. Results of these reports are distributed and reviewed internally at KDADS and KDHE, in addition to being posted publicly on the KanCare website. Also submitted by KDHE in KanCare Special Terms and Conditions quarterly and annual reports.

ii. System Improvement Activities

Responsible Party*(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.

KDADS Quality Assurance Team reviews quarterly submissions from the contracted assessor to ensure accurate information is being obtained and the Level of Care assessments are being completed correctly within the appropriate timeframe. KDADS Quality Assurance Team reviews quarterly submissions from the Managed Care Organizations to ensure accuracy and appropriateness of the Person-Centered Service Plan, to ensure health and welfare of the waiver children, to ensure adequacy of qualified providers and to ensure financial accuracy in billing. A representative sample of HCBS Waiver individual's case files, to include National Core Indicators (NCI surveys), will be selected quarterly by KDADS Financial and Information Services Commission (FISC), and assigned to the appropriate KDADS Quality Management Specialist (QMS) for review. The selected cases will include both Primary (P) and Secondary (S) listing of cases. Record cases open for 30 days or less, from MMIS eligibility date, are considered a "non-review" and will not be reviewed by QMS. A secondary case will be substituted when the case is deemed a "non-review."

FISC will generate and provide a report regarding findings to the KDADS Program Manager to review and to remediate as necessary.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Data analysis is completed and remediated for any assurance or sub-assurance less than 87%. KDADS Quality and Program Coordinator 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 HCBS Director 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 Quality and Program Coordinator will continue to monitor through Quality Reviews to ensure compliance and recommend system improvements and/or next steps as needed.

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.

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.

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 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*** *Specify:* *KanCare MCOs participate in analysis of this measure's results as determined by the State Operating Agency*	☒ ***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:

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 reates 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:*	☒ ***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 established an interagency monitoring team to ensure effective interagency coordination as well as overall monitoring of MCO contract compliance. This work will be governed by the comprehensive state Quality Improvement Strategy for the KanCare program, a key component of which is the interagency monitoring team that 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 a state interagency monitoring team, which includes program managers, contract managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

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

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 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.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

Under the KanCare comprehensive managed care program, capitation rates are established consistent with federal regulation requirements, by actuarially sound methods, which take into account utilization, medical expenditures, program changes and other relevant environmental and financial factors. The capitated rates are developed by a State Contracted Actuary. The resulting rates are certified to and approved by CMS.

Under managed care, HCBS provider rates are determined through contracting with the MCO while the state sets actuarial sound capitation rates that are paid to the MCO for each waiver beneficiary. The state sets the floor for the minimum rates that are required to be paid by the MCO, however. For the SED Waiver, the State's floor rates are based on prior fee for service rates and are available through KMAP. Capitation rates are based on actuarial analysis of historical data for all SED 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.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

Claims for services are submitted to the MCOs directly from waiver provider agencies delivering SED waiver services. All claims are either submitted through the MMIS portal, the State's front end billing solution or directly to the MCO either submitted through paper claim format or through electronic format. Capitated payments in arrears are made only when the participant was eligible for the Medicaid waiver program during the month.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- ◉ ***No. state or local government agencies do not certify expenditures for waiver services.***
- ○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it

is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

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 to see if choice was provided and if the participant signed the Choice document. Additionally, participant interviews have been completed, inquiring if they were provided choice. During the interview of the participant QMS identifies if a provider choice form was presented to the family, asks how the provider choice was decided and if services were rendered according to those identified on the participant's Service Plan.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

- ○ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ○ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ○ ***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.

All of the waiver services in this program are included in the state's contract with the KanCare MCOs. The MCOs reimburse on claims provided. Providers are paid by the MCOs.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

◉ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*

○ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

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

○ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***

○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***

○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ○ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ◉ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

No. The monthly capitated payments to the MCOs are not reduced or returned in part to the state.

Appendix I: Financial Accountability

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:*

Per Appendix 1-2-a., Capitation rates are based on actuarial analysis of historical data for all SED program services. These rates are based on historical claims and carried forward for KanCare Managed Care. The MCO's are responsible for trending costs and demonstrating financial experience going forward. Based on the data collected, the MCO may request the State's review for cost adjustments.

Payments to providers for room and board are not processed through the Medicaid system and are therefore not included in any Medicaid cost reports.

Consistent with statute, the State contracts for a biennial rate study every other year. Although the vendor collects financial information regarding room and board, the information is excluded from any vendor recommendations regarding reimbursement rates.

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	*1699.00*	*13500.00*	*15199.00*	*33458.67*	*8541.33*	*42000.00*	*26801.00*
2	*1714.07*	*13500.00*	*15214.07*	*33458.67*	*8541.33*	*42000.00*	*26785.93*
3	*1726.30*	*13500.00*	*15226.30*	*33458.67*	*8541.33*	*42000.00*	*26773.70*
4	*1741.19*	*13500.00*	*15241.19*	*33458.67*	*8541.33*	*42000.00*	*26758.81*
5	*1753.00*	*13500.00*	*15253.00*	*33458.67*	*8541.33*	*42000.00*	*26747.00*

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	*4900*	*4900*
Year 2	*4900*	*4900*
Year 3	*4900*	*4900*
Year 4	*4900*	*4900*
Year 5	*4900*	*4900*

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The average length of stay estimate is derived from the unduplicated participants and the total days of actual waiver coverage from the CMS-372 reports for Waiver Years 1-3 prior to the COVID pandemic (04/01/2017-03/31/2020). Based on that analysis, the state used an estimated average of 245 for the upcoming Waiver period.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

Factor D was estimated by utilizing Managed Care encounter data from the Kansas Medicaid Information System and analyzing trends of annual utilization from April 2017 through March 2021. This will only be a projection of MCO encounters and not be reflective of the State's Capitation payments made to the MCO.

Service level assumptions include the following. The State assumed overall utilization would align with pre-COVID pandemic levels. The SED Waiver did experience overall decreases in participation and utilization during the COVID pandemic. Specifically, the State assumed Wraparound Facilitation, Short-Term Respite and Attendant care would all resume pre-COVID levels of utilization throughout the 5 years of the renewal periods.

For Attendant Care services: in light of the prolonged periods of isolation and increased mental health challenges resulting from the pandemic, the State anticipates a continued growth in the utilization of this service. The State also based estimates on the growing need for support services due to the increase in anxiety and depression rates nationwide that impact our community mental health centers that serve the SED waiver children. Attendant Care services offer essential one-on-one mental health support to address the specific needs of individuals affected in their homes and communities.

For Parent Support and Training services, the State assumed a 10% increase in participation and a slight increase in utilization per participant over the course of the 5-year period. This estimated increase is primarily related to the change in allowing tele video options for training.

For Professional Resource Family Care, the State assumed a participation level that was an average of the 3-year period prior to the pandemic.

For Independent Living/Skills Building, the State assumed an approximate 10% annual increase in participants of this service over the waiver period. This assumption is based on the change in the Waiver that will change the minimum age for this service from 17 to 14 years. The State estimates that 20% of the expanded age group will utilize this service and the end of the waiver period.

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. 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. 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	
Attendant Care	
Independent Living/Skills Building	

Waiver Services	
Short-Term Respite Care	
Parent Support and Training	
Professional Resource Family Care	
Wraparound Facilitation	

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
Attendant Care Total:							**978000.00**
Attendant Care	☒	15 minutes	2000	75.00	6.52	**978000.00**	
Independent Living/Skills Building Total:							**117423.00**
Independent Living/Skills Building	☒	1 hour	450	6.00	43.49	**117423.00**	
Short-Term Respite Care Total:							**4156500.00**
Short-Term Respite Care	☒	15 minutes	1500	425.00	6.52	**4156500.00**	
Parent Support and Training Total:							**831550.00**
Individual	☒	15 minutes	3000	25.00	10.87	**815250.00**	
Group	☒	15 minutes	200	25.00	3.26	**16300.00**	
Professional Resource Family							**67518.00**

GRAND TOTAL:		**8325991.00**
Total: Services included in capitation:		8325991.00
Total: Services not included in capitation:		
Total Estimated Unduplicated Participants:		**4900**
Factor D (Divide total by number of participants):		**1699.00**
Services included in capitation:		1699.00
Services not included in capitation:		
Average Length of Stay on the Waiver:	245	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Care Total:							
Professional Resource Family Care	☒	1 day	25	18.00	150.04	**67518.00**	
Wraparound Facilitation Total:							**2175000.00**
Wraparound Facilitation	☒	15 minutes	4000	25.00	21.75	**2175000.00**	

GRAND TOTAL:	**8325991.00**
Total: Services included in capitation:	8325991.00
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**4900**
Factor D (Divide total by number of participants):	**1699.00**
Services included in capitation:	1699.00
Services not included in capitation:	
Average Length of Stay on the Waiver:	245

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
Attendant Care Total:							**1017120.00**
Attendant Care	☒	15 minutes	2000	78.00	6.52	**1017120.00**	
Independent Living/Skills Building Total:							**130470.00**
Independent Living/Skills Building	☒	1 hour	500	6.00	43.49	**130470.00**	
Short-Term Respite Care Total:							**4156500.00**

GRAND TOTAL:	**8398946.75**
Total: Services included in capitation:	8398946.75
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**4900**
Factor D (Divide total by number of participants):	**1714.07**
Services included in capitation:	1714.07
Services not included in capitation:	
Average Length of Stay on the Waiver:	245

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Short-Term Respite Care	☒	15 minutes	1500	425.00	6.52	4156500.00	
Parent Support and Training Total:							852338.75
Individual	☒	15 minutes	3075	25.00	10.87	835631.25	
Group	☒	15 minutes	205	25.00	3.26	16707.50	
Professional Resource Family Care Total:							67518.00
Professional Resource Family Care	☒	1 day	25	18.00	150.04	67518.00	
Wraparound Facilitation Total:							2175000.00
Wraparound Facilitation	☒	15 minutes	4000	25.00	21.75	2175000.00	

GRAND TOTAL:	8398946.75
Total: Services included in capitation:	8398946.75
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	4900
Factor D (Divide total by number of participants):	1714.07
Services included in capitation:	1714.07
Services not included in capitation:	
Average Length of Stay on the Waiver:	245

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
Attendant Care Total:							**1043200.00**
Attendant Care	☒	15 minutes	2000	80.00	6.52	**1043200.00**	
Independent Living/Skills Building Total:							**143517.00**
Independent Living/Skills Building	☒	1 hour	550	6.00	43.49	**143517.00**	
Short-Term Respite Care Total:							**4156500.00**
Short-Term Respite Care	☒	15 minutes	1500	425.00	6.52	**4156500.00**	
Parent Support and Training Total:							**873127.50**
Individual	☒	15 minutes	3150	25.00	10.87	**856012.50**	
Group	☒	15 minutes	210	25.00	3.26	**17115.00**	
Professional Resource Family Care Total:							**67518.00**
Professional Resource Family Care	☒	1 day	25	18.00	150.04	**67518.00**	
Wraparound Facilitation Total:							**2175000.00**
Wraparound Facilitation	☒	15 minutes	4000	25.00	21.75	**2175000.00**	

GRAND TOTAL:		**8458862.50**
Total: Services included in capitation:		8458862.50
Total: Services not included in capitation:		
Total Estimated Unduplicated Participants:		**4900**
Factor D (Divide total by number of participants):		**1726.30**
Services included in capitation:		1726.30
Services not included in capitation:		
Average Length of Stay on the Waiver:	245	

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*
Attendant Care Total:							***1082320.00***
Attendant Care	☒	*15 minutes*	*2000*	*83.00*	*6.52*	***1082320.00***	
Independent Living/Skills Building Total:							***156564.00***
Independent Living/Skills Building	☒	*1 hour*	*600*	*6.00*	*43.49*	***156564.00***	
Short-Term Respite Care Total:							***4156500.00***
Short-Term Respite Care	☒	*15 minutes*	*1500*	*425.00*	*6.52*	***4156500.00***	
Parent Support and Training Total:							***893916.25***
Individual	☒	*15 minutes*	*3225*	*25.00*	*10.87*	***876393.75***	
Group	☒	*15 minutes*	*215*	*25.00*	*3.26*	***17522.50***	
Professional Resource Family Care Total:							***67518.00***
Professional Resource Family Care	☒	*1 day*	*25*	*18.00*	*150.04*	***67518.00***	
Wraparound Facilitation Total:							***2175000.00***
Wraparound Facilitation	☒	*15 minutes*	*4000*	*25.00*	*21.75*	***2175000.00***	

GRAND TOTAL:	***8531818.25***
Total: Services included in capitation:	*8531818.25*
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	***4900***
Factor D (Divide total by number of participants):	***1741.19***
Services included in capitation:	*1741.19*
Services not included in capitation:	
Average Length of Stay on the Waiver:	*245*

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
Attendant Care Total:							**1108400.00**
Attendant Care	☒	15 minutes	2000	85.00	6.52	**1108400.00**	
Independent Living/Skills Building Total:							**169611.00**
Independent Living/Skills Building	☒	1 hour	650	6.00	43.49	**169611.00**	
Short-Term Respite Care Total:							**4156500.00**
Short-Term Respite Care	☒	15 minutes	1500	425.00	6.52	**4156500.00**	
Parent Support and Training Total:							**914705.00**
Individual	☒	15 minutes	3300	25.00	10.87	**896775.00**	
Group	☒	15 minutes	220	25.00	3.26	**17930.00**	
Professional Resource Family Care Total:							**67518.00**
Professional Resource Family Care	☒	1 day	25	18.00	150.04	**67518.00**	
Wraparound Facilitation Total:							**2175000.00**
Wraparound Facilitation	☒	15 minutes	4000	25.00	21.75	**2175000.00**	

GRAND TOTAL:	**8591734.00**
Total: Services included in capitation:	8591734.00
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**4900**
Factor D (Divide total by number of participants):	**1753.00**
Services included in capitation:	1753.00
Services not included in capitation:	
Average Length of Stay on the Waiver:	245