# Kansas - HCBS Corrective Action Plan

| Authority | CMS Identified Issue | Requirements to demonstrate compliance | State Deliverables |
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| Administrative Authority (AA) Assurance:<br>The State Medicaid Agency (SMA) 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.<br><br>Regulation:<br>42 CFR § 431.10(b) | AA1. The state's quality improvement strategy for Appendix A within its 1915(c) waivers, does not provide sufficient information about the SMA's supervision of the waiver administrative functions that have been delegated to other entities.<br><br>AA2. The current performance measures in Appendix A, do not adequately capture pertinent data regarding the state's oversight activities to fully demonstrate that it establishes and/or approves policies that affect the delegated functions, including oversight of managed care organizations (MCO) serving HCBS participants. | The state must demonstrate that its internal process, related policy, and performance measures/activities assure ultimate administrative authority oversight over all of its 1915 (c) waivers. This includes demonstrating comprehensive administrative authority over all delegated functions, including operating agencies, its MCOs and all other contracted entities specific to each waiver.<br><br>The state must report AA data annually via the CMS-372 report when deficiencies in meeting the 86% compliance level are identified. Additional 372 information is available at: https://wms-mmdl.cms.gov/WMS/help/372/Sample372ReportEmailNotification.pdf | The state must submit a draft Appendix A with quantifiable performance measures to CMS outlining how the SMA oversees the functions it has delegated to various entities, such as contractors and/or operating agencies. This should include:<br>1. The establishment of a viable data source, from which information will be collected, analyzed, aggregated and reported to CMS on an annual basis within its CMS-372 reports.<br>2. Documentation demonstrating state policies and procedures outlining Kansas' administrative oversight of all operating agencies, contractors-including its MCOs.<br>3. Revised sections A.2, A.3 and A.6 in Appendix A.<br><br>Once the CMS has reviewed the state's policy and procedure documentation and verified that the draft Appendix A submission includes appropriate criteria to demonstrate the assurance, the state will amend its 1915(c) waivers to replace its current measures for Appendix A.<br><br>This CAP action will be closed upon approval of the state's 1915(c) amendment incorporating the updated Appendix A and the submission of one full year of 372 data |

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| Level of Care (LOC): 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 waiver eligibility consistent with care provided in a hospital, NF, or ICF/ID-DD | LOC 1. The state has been unable to demonstrate that it has an established a process to adequately evaluate and reevaluate LOC.<br><br>LOC 2. The state has not demonstrated it has an effective process to collect, aggregate and report adequately, ultimately failing to meet the 86% compliance threshold consistently for LOC performance measures.<br><br>LOC 3. The state has failed to meet the 86% compliance threshold for LOC in its 372 reports for the past two cycles. The 372 reports have not provided quality data for the required time period (the entire most recently completed waiver year).<br><br>LOC 4. The state has been using a non-governmental entity to conduct LOC reevaluations for the SED Waiver (see 42 CFR § 431.10(c)(2) and 441.302(c)(2).<br><br>LOC 5. The state's Autism and SED Waivers serve children under the age of 6, but do not have any institutional settings as alternative placement for these children, should the family choose such placement. Additionally, the state has not been able to make accurate estimates for Factors G and G' for these waivers due to the lack of comparable institutional setting for this population. | The state must ensure the LOC evaluations and reevaluations are completed by the SMA or a SMA-delegated government agency for all waivers.<br><br>The state must demonstrate that it has effective policies and procedures to assure it evaluates and reevaluates LOC consistent with required timelines.<br><br>The state must report LOC data annually via the CMS-372 report when deficiencies in meeting the 86% compliance level are identified.<br><br>The state must identify a state which has institutional settings that serve children under the age of 6 that would be eligible for the SED or Autism waivers but have elected institutional placement. | 1. *If the state elects to delegate this function, it must provide a written agreement /contract, outlining roles and responsibilities of the responsible government agency.<br><br>2. The state must submit a draft Appendix B with quantifiable performance measures to CMS, outlining the level of care evaluation and reevaluation process. The draft must contain policies and procedures, documenting how the state timely secures data from the SMA-delegated government agency, along with a deliverables schedule from the SMA-delegated agency demonstrating that the SMA and its operating agency will successfully procure the information and how it will be analyzed, aggregated and reported to CMS.<br><br>3. Any relevant existing policy and procedure documents must be submitted to CMS within an agreed upon timeline. Newly created policy and procedure documents will be considered deliverables for this CAP and delivered to CMS following the agreed upon timelines.<br><br>Once the CMS has reviewed the state's policy and procedure documentation and verified that the draft Appendix B submission includes appropriate criteria to demonstrate the assurance, the state will amend its 1915(c) waivers to replace its current measures for Appendix B.<br><br>This CAP action will be closed upon approval of the state's 1915(c) amendments incorporating the updated Appendices B and J, and the submission of one full year |

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| | | | of 372 data.<br><br>*The state should consider the Conflict of Interest regulation when delegating this function.<br><br>4. The state must develop a MOU or other agreement with an out of state partnering Medicaid agency for the placement of individuals under the age of 6 electing placement in an institution.<br><br>5. The state must use the institutional costs of the out-of-state setting to recalculate Factors G and G' for the SED and Autism waivers, and submit an amendment to CMS with updated estimates in Appendix J. |

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| 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. | QP 1. The state has been unable to demonstrate that it has an adequate system in place to ensure all providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.<br><br>QP 2. The state has failed to meet the 86% compliance threshold for Qualified Providers in its 372 reports for the past two cycles. The 372 reports have not provided quality data for the required time period (the entire most recently completed waiver year). | The state must provide information on the process that it utilizes to assess whether its providers meet its required licensure and/or certification standards and/or adhere to other standards prior to their furnishing waiver services.<br><br>The state must report qualified provider data annually via the CMS-372 report when deficiencies in meeting the 86% compliance level are identified. | The state must provide the following:<br>1. Operating procedures that outline steps the state will take to ensure initial and on-going provider compliance with qualification criteria.<br><br>2. Its policies along with monitoring/oversight activities that will be conducted to ensure that only qualified providers receive reimbursement and FFP for providing HCBS services.<br><br>Once the CMS has reviewed the state's policy and procedure documentation and verified that the draft Appendix C submission includes appropriate criteria to demonstrate the assurance, the state will amend its 1915(c) waivers to replace its current measures for Appendix C.<br><br>This CAP action will be closed upon approval of the state's 1915(c) amendment incorporating the updated Appendix information and the submission of one full year of 372 data. |

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| Service Plan: The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for the waiver participants. | SP 1. The state has been unable to demonstrate that it has an adequate system in place to monitor service plan development and annual review in accordance with its policies and procedures.<br><br>SP 2. The state has failed to meet the 86% compliance threshold for Service Plans in its 372 reports for the past two cycles. The 372 reports have not provided quality data for the required time period (the entire most recently completed waiver year). | The state must demonstrate its process to validate that the services received by waiver members are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the plan.<br><br>The state must service plan data annually via the CMS-372 report when deficiencies in meeting the 86% compliance level are identified. | The state must submit:<br>1. Its methods for monitoring activities and the MCO's protocols to ensure that services are received in accordance to the service plan.<br>2. Evidence that services are being provided at the appropriate type, amount, scope, frequency and duration outlined in the service plan.<br>3. Data that service plans accurately reflect the needs of waiver participants.<br>4. New quantifiable performance measures that accurately assess whether all services plans contain the appropriate signatures. |
| Person-Centered Planning Process:<br>42 C.F.R § 441.301(c)(2) | SP 3 (PCP). The state has been unable to demonstrate that the process to develop care plans is person-centered, and that these plans have been agreed to by individuals or their representatives, as well as all individuals and providers who must implement the plan.<br><br>SP 4 (PCP). The state failed to meet the 86% compliance threshold consistently for Service Plan performance measures due to a failure to obtain informed consent of waiver participants and other relevant parties in writing. | The state must ensure that services within the person-centered plan are finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation. | Once the CMS has reviewed the state's requested documentation and verified that the draft Appendix D submission includes appropriate criteria to demonstrate the assurance, the state will amend its 1915(c) waivers to replace its current measures for Appendix D.<br><br>This CAP action will be closed upon approval of the state's 1915(c) amendment incorporating the updated Appendix D and the submission of one full year of 372 data. |

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| Health and Welfare: The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. | H&W 1. The state has been unable to demonstrate that it has an adequate system in place to assure participant health and welfare.<br><br>H&W2. The state has failed to meet the 86% compliance threshold for Health & Welfare in its 372 reports for the past two cycles. The 372 reports have not provided quality data for the required time period (the entire most recently completed waiver year). | The state must demonstrate it has designed and implemented an effective system for assuring waiver participant health and welfare that includes an ability to provide oversight of the full health & welfare critical incident system.<br><br>The state must report health & welfare data, including remediation efforts, annually via the CMS-372 report. | The state is required to develop and submit to CMS:<br>1. Its policy to identify, investigate, and resolve incidents of abuse, neglect, exploitation, and unexpected deaths that are substantiated. The state must develop and implement a strategy designed to prevent the same type or similar incidents from occurring in the future.<br>2. Its process to identify, track investigate, and remediate A/N/E incidents.<br><br>Once the CMS policy review is completed, including any identified technical assistance work, the state will submit amendments to its Appendix G to document the changes.<br><br>This CAP action will be closed upon approval of the state's waiver amendment submissions and the submission of one full year of 372 data. |

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| Financial Accountability: The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. | FA 1. The state has been unable to demonstrate that it has an adequate system in place to ensure financial accountability of payments for waiver services.<br><br>FA 2. In order to resolve the state's legacy CAP (implemented in 2017), the state was required to document that it had met the required 86% compliance threshold for the assurance via ongoing KanCare 1115 quarterly reporting, and update and implement processes to improve the collection and reporting of financial data on annual 372 reports. To date the state has not been able to demonstrate the assurance. (Note: the state is transitioning from 1115 authority to 1915(b) for managed care effective January 1, 2024, and quarterly reporting will no longer be submitted.) | The 372 Guidance Requires the state to report financial/utilization information annually. https://wms-mmdl.cms.gov/WMS/help/372/Sample372ReportEmailNotification.pdf<br><br>The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. | The state must submit information regarding:<br>1. The monitoring activities it conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits.<br>2. Its process to collect, aggregate and analyze and report data regarding its financial accountability process, as required in the annual 372 Reports for each waiver.<br><br>Once the CMS SMEs have reviewed the state's policy and procedure documentation and verified that the draft Appendix I submission includes appropriate criteria to demonstrate the assurance, the state will amend its 1915(c) waivers to replace its current measures for Appendix I.<br><br>This CAP action will be closed upon approval of the state's 1915(c) amendments incorporating the updated Appendix I and the submission of one full year of 372 data |

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| **Provider Network Adequacy:**<br>**42 CFR 438.206 (b) Delivery network**<br>**42 CFR 438.207(d) Assurance of adequate capacity and services.**<br><br>After the state reviews the documentation submitted by the MCO, PIHP, or PAHP, the state must submit an assurance of compliance to CMS that the MCO, PIHP, or PAHP meets the state's requirements for availability of services, as set forth in § 438.68 and § 438.206. | The state has been unable to demonstrate adequate oversight over the MCO requirement to maintain network adequacy. | The state must establish a mechanism to ensure that that MCOs comply with network adequacy standards. | The state must submit the following within a timeframe agreed upon with CMS:<br><br>1. The standards it utilizes to determine whether participating providers are geographically accessible to plan enrollees.<br><br>2. An outline of the methods it utilizes to ensure that network adequacy is consistently maintained according to state established standards.<br><br>This CAP action will be closed once the information requested above has been submitted and deemed acceptable by CMS. |

| Timelines | | |
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| **Objective** | **Anticipated Begin Date** | **Anticipated Completion Date** |
| Objective 1 Administrative Authority | | |
| Objective 2 Level of Care (LOC) | | |

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| Objective 3 Qualified Providers | | |
| Objective 4 Service Plan | | |
| Objective 4a Person-Centered Planning Process | | |
| Objective 5 Health and Welfare | | |
| Objective 6 Financial Accountability | | |
| Objective 7 Provider Network Adequacy | | |