Kansas
Department for Aging and Disability Services

KDADS LTSS PUBLIC COMMENT MATRIX

Comment Period: 1/24/2024 - 2/23/2024 Program: Home and Community-Based Services

BRIEF DESCRIPTION OF DOCUMENT SUBMITTED FOR PUBLIC COMMENT AND COMMENT SUMMARY

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#	SENDER	PUBLIC COMMENT	KDADS RESPONSE
1.	Jeannette Livingston Sedgwick County Developmental Disability Organization	Under C. Providers unable to comply with Settings Final Rule, #2. Should also notify CDDO (if an IDD client). Under 4. Providers work to develop a Transition Plan, item b) Targeted Case Managers should be moved into the first group developing the transition plan. The way it's worded now makes it sound like they may or may not be part of the process.	Thank you for your comment. Language has been updated to read: "2. For settings found non-compliant through the KDADS HCBS Compliance Portal and other ongoing monitoring activities, the HCBS Compliance Unit shall notify the provider and MCO to begin transition proceedings. CDDOs shall be notified when proceedings involve an IDD waiver participant. 4.Providers shall work with their MCOs and person-centered planning team members to develop a Transition Plan for HCBS participants impacted by transition proceedings. The CDDO shall be notified when proceedings involve an IDD waiver participant. b. The Transition Plan shall be the cumulative effort of the provider, the MCOs, the person-served, the natural and professional supports, TCMs (where applicable), and KDADS. This can include feedback from CDDOs, the KanCare Ombudsman, the MCO Care Coordinator, State Licensing, Quality Review staff, family, community members, and all other forms of natural support.
2.	Jeannette Livingston Sedgwick County Developmental Disability Organization	Under section C providers unable to comply with settings final rule, item 5: this reads as though the provider will not be paid as of date of noncompliance even though the expectation is to serve the person for 90 more days. This could result in providers giving folks the boot immediately upon noncompliance determination.	Thank you for your comment. The purpose of this 90-day transition is to allow a provider to continue billing for services rendered as the complete a successful transition process. If transition is unsuccessful, recoupment of funds could be backdated to the beginning of the 90-day transition period. Language has been updated to read: "5. Providers who are determined to be noncompliant by KDADS with the requirements outlined in Section II.C.1-4 of this policy may be at risk to have HCBS payments for participants in that setting paused or recouped back to the date of the transition notification if it fails to engage with KDADS and other necessary entities. Providers shall be reimbursed for services during the 90 – Day transition period while engaging with KDADS and other appropriate entities to support transition plan proceedings."
3.	Amy Hyten Topeka Independent Living Resource Center	The policy is incredibly insular to a process between KDADS and the managed care insurance providers contracted to provide	

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		benefit payment and coverage for Home and Community Based Waiver beneficiaries. Referrals to community agencies as required under Section Q of the Minimum Data Set are not mentioned anywhere in the policy. The only community-based entities specifically referred to in the policy, the ADRCs and CDDOs, assess beneficiary eligibility. Notwithstanding the policy's application to "Home and Community Based Services Providers", there is not a single provision in the policy that outlines what the role of such providers should or even could be in the process. As the policy does not outline a baseline for how such providers could be included in the transition policy, it allows the Managed Care Organizations (MCOs) and facilities to refuse to make referrals as required under the MDS Section Q, which has meant that some of the MCOs do not utilize community providers to support people making transitions. Having a contact in the community is critical for people experiencing the isolation of institutionalization to successfully transition into the community. Communication such as Notices of Action do not have context or meaning beyond the professionals involved in administering the state's Medicaid health insurance. People need assistance with using appeals processes. Some people need help working with a guardianship to remove barriers or set up services; neither the state or managed care organizations help people address guardian and guardianship issues. If the only point of access someone has is the employee of an insurance company that relies on contracts with the state, they do not have meaningful access to appeals processes or assistance when advocacy is necessary to support a transition.	Section II C.4.b. reads The Transition Plan shall be the cumulative effort of the provider, the MCOs, the person-served, the natural and professional supports, and KDADS. This can include feedback from Targeted Case Managers (where applicable), CDDOs, the KanCare Ombudsman, the MCO Care Coordinator, State Licensing, Quality Review staff, family, community members, and all other forms of natural support. Potential providers, current providers, MCOs, and natural support network have the obligation of ensuring the health and well being of the individual and getting them the adequate services that they need. We will further define "natural supports" in the language. New language includes the following: "Natural supports mean personal associations and relationships typically developed in the community that enhance the quality and security of life for people. They can include family members, neighbors, teachers, church members, co-workers, friends, housemates, classmates, club members, etc." *The policy states the following: "*Confirmation if the individual has been provided a referral to the Center for Independent Living (current location or discharging location depending on need), or if the offer to refer has been declined by the participant; document reason for refusal."

Commented [TS[1]: Leigh, please review policy to review language about "natural supports" to further define what that entails. Add language from policy and our amended language here.

Commented [TS[2R1]: Please address following para. as well.

Commented [L[3R1]: Please see proposed highlighted language.

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		Specific comments and questions: Section I. Policy C.2. If IMDs are being included as institutional settings, would the PASAAR be a potential source of referrals for transition that should be included under the policy? C.5. What does it mean that transitions from PRTFs "will not be based on supervisory needs"? Section II Procedures A.2.b. The definition of "institutional setting" from Section I.C.1. does not make a distinction for "Skilled nursing" placement in a nursing facility. Without making that distinction a person who goes from hospital to a SNF bed in a facility gets to start counting their 60 days from the date of hospital discharge. While we absolutely endorse this, as it may mean the difference between a person who is able to retain housing if their institutional stay is shorter, it is a change from previous policies. A.3. Comments above about limiting the service to only waiver-eligible people may exclude people who could transition out of institutional settings but who need a level of support that is not the full waiver menu of services to make the move. The language would be more clear if it read, "Meet the applicable HCBS waiver program eligibility criteria, if they are transitioning to a waiver." B.1.a.viii. Home and Community Based waiver services are non-medical supports based on functional need, not diagnosis. The specific language from Kansas' approved PD waiver defines the requirement for eligibility for the program as participants who "have a documented physical disability as determined by the Social Security Disability Administration". The requirement for evidence through medical documentation of diagnosis is a deviation from the waiver language and should be amended to reflect the waiver requirements.	The PASRR could potentially notate if the person was interested in returning to the community. They may also do so via IMD staff, as a self referral or as a referral from other members of their support team. C.5: We will remove the language that says it will not be based on supervisory needs. Per Section 1.C.1, Hospitals are considered an institutional facility, so the facility starts counting their 60 days from the date of the hospital admission. A.3. While there are a variety of ways an individual could transition out of a facility, they would have to transition onto an active waiver to be considered an Institutional Transition via the KDADS Institutional Transition process.

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		B.1.a.ix. Treating medical professionals are not generally familiar with the functional needs of their specific clients. As with the previous section, language from the approved waiver should be used rather than placing additional burdens on people leaving institutional settings. To the extent these determinations are in addition to the determinations necessary to establish eligibility for institutional long term care they are a potential Olmstead violation. B.4.a. A timeline is necessary to include for providing a notice of action denying people their right to leave institutions as part of a formal transition. The state should also include language that commits to the use of plain language in providing communication with beneficiaries, particularly as people's rights are implicated. Previous comments about the systemic inadequacy in expecting institutionalized people to navigate appeals processes without support also apply here. C.1.a. Typographical error: Providers	B.1.a.viii.: We will compare waiver language for each waiver and update as appropriate. i. Proposed language: "Evidence for programmatic eligibility which can include medical condition(s), Social Security Administration disability determination and/or age as appropriate per waiver. ii. Evidence as to how the eligibility criteria relates to needed supports in the community via waiver services. (a) Recent medical records or an attestation form from a treating physician to verify a current need relevant to the requested waiver may be required when applicable.

Commented [TS[4]: Leigh will review.

Commented [L[5R4]: See proposed highlighted language

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			B.1.a.ix.: We will compare waiver language for each waiver and update as appropriate.
			B.4.a.: We will review the NOA appeal rights.
			C.1.a.: Thank you for your comment. We have updated this.
4.	Nichole Hall, CDDO of Butler County	II Procedures – the enumeration appears to be messed up in this section there are two number 2's • II.B.2 (top of page 6) – the CDDO needs to be notified as well as the MCO • II.B.4 – is the Transition Plan a new/formal document?	II Procedures: This has been updated. II.B.2.: The CDDO is notified when the MCO requests eligibility from them. II.B.4: It is an informal process. We have updated language to further clarify.
5.	Kylee Childs, LeadingAge Kansas	LeadingAge Kansas is the state association for not-for-profit and other mission-focused aging services. We have 150 member organizations across Kansas, which include over 100 not-for-profit nursing home providers, and 50 assisted living providers. Our full membership serves more than 25,000 older Kansans each day and employs more than 20,000 people across the state. While we agree with the concept of allowing individuals to transition to the least restrictive setting possible, we have	

Commented [TS[6]: Leigh will verify that this aligns with review of comment response above.

Commented [L[7R6]: Review above.

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		concerns the Final Settings Rule will result in fewer HCBS/FE compliant providers – thereby limiting settings options. This policy will require more administrative effort on part of our nursing home providers, defined as institutional facilities, and assisted living providers who choose not to participate in the HCBS program any longer as they work with MCOs to attempt to identify alternative settings that can still accommodate the needs of the resident. Providers having to provide 180 days, or a 6 month notice to residents on the decision to terminate waiver services is unreasonable. Additionally, the expectation for the notice to be sent to residents in an assisted living through certified mail does nothing but require extra administrative cost and burden. The additional administrative burden associated with the Final Settings Rule outlined in the Transition Policy and the Ongoing Monitoring Policy does not ensure quality care, will result in fewer providers accepting HCBS, and lead to disparities in cares for aging Kansans.	Thank you for your comments. KDADS will consider this feedback in planning of Final Rule compliance requirements by providers.
6.	Melinda Alleyne, Sedgwick County CDDO	I don't know why a person who was in a PRTF for over a year, was discharged and sent to a hospital for less than 2 days due to an emergency and then sent home after less than 48 hours not only did not qualify for a transitional transfer off the waiting list onto the I/DD waiver, but ALSO lost his place on the waiting list and had to start waiting all over again. This policy needs fixing. My client was and continues to be seriously harmed by that policy.	If you have questions about a specific case, you are encouraged to reach out to us at kdads.hcbs-ks@ks.gov.
7.	Deonne Wilson, RCIL	RCIL recommends that a streamlined, expediated coding process be developed and implemented for individuals that are returning to the community. Significant delays in communication and KDHE/KMMS coding updates are a barrier to accessing the HCBS that supports their successful transition.	Thank you for your comment.
8.	InterHAB	The section on Non-Compliant Setting Transitions is very brief and references a process for determining non-compliant settings	Thank you for the comment.

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	InterHAB *(continued)*	that has been cumbersome and drawn out for many years. It is not clear that KDADS staff know what a non-compliant setting is and their interpretations have been inconsistent over the course of the HCBS Final Rule self-assessment process. The passage in this draft policy which states that "Affected HCBS participants shall be entitled to and receive advance notification of findings of non-compliant settings to avoid gaps in service delivery" is inadequate to ensure that the due process rights of waiver participants are respected and that they will be well informed of their rights to access grievances and appeals processes. KDADS seems poised to begin denying services through the MCO's prior authorization functions without taking responsibility to ensure that the participants needs for health and safety will continue to be met and that they are transitioned to a service or service array that fits with their individualized assessed needs and interests. CMS' Instructions, Technical Guide and Review Criteria for 1915c waivers and State Medicaid Director letters address service reductions that are a result of a waiver renewal. A transition plan must accompany a waiver application whenever individuals who participate in an approved waiver might be adversely affected when a renewal or amendment includes certain types of changes in the approved waiver. A transition plan must accompany the waiver amendment when the renewal or amendment would eliminate or limit any of the services that are furnished under the approved waiver or that result in reduced services to participants. For every affected	The implementation of Final Rule across the nation has been a learning experience for all levels of government. The assessment checkpoints have changed over the years as KDADS worked with contractors to provide supports and CMS gave further guidance on proper interpretation of the federal regulations. The determination of compliance or noncompliance is based off federal regulation requirements of CFR 441.301 in relation to the person-centered planning process, and the Home and Community Based Settings qualities, including residential settings that are provider owned or controlled. A non-compliant setting is one that is unable to verify any qualities as required by CFR 441.301. This policy in conjunction with the determination process for Non-Compliance provides waiver recipients with appropriate information to make an informed decision on how they wish to continue receiving services. The timeline identified in this policy is designed to allow the waiver participant adequate time to evaluate their options which include exploring other community supports, touring final rule compliant settings, or securing other means of funding sources to remain with the current non-compliant provider. The individual can work with their support team to make an informed decision on how they wish to proceed and where they would like to live. The allotted time frame for transition outlined in this policy ensures the health and welfare of individuals in a non-compliant setting. Thank you for your comment. As we continue reviewing unbundling of services, we will ensure the health and wellbeing of individuals served.

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		participant, KDADS must provide an assurance and methodology demonstrating how individuals currently served by the waiver will not be adversely affected by the proposed amendment.	
	InterHAB *(continued)* InterHAB *(continued)*	KDADS must provide an assurance that the IDD waiver program will have sufficient service capacity to serve at least the number of current participants enrolled in the waiver as of the effective date of the amendment. Based on multiple reports and complaints across the system and testimony from KDADS to State Legislative Budget committees, it does not seem that KDADS has enough dollars in services like Assistive Technology and Supported Employment to even serve the current estimated number of participants in the Cost Neutrality estimates for the IDD waiver. Without an adequate budget for these services and a new service array to support community inclusion, there are no services to transition participants to if they have their current habilitation services disrupted.	Thank you for your comment.
		KDADS should describe a plan and train TCMs, CDDOs, and CSPs about what happens if implementation of these policies results in some services in the currently approved waiver becoming unavailable through the new or renewed/amended waiver or will be available in lesser amounts, that describes how the health and welfare of persons who receive the services that are terminated will be assured. And when the renewed/amended waiver includes limitations on the amount of waiver services that were not included in the approved waiver, how the limitations will be implemented.	The goal of this plan is to provide person-centered services based off individual need. The intent is not to remove any form of service but to unbundle services to better serve the individual's needs.
		In this plan, if some persons served in the approved waiver will not be eligible to participate in the new or renewed/amended waiver, describe the steps that the state will take to facilitate the transition of affected individuals to alternate services and supports. KDADS should also articulate a clear timetable for transitioning all affected individuals to the renewed/amended waiver. Verbal notices from MCO prior authorization staff are not adequate and violate due process protections for participants.	Thank you for your comment. We will take this into consideration for further review.

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9.	CDDO	II Procedures – the enumeration appears to be messed up in this section there are two number 2's • II.C.2 (top of page 6) – the CDDO needs to be notified as well as the MCO • II.C.4 – is the Transition Plan a new/formal document? Recommend to clarify language on provider choice/options counseling processes that are protected in CDDO Contract and DDRA/State Regulation for the IDD Waiver that activity can only be performed by CDDOs – the language is somewhat confusing in the policy. The MCO will have to partner with the CDDO on that task as it relates to transition and selection of IDD provider(s). • Pg 5 C(1)(a): Provides (should say providers…..We recently sent 2 certified letters and never received the signed forms, after following up with USPS they said the certified letter tracking won't follow/track if someone forwards an address.) Would it make more sense to simply request they must put it in writing and send to person supported and/or guardian…etc	II Procedures - has been updated. We will review capitalization and word to ensure correct intent is communicated. Language will be amended to read: "IIB2e Once functional eligibility is determined, and options counseling is completed **by the CDDO**, the CDDO shall inform the MCO via email evidence of the functional assessment and the options counseling." Pg. 5 C(1)(a):We have amended language to read "providers." Thank you for your comment. Certified mail is the minimum requirement; however, providers can notify individuals served in any additional methods they prefer. Pg. 6 4(d): The language has been updated to read "non-compliant provider" in the policy.

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		• Pg 6 4(d) If the individual or guardian have the option to continue services from the current non-compliant provider…	